MULTI-SECTOR NEEDS ASSESSMENT (MSNA)

KAKUMA REFUGEE CAMP | TURKANA COUNTY, KENYA

OCTOBER 2022

CONTEXT

As of October 2022, a total of 193,776 refugees and asylum seekers, mostly South Sudanese, resided in Kakuma refugee camps. Humanitarian needs remain high in the four camps (Kakuma 1, 2, 3 and 4). Continued conflict and instability in South Sudan, in addition to climatic shocks resulting in extraordinary flooding and localized drought, have resulted in large-scale cross-border displacement. This, coupled with reduced humanitarian funding, increases the need to strengthen available information on humanitarian needs and access to assistance and services in the camps. Such information is needed to support evidence-based planning of the immediate refugee response and further inform the development of longer-term response strategies, such as the government-led Comprehensive Refugee Response Framework (CRRF) annual plans and county-level development plans.

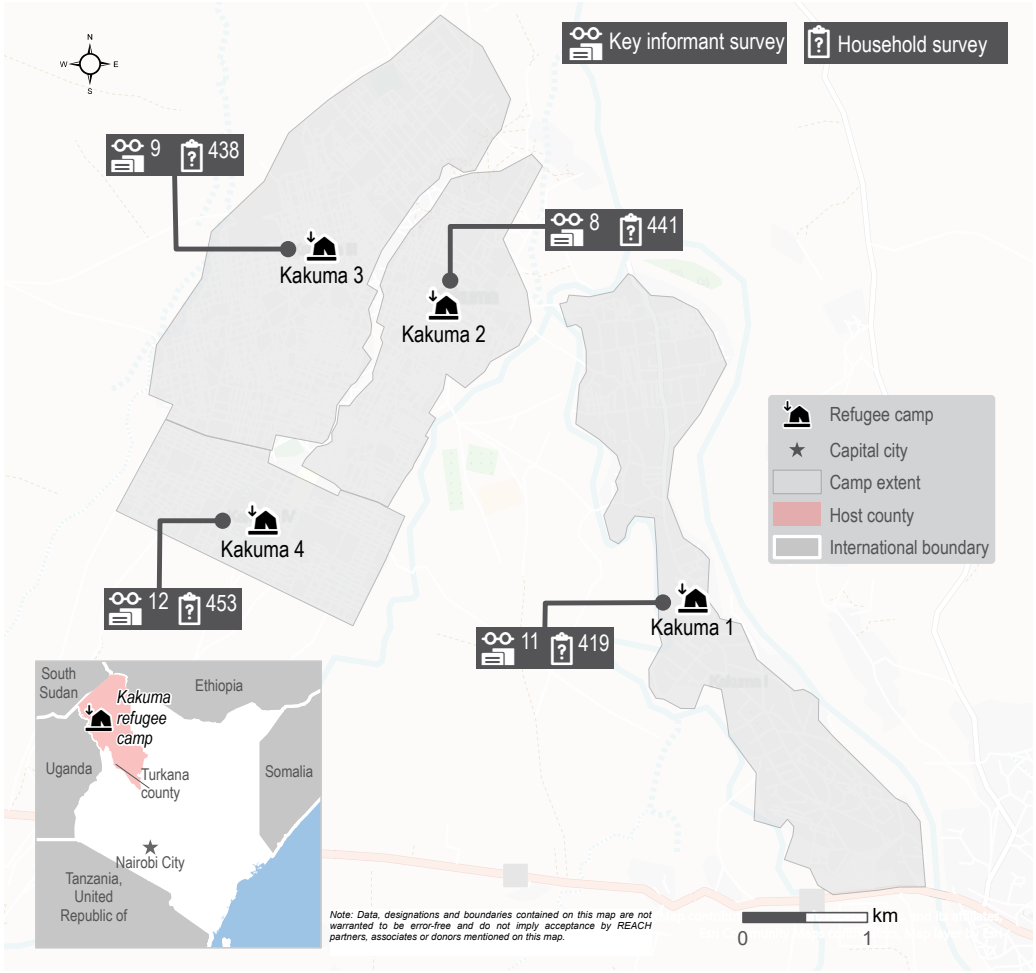
This situation overview presents findings of a Multi-Sector Needs Assessment (MSNA) conducted in October 2022 across the four Kakuma camps by REACH Initiative in close collaboration with the Norwegian Refugee Council (NRC). A similar round of MSNA was conducted in October 2020. It provides an analysis of needs across the following sectors; education, protection, livelihoods and food security, health and nutrition, water, sanitation and hygiene (WASH), and provides a trend analysis of some key indicators over the period from October 2020 to October 2022.

METHODOLOGY

REACH conducted the assessment through household (HH) level interviews and key informant interviews (KIIs). A total of 1,751 HH level interviews and 38 KIIs with leaders of various groups in the four camps, were conducted between 11 and 21 October 2022. (See table 1 and table 2 for HH and KI interviews breakdown).

The sample for HHs interviews was selected through probability random sampling at individual camp level to fulfill a 95% confidence level and 5% margin of error and was calculated based on the HH population of each camp.

LOCATION OF DATA COLLECTION



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REACH Informing more effective humanitarian action

The confidence level is guaranteed for all questions that apply to the entire surveyed population of each camp. Findings relating to a subset of the surveyed population may have a wider margin of error and a lower confidence level.

The data was weighted during analysis to account for lack of proportionality for individual camp samples. The data was aggregated at the overall Kakuma camp level to fulfill a 95% confidence level and 5% margin of error.

To ensure randomness in the sampling approach, random GPS points were generated using ESRI's ArcMap in the residential areas, which are clearly divided into blocks. Enumerators accessed the random GPS points from their android phones using MAPinr, and they interviewed HHs that fell on particular points. In case there was no person to interview in the selected HH, or the respondent was unwilling to participate, enumerators targeted the nearest HH in a radius of 5 meters. If there was still no HH to interview, then they interviewed the HH that fell on the next point. This situation overview represents findings from the October 2022 MSNA, unless otherwise specified. More information about the methodology used for this assessment is found in the terms of reference.

Table 1: HHs sample

	Kakuma 1	Kakuma 2	Kakuma 3	Kakuma 4
Population size (of HHs)	15,410	5,766	12,348	5,020
Sample size	419	441	438	453

Table 2: KIs sample

Community leader group	Kakuma 1	Kakuma 2	Kakuma 3	Kakuma 4
Camp leaders	3	2	2	2
Youth leaders	2	2	2	2
Leaders of persons with disabilities	2	1	1	2
Minority group leaders	2	1	2	2
Leaders of older persons	2	2	2	2
Total	**11**	**8**	**9**	**10**

KEY FINDINGS

- Findings indicate that HHs in Kakuma refugee camps have various needs across multiple sectors. Despite the Food Consumption Score[7] (FCS) suggesting an overall reduction in the proportion of HHs experiencing poor food consumption (16% of HHs in 2022 down from 35% of HHs in 2020 who were found to have poor FCS), **HHs across the four refugee camps were still experiencing poor food consumption**. Most notably, 46% of HHs in Kakuma 2 and 45% of HHs in Kakuma 4 had borderline or poor FCS. Furthermore, higher proportions of HHs in Kakuma 2 (72%) and Kakuma 4 (70%) were found to be using stress, crisis or emergency livelihood-based coping strategies, indicating that their food security situation would likely have been lower were they not engaging in these unsustainable coping strategies. **High food prices** and **reduced food assistance** could have potentially led to the decrease in the **quantity, quality and variety of food** consumed in some of the HHs.
- **Unregistered community members reportedly lacked access to essential services**. Despite the majority of HHs (80%) reportedly having members registered as refugees or asylum seekers, 34%, 21%, 18% and 9% of HHs in Kakuma 4, 3, 1 and 2 respectively, reported having at least one HH member who was unregistered. **Such unregistered members reportedly lacked access to essential services like food assistance, access to education, access to healthcare,** and **voluntary repatriation** among others.
- The security situation in Kakuma camps has likely improved since October 2020 (6% of HHs down from 27% in October 2020, perceived that the security in the camps was poor or very poor). **A perceived risk of physical attacks by fellow refugees** was the top reported reason why HH members felt unsafe, with a higher proportion of such HHs reportedly in Kakuma 3 (63%) and Kakuma 2 (59%). That said, two-thirds of HHs perceived that it takes less than one month for the police or community leaders to resolve insecurity cases that are reported by community members, suggesting that security agencies resolved cases promptly.
- Even though almost all of the HHs (98%) were found to **be accessing an improved water source,** 21% of HHs reported not having access to adequate water to meet their HH's needs in the 30 days prior to data collection. Among these, 72% and 42% **reportedly reduced water consumption for hygiene practices** and **fetched water at another water point further away** to cope with the lack of adequate water respectively, thus spending up time meant for other vital activities.

- Despite having health facilities within a walking distance, almost half (49%) of HHs reported experiencing challenges related to accessing healthcare. The majority of HHs (86%) and 29/38 KIs reported the **long waiting time as a barrier to accessing healthcare**, suggesting that some community members were dissatisfied with healthcare services in the camps.

- While the majority of HHs (84%) reported having pit latrines, 25% of HHs reported experiencing some challenges. Most notably, two-thirds (67%) of HHs in Kakuma 1 reported having unsafe latrines (mostly unlockable). In addition, **about half of KIs reported that latrines lacked privacy, sometimes overcrowded or the cesspit was full so latrine is not in use, thus exposing users to risk of contracting diseases.**

- Overall, the proportion of HHs that reported having school-aged girls who were not attending school appeared to be slightly higher (12%) than those with school-aged boys (9%) who were not attending school. **Children being too young to attend school** and **early pregnancies**, were the commonly cited reasons for school-aged girls missing school, reported by 29% and 19% of HHs respectively. Most notably, **more than one-third (37%) of HHs in Kakuma 4 reported girls falling pregnant** as the common reason why they were not attending school. This indicates that **school-aged girls in the camps are at a higher risk of dropping out of school**.

- Whereas 65% of HHs were found to be using mobile money services, 30% of HHs reported not having access to any financial institution. This potentially limited **access to credit among traders in the camps.** About two-thirds (65%) of HHs reported lacking capital to expand their businesses (among 33% of HHs that reported having at least one member running a business). Furthermore, a smaller proportion of HHs (5%) and 2% of HHs reported having access to banks and community-based saving schemes respectively.

- A considerable proportion of HHs were found to be in need of shelter and/or shelter materials. Thirty percent (30%) of HHs reported being in need of shelter materials at the time of data collection. In addition, the majority of KIs (28/38) reported that shelter/housing was a top priority need for most community members. In particular, more than half (55%) of HHs and the majority of KIs (10/17) **in Kakuma 4 reported having at least one member who had to sleep outside or on the floor because of insufficient space,** suggesting that HHs in Kakuma 4 were in dire need of shelter assistance.

DEMOGRAPHICS

Two-thirds (67%) of HH survey respondents were female, and the average age of respondents was 42 years. The population pyramid in figure 1 shows the aggregated demographics for all the four camps. The results indicate that Kakuma's population pyramid is skewed towards the younger segments of the population, with a minority of HH members aged 60 years or older.

The average household size was found to be approximately 6.

Figure 1: Proportion of HHs by age and gender:

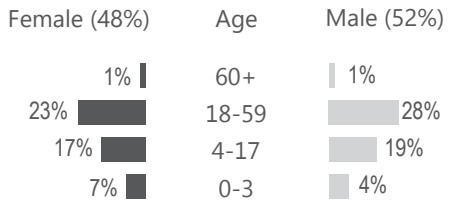
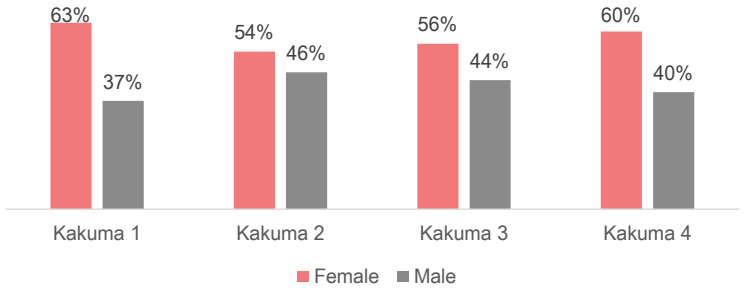


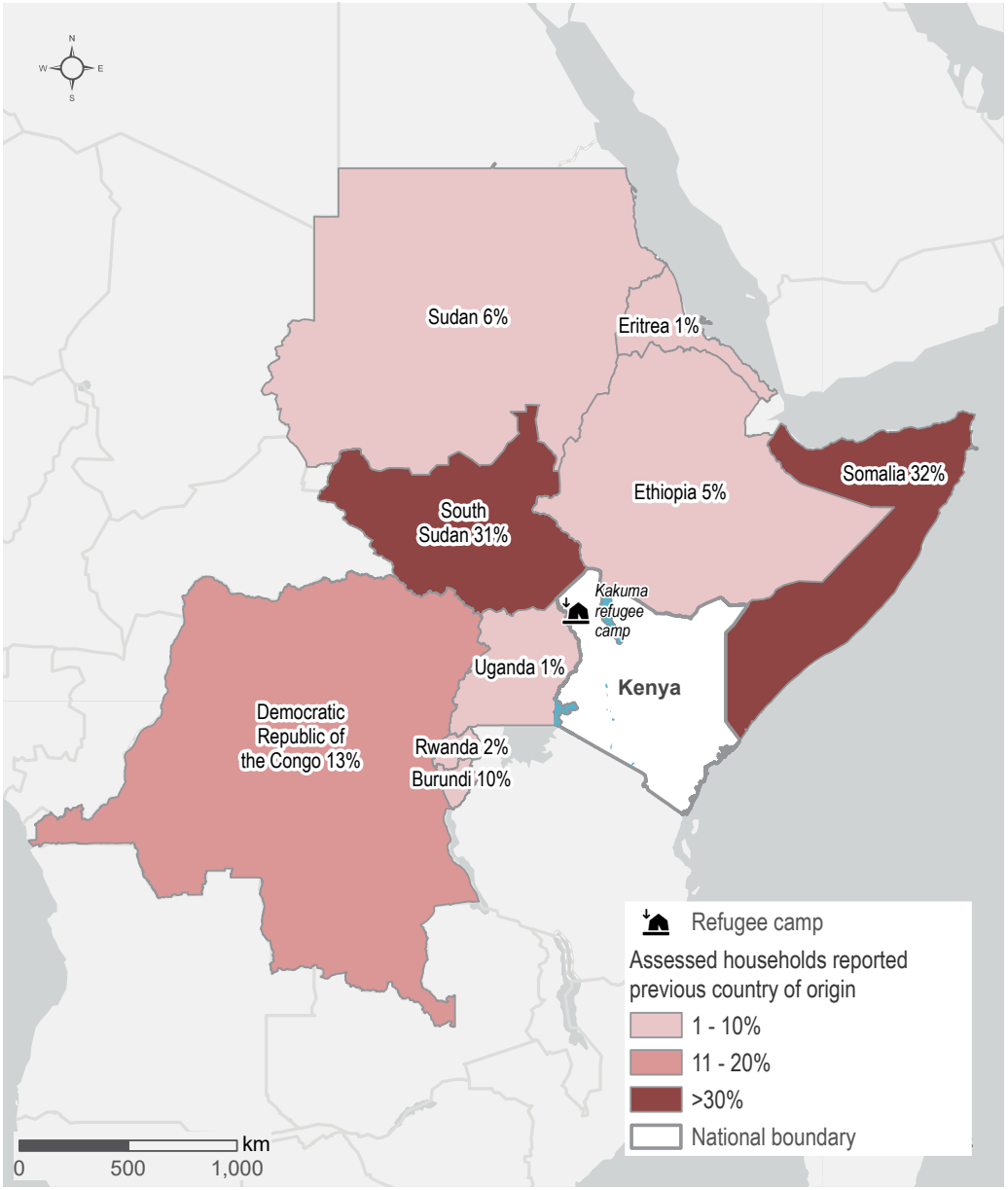
Figure 2: Gender of head of HH:



A slightly higher proportion of female-headed HHs than that of male-headed HHs was reported in the four Kakuma camps.

A higher proportion of HHs in Kakuma 4 and 3, (24% and 17% respectively) reportedly received additional HH members than in Kakuma 1 and 2, (2% and 8% respectively) between the year 2021 and 2022. Of these, the majority (69%) and 57% reportedly came from South Sudan, respectively. Furthermore, half of the HHs in Kakuma 2 reportedly received additional members from the Democratic Republic of Congo. HHs commonly reported the **fear of insecurity and/or conflict as the reason for new members arriving in the camps**.

REPORTED COUNTRIES OF ORIGIN OF HEADS OF HOUSEHOLDS



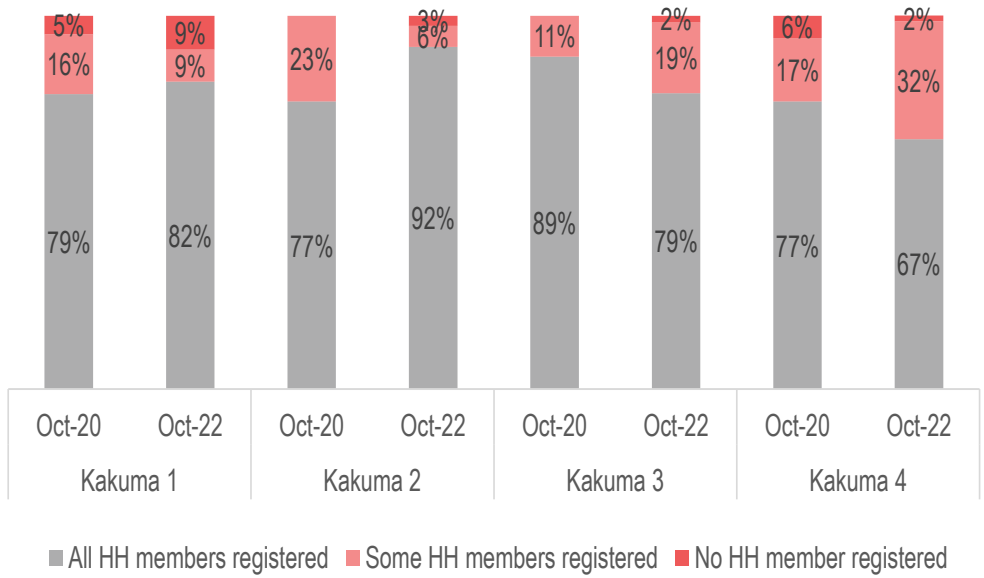
PROTECTION

REGISTRATION AND DOCUMENTATION:

The proportion of HHs reporting that some or all of their HH members **were not registered as refugee or asylum seekers seems to have increased by 10% and 11%** in Kakuma 3 and 4 respectively, between October 2020 and October 2022. This is probably because higher proportions of HHs in Kakuma 4 (24%) and 3 (17%) reported having received addition HHs members between the year 2021 and 2022. In addition, the majority of HHs (89%) reported that **all or some of their HH members who were unregistered had been in the country for less than 2 years**.

On the other hand, the proportion of HHs that reported having some or all of their HH members unregistered decreased slighltly in Kakuma 1 and 2. This probably because HHs reportedly had fewer additional members arriving between the year 2020 and 2022 (2% and 7% for Kakuma 1 and 2 respectively).

Figure 3: % of HHs per registration status of HH members:



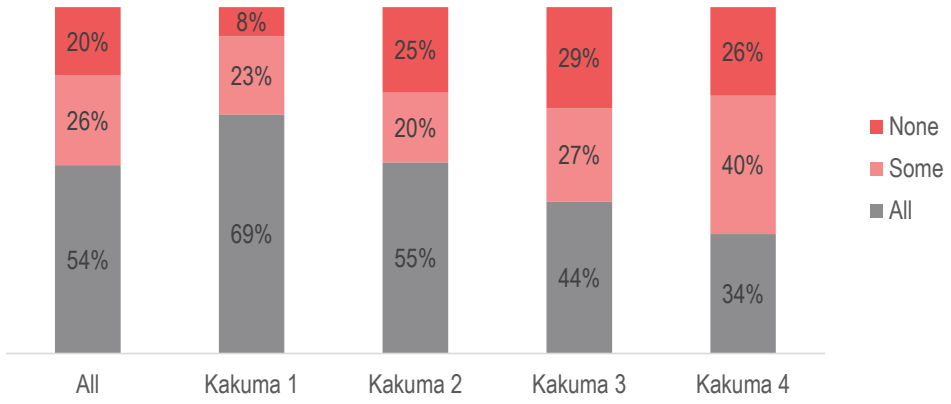
The top reported reasons for HH members not **being registered were; some members had applied for registration but had not received feedback (52%), a lack of knowledge about the process of applying for registration (16%), and unavailability of registration services (13%)**.

A considerable proportion of HHs with unregistered members (64%, 44% and 40%) reported that these members did **not have access to food, education and health care services** respectively. In addition, **30/38 KIs reported a lack of documentation to register in schools as a barrier that undocumented children encountered in accessing education**. Most notably, 88% and 67% of HHs in Kakuma 4 reported that unregistered members in their HHs could not access food assistance and education services, respectively.

Furthermore, 26/38, 22/38 and 20/38 of KIs commonly reported that community members who did not posses identification documents **could not access humanitarian aid, public services (like education, legal aid),** and **employment** respectively.

Twenty-percent (20%) of HHs reported having members aged 18 years and older, who **did not posses alien cards issued by the government of Kenya**. Among these, 61% commonly reported that HH members had applied but not collected the cards, and one quarter of HHs reported that members did not know the process of applying for alien cards.

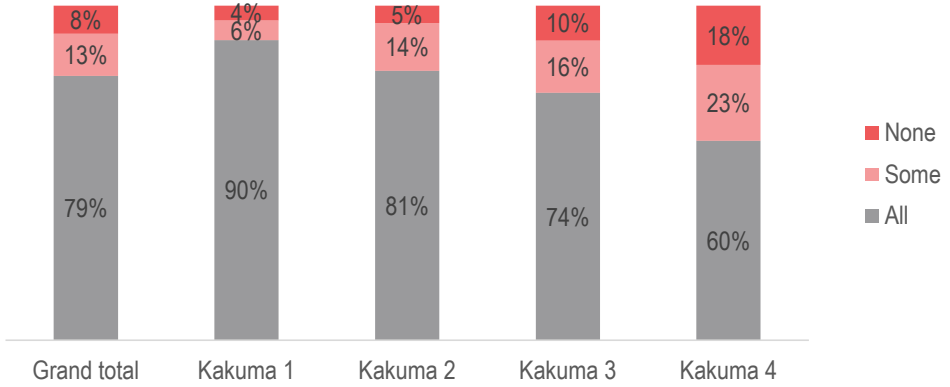
Figure 4: % of HHs with members aged 18 years and older, who possessed alien cards issued by the government of Kenya:



Twenty-four (24/38) and 16/38 KIs commonly reported the **lack of communication from officials when the alien cards are ready** and **overcrowding in the service provider offices** as barriers that community members faced while applying for alien cards.

Two thirds (67%) of HHs reported having all or some of the their members who were born in the camps. Among these, 8% reported that none of their members possessed Kenyan birth certificates. The top reported reasons why HH members who were born in the camps lacked Kenyan birth certificates were; members had applied but not collected the cards (69%), members did not know the process of applying for birth certificates (15%) or members experienced difficulties in accessing the humanitarian actors office for the registration (14%).

Figure 5: Of the 67% of HHs who had members born in Kakuma camps, % reporting that the members possessed Kenyan birth certificates:



PERSONS WITH SPECIFIC NEEDS:

Twenty-seven percent (27%) of HHs reported having at least one member who had special needs. In addition, 15/38 and 8/38 KIs perceived that persons with chronic medical conditions lacked proper medication when they needed it and money to cover for basic services such as education, health or shelter, respectively. Moreover, 8/38 KIs perceived that children with chronic medical conditions lacked money to cover for school-related costs, which **served as a barrier in accessing education.**

Furthermore, KIs perceived that older persons (aged 60 years and older) experienced unique challenges. Half (50%) of HHs and 12/38 KIs perceived that older **persons lacked proper medication** and **clear channels to seek help when they encountered protection concerns,** respectively.

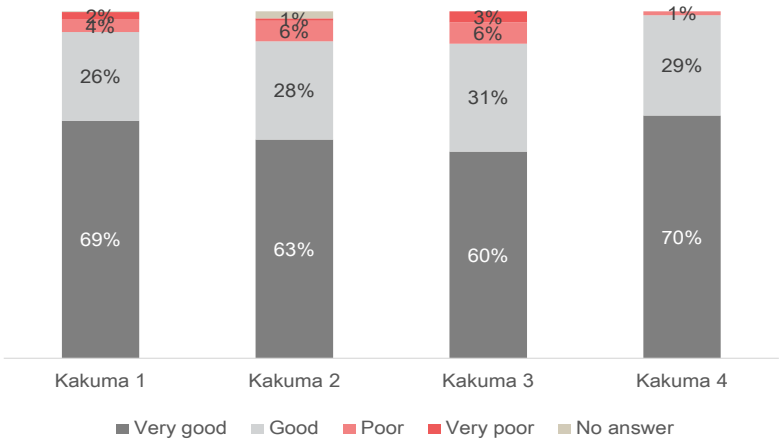
Figure 6: % of HHs reporting having at least one of the following vulnerability[1] profiles among their HH members, by gender :[2]

	Men	Women
Pregnant/ lactacting women		26%
Chronic illness	5%	8%
Mental health issues	2%	2%

SECURITY

Six-percent (6%) of HHs percieved that the safety and security situation in the camps was either poor or very poor in the six months prior to data collection. Of these, more than half (53%) **perceived the risk of physical attacks by the refugee community** as the reason why they felt unsafe.

Figure 8: Reported perception of safety and security by % of HHs:



1. For more information on vulnerability profiles based on the Washington Group Guidance, please see here

KIs also reported on the security concerns of women and girls. Most notably, half of the KIs in Kakuma 2 perceived that girls younger than 18 years suffered physical and verbal harassment. Furthermore, all KIs (10/10) in Kakuma 4 and 6/11 KIs in Kakuma 1, perceived that girls younger than 18 years feared **being sent abroad to find work** and being **forcibly married,** respectively. Additionally, the majority of KIs (30/38) reported that women and girls felt **unsafe while going to collect firewood**. On the other hand, 6/11 KIs in Kakuma 1, and (8/10) KIs in Kakuma 4 perceived that boys younger than 18 years feared being **kidnapped** and **sent abroad to find work**, respectively.

About two-thirds (66%) of HHs reportedly sought help from **community leaders** or the **police** when they experienced insecurity incidents. More than half of the KIs (20/38) and 18/38 KIs perceived that community members mostly reported security concerns to community leaders and the police because they were the **most accessible** and **trusted** security personnel in the camps, respectively.

The majority of HHs **(84%) reported perceiving that it took less than a month for security providers to resolve insecurity cases.** Particularly, 58% of HHs who had reported insecurity cases to the community leaders, mentioned that these cases had been resolved in less than one week.

RELATIONS WITH THE HOST COMMUNITY:

A smaller proportion of HHs (5%) reported **having poor or very poor relations with the host community** while 1% reported not having any relations with the host community. The top reported reasons for the poor relations between HH members and the host community were **perceived crimes committed by members of the host community** and **competition for water and food assistance**, reported by 63% and 29% of HHs respectively.

On the other hand, a considerable proportion (11/38) KIs reported that community members were involved in disputes within and/or between the camps, as well as the host community. Among these, 8/11, 6/11 and 5/11, reported that **community members were involved in shelter, clan or land disputes.** In particularly, 6/8 KIs in Kakuma 3 reported that community members were involved in disputes due to shelters, indicating that community members were conflicting over resources in the camps.

2.Households could select multiple answers

FOOD SECURITY

The majority of HHs in Kakuma refugee camps seem to be commonly relying on unsustainable food sources. The majority (95%) of HHs and 28/38 KIs reported food assistance (voucher and in-kind) to be their most common source of food in the 6 months prior to data collection.

Despite food being the top priority need in most HHs, findings suggest that food availability may be decreasing. Almost all (36/40) KIs **reported food to be among their priority needs** at the time of data collection. However, about 30% of HHs perceived that the quantity, quality and variety of food in their HHs had decreased in the 6 months prior to data collection. Among these, the majority in Kakuma 1 and Kakuma 2 (86% and 78% respectively) **attributed it to high food prices**. Furthermore, 64% of HHs in Kakuma 3 and half of the HHs in Kakuma 1 reported reduced **food assistance as the reason for the decreased quantities, quality and variety of food**.

Findings also suggest that HHs were **experiencing various levels of food insecurity** with **one-third (33%) of HHs being found to have a borderline or poor FCS[3].** Furthermore, **over half (55%) of HHs were found to be using stress, crisis or emergency livelihood-based coping strategies**, indicating that their food security situation would likely have been lower were they not engaging in these unsustainable coping strategies. Moreover, about **two-thirds (64%) of HHs were found to have a medium or low household dietary diversity score (HDDS)**, suggesting that their diets were likely suboptimal and non-diversified. The HDDS aims to reflect the economic ability of HHs to access a variety of foods and is based on HHs' self-reporting of the 12 food groups consumed in the previous 24 hours.

FOOD CONSUMPTION SCORE (FCS)[3]

The FCS is a composite score based on HHs' dietary diversity, food frequency, and relative nutritional importance of different food groups. It is calculated by inspecting how often HHs consume food items from the different food groups during a 7-day reference period. Only foods consumed in the home are counted in this indicator.

The FCS is used to classify HHs into three groups; those with a poor FCS, those with a borderline FCS, and those HHs with an acceptable FCS. A borderline FCS implies that HHs are consuming staples and vegetables everyday accompanied by oil and pulses a few times in week. A poor FCS implies that HHs are not consuming at least staple foods and vegetables on a daily basis, and rarely consumed protein rich foods, thus considered to have poor food consumption.

Overall, the proportion of HHs with an acceptable FCS doubled (67% up from 33%) and those with poor FCS reduced by more than half (16% down from 35%) between in October 2020 and October 2022. Most notably, the proportion of HHs with poor FCS decreased from 48% to 20% in Kakuma 1 and 43% down to 14% in Kakuma 4. These findings suggest that **the proportion of HHs that were experiencing food consumption gaps had decreased.**

Figure 9: % of households per FCS[3], per camp:

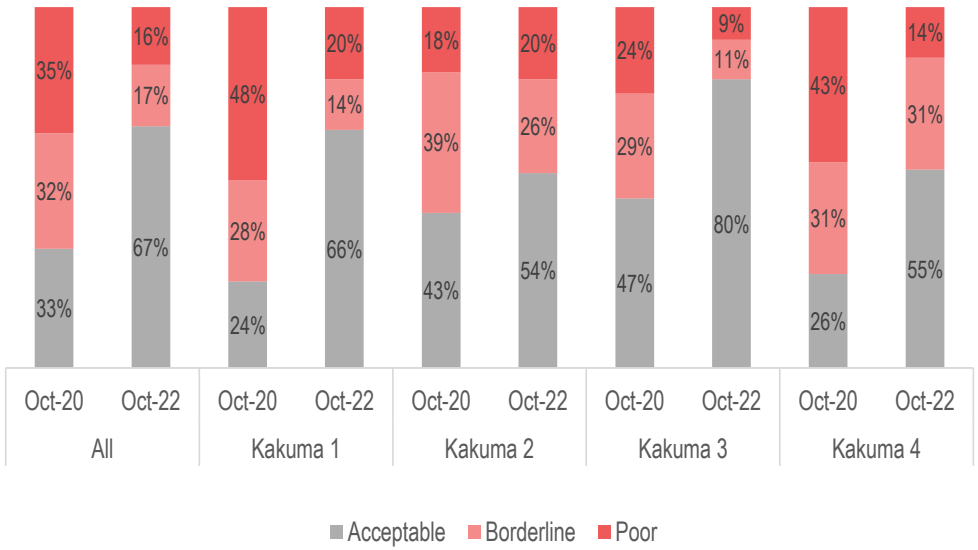


Table3: Average number of days that HHs consumed various food groups in the seven days prior to data collection, per camp:[2]

Food group	Main Staples	Pulses	Meat/Fish/ Eggs	Milk	Vegetables	Fruits
Kakuma 1	5	5	2	2	4	2
Kakuma 2	5	5	2	3	3	2
Kakuma 3	6	6	3	3	4	3
Kakuma 4	6	5	2	2	4	3

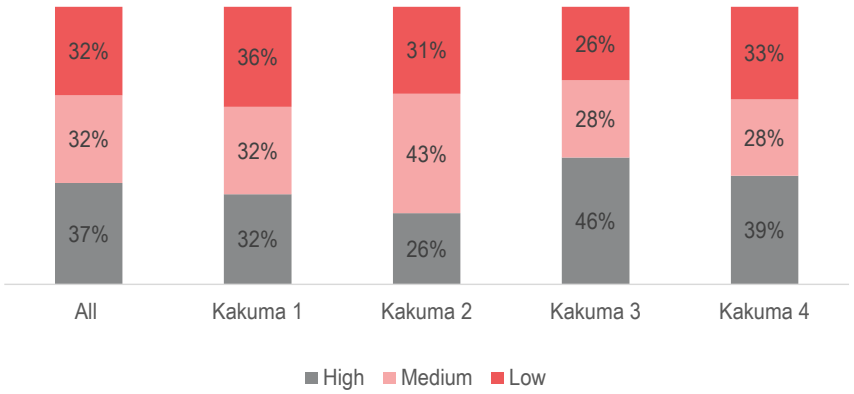
3.For more information on food security indicators (FCS,CSI, HDDS) please see here

HOUSEHOLD DIETARY DIVERSITY SCORE (HDDS)[3]

HHs can be further classified as food insecure if their diet is non-diversified, unbalanced and unhealthy. The previous 24-hours' (before data collection) food intake of any member of the HH was used as a proxy to assess the dietary diversity of HHs. The HDDS is used to classify HHs into three groups: high, moderate or low dietary diversity. A high HDDS indicates food security, while moderate and low HDDS' suggest moderate and more severe food insecurity, respectively.

Overall, (64%) of HHs were found to have a medium or low HDDS, **suggesting that their diets were likely suboptimal and non-diversified.** Specifically, the majority of HHs (74%) Kakuma 2 were found to have a medium or low HDDs .

Figure 10: Proportion of HHs per HDDS[3], per camp:

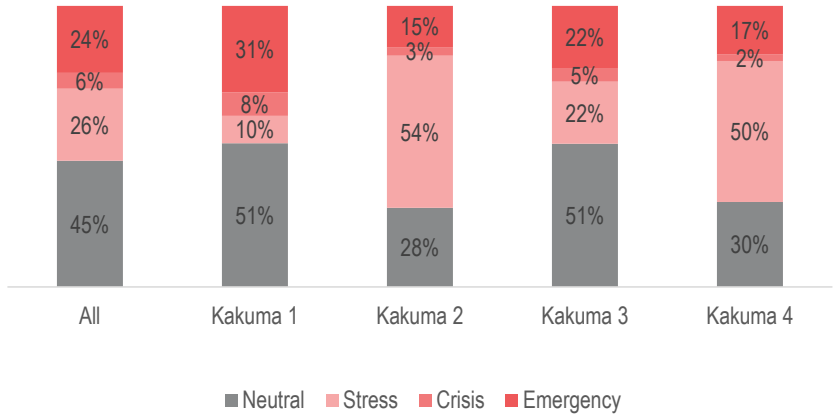


LIVELIHOOD COPING STRATEGY INDEX (LCSI)[3]

The Coping Strategy Index (CSI) is an indicator of a HH's food security assessing the extent to which HHs use harmful coping strategies when they do not have enough food or enough money to buy food.. The LCSI is used to classify HHs into four groups: HHs using emergency, crisis, stress or neutral coping strategies to cope with livelihood gaps, in the 30 days prior to data collection. The use of emergency, crisis, or stress-level livelihoods-based coping strategies typically reduces HHs' overall resilience and assets, in turn increasing the likelihood of food insecurity.

The majority of HHs (72%) and 70% of in Kakuma 2 and Kakuma 4 were found to be using **stress,emergency or crisis level coping strategies, suggesting that HHs have been experiencing gaps in their ability to meet basic needs** in the 30 days prior to data collection.

Figure 11: Proportion of HHs per LCSI[3] score, per camp:



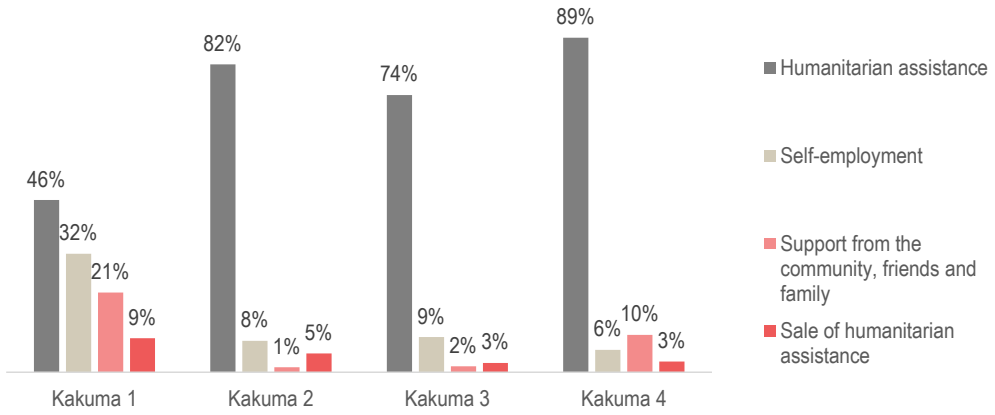
LIVELIHOODS

INCOME:

Findings suggest that HHs were commonly relying on humanitarian assistance as their primary source of income. About two-thirds (66%) of HHs reported humanitarian assistance as the primary source of income in the 30 days prior to data collection. Specifically, the proportion of HHs reporting **humanitarian assistance as their primary source of income increased from 47% in October 2020 to 65% in October 2022**. On the other hand, **the proportion of HHs reporting self employment as their primary source of income decreased by 8%, 7% and 2% in Kakuma 2, 3 and 4 respectively,** indicating that fewer community members were engaging in income generating activities and depending more on humanitarian Aid.

This situation could have been potentially exacerbated by the drought situation, as the majority of KIs (86%) perceived that the ongoing drought in Northern parts of Kenya had decreased access to food for most HHs, thus deepening HHs reliance on humanitarian assistance.

Figure 12: % of HHs by source of income, per camp:[2]



The proportion of HHs that reported having members who did not have any source of income in the 30 days prior to data collection, **decreased by more than half (12% down from 25% in October 2022).** Nevertheless, the greater majority of KIs (29/38) perceived that community members **were not getting work permits,** thus potentially limiting their chances of getting work and/or business opportunities. In particular, fewer HHs in Kakuma 4 (6%) reported self-employment as their source of income, corresponding with a greater number of KIs (11/29) in Kakuma 4, who reported that community members were not getting work permits.

One-third of HHs (33%) reported having a member operating a business. Of these, 57% reported having borrowed money from friends and/or relatives to start their businesses and 52% reported having spent their savings to set up their businesses.
The proportion of business owners who possessed business permits seems to have increased since the last round of MSNA. In particular, the proportion of HHs that reported having a member who owned a business without possessing a business permit decreased by half (33% down from 66% in October 2020), suggesting that more business owners had acquired business permits.

Despite the proportion of HHs without business permits having reduced by half, 26/38 KIs perceived the **lack of business permits and money for stocking up the business** to be the common challenges that business people faced in the camps.

HOUSEHOLD DEBT:

Almost two-thirds of HHs (65%) reported having borrowed money from family, friends or traders, at the time of data collection. Of these, 89% reportedly borrowed the money to buy food, 39% borrowed money to meet other basic HH needs and 25% borrowed money to pay for education. Among HHs that borrowed money, 20% reported borrowing more money to pay debts. **Over-reliance on debt to purchase food suggests that HHs were struggling to meet their food consumption needs, indicating that HHs were facing food consumption gaps.**

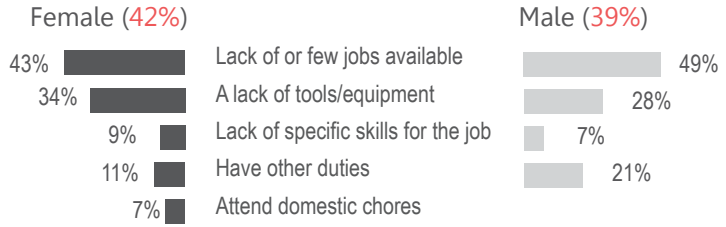
Figure 13: Average HH debt, per camp (in KES):

Kakuma 1	3,116
Kakuma 2	1,220
Kakuma 3	2,735
Kakuma 4	1,072

VOCATIONAL TRAINING AND EMPLOYMENT:

At the time of data collection, 45% and 40% of HHs reported having at least one male and female adult member respectively, who had attended training, work experience, or vocational training. Among these, 39% and 42% of HHs reported having at least a male and female HH member respectively, who was not using the skills and experiences. Among HHs with male and female members who were reportedly not using their skills, almost half (49%) and 43% respectively, attributed this to **few job opportunities** or **unavailability of jobs.**

Figure 14: Commonly reported reasons why members with skills and work experience were not using their skills, by % of HHs:[2]

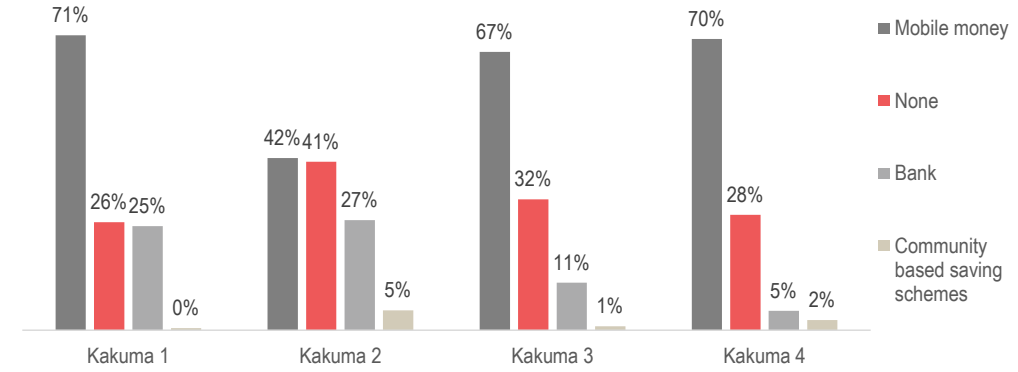


FINANCIAL INSITUTIONS:

The availability and access to financial institutions is a key part of HHs' livelihood. About two-thirds (65%) of HHs reported having access to **mobile money**.

However, **a considerable proportion (30%) of HHs, reported not having access to any type of financial institution**. In particular, a relatively high proportion (41%) of HHs in Kakuma 2 reported not having access to a finacial institution in the six months prior to data collection.

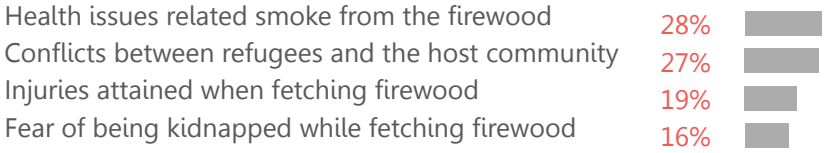
Figure 15: Commonly reported financial institutions accessed by HHs reporting to have access to financial institutions in Kakuma camps:[2]



ENERGY

Despite the negative health and environmental impact caused by using firewood and the burning of charcoal, 71% and 28% of HHs in Kakuma reported using **charcoal** and **firewood** respectively, as their main source of fuel for cooking.

Figure 16: Most commonly reported challenges faced while fetching or using firewood, reported by 28% of HHs encountering challenges:[2]



4. School-aged children are children between 4 and 17 years old

EDUCATION

Among all school-aged[4] boys and girls in the assessed HHs, a slightly higher proportion of girls (12%) than boys (9%) were reportedly not attending school in the 12 months prior to data collection. Among HHs that were found to have school-aged[4] children who were not attending school, 46%, 41% and 11% reported that the children were previously in (Early childhood Education) ECD, primary and secondary level of education respectively. The top reported reason for school-aged[4] children not attending school was that parents or guardians perceived their children to be too young to attend school.

Figure 17: Proportion of HHs with school-aged[4] boys reportedly attending school (ECD, primary, and secondary) in the 12 months prior to data collection:

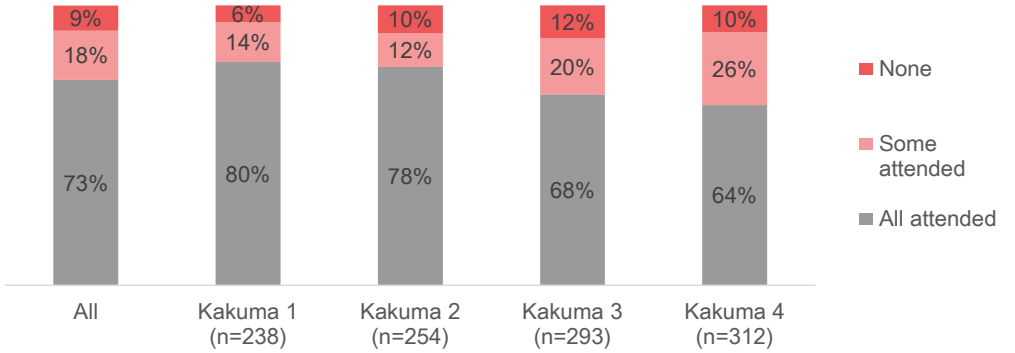


Figure 18: Proportion of HHs with school-aged[4] girls reportedly attending school (ECD, primary, and secondary) in the 12 months prior to data collection:

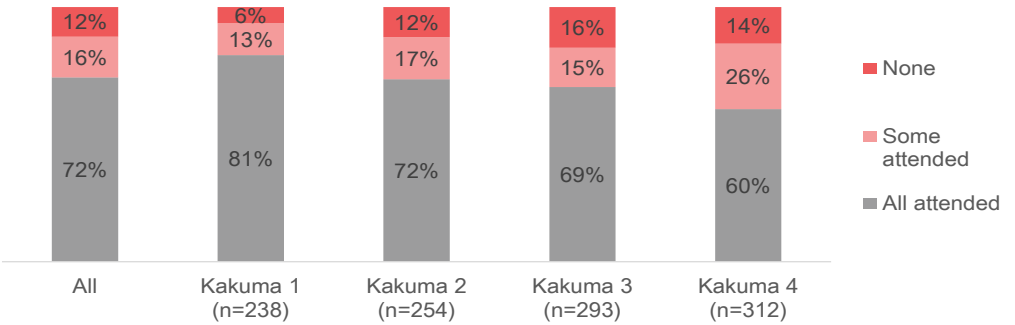
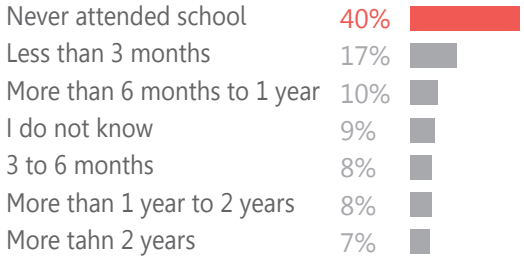


Figure 19: % of HHs reporting the last time that children who were not accessing education, attended school:



Findings suggest that **a relatively higher proportion of school-aged[4] children who were not attending school were younger than 9 years**. More than half of HHs (58%) with school-aged[4] girls and 53% with school-aged[4] boys who were not attending school were found to be aged between 4 and 9 years.

In addition, 44% of HHs with school-aged[4] girls and 47% of HHs with school-aged boys who were not attending school were found to be aged between 10 and 17 years.

The top reported reason by 29% and 31% of HHs with school-aged[4] girls and boys respectively, for school-aged[4] children not attending school was that **children were too young to attend school**. The majority of HHs (70%) with parents and guardians who perceived that children in their HHs were **too young to attend school perceived that the distance their children were required to walk was too long.**

The top reported barriers by 32%, 24% and 21% of HHs with girls who were attending school were: **the long distance to school, lack of fees and/or school-related costs** and **early marriages/pregnancies,** respectively. Similarly, the top reported barriers by 25%, 21% and 17% of HHs with boys who were attending school were: **the long distance to school, lack of fees and/or school-related costs** and **overcrowding in schools**, by respectively.

Twelve-percent (12%) of HHs reported that they had at least one member of their HH who did **not transition to tertiary education after completing secondary school** in the five years prior to data collection. The top reported barriers for these HH members not transitioning to tertiary education were **to get married** (22%) and **lack of motivation to further their education** (15%).

WATER, SANITATION AND HYGIENE

WATER:

Although the majority of HHs (79%) reported having access to adequate water for all members, 21% reported that members could not access adequate water. Among HHs that reported not having access to adequate water to meet their HH's needs, 72% reportedly **reduced the consumption of water for hygiene practices** and 42% **fetched water at another water point further away** to cope with the lack of sufficient water. HHs with members who reduced consumption of water for hygiene practices were exposed to the risk of contracting diseases. Moreover, HHs that had members fetching water further way, potentially used up time meant for other vital activities.

The majority (98%) of HHs reported using improved water sources as their main source of water for drinking and other HH uses. The remaining 2% of HHs reported using surface water and unimproved water sources, as their main sources of water for drinking and HH use.

Table 4: Average volume of water used for drinking and domestic hygiene per HH, per day:

	Average number of litres of water consumed per HH, per day	Average HH size	Average litres of water used per HH member, per day
Kakuma 1	99	6	16.5
Kakuma 2	113	6	18.8
Kakuma 3	107	7	15.3
Kakuma 4	108	8	13.5

On average, a HH member in Kakuma 4 reportedly used 13.5 litres of water for drinking and domestic hygiene per day, which is slightly below the minimum of 15 litres per person per day according to the sphere standards.

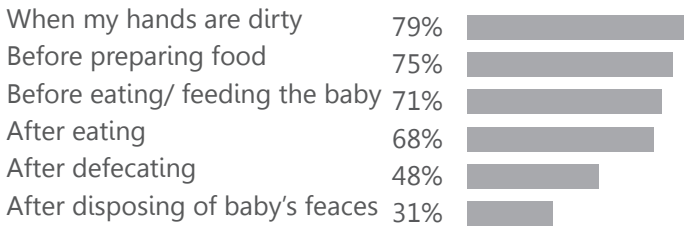
Forty-three percent (43%) of HHs reported having challenges in accessing water. The top reported challenges were **a lack of enough water at the source** (60%) and **long waiting/queuing time** (58%). Eight-percent (8%) of HHs reported walking for over 30 minutes to fetch water and more than one-third (37%) of HHs reported **having to wait for over 30 minutes for their turn to fetch water at the water points.**

HYGIENE AND SANITATION:

A considerable proportion of HHs (23%) reported not having soap at the time of data collection, the majority of them (74%) reported not being able to afford soap, while 41% reported that they were waiting for the next distribution.

Seventeen percent (17%) of HHs in Kakuma camps reportedly washed their hands during all the critical hand washing occasions, 80% reportedly washed their hands during some critical hand washing occasions while 3% reported not washing their hands at critical hand-washing occasions. HHs with members who did not wash their hands during the critical hand washing occasions, (5% in Kakuma 2, and 4% in Kakuma 1) **might be at elevated risk of disease transmission**.

Figure 20: % of HHs that reportedly washed their hands during the following occasions:[2]



The majority (84%) of HHs reported having access a pit latrine. Among these, 31% reported sharing their latrine with other HHs. Moreover, the majority (88%) of HHs reported that the shared sanitation facilities did not have separate stalls for women.

On average, 5% of HHs and 3/38 KIs reported that none of the community members in the camp had access to a functioning latrine. Particularly, 10% of HHs in Kakuma 1 and 3/9 KIs in Kakuma 3 reported that none of the community members had access to a functioning latrine. Furthermore, 18/38 and 10/38 KIs commonly cited a **lack of latrines and/or available latrines being crowded** and **latrines lacking privacy** (without locks/doors/walls/lighting etc.) as barriers that most community members encountered in accessing sanitation facilities.

Overall, one-quarter of HHs (25%) reported experiencing challenges related to accessing sanitation facilities.

Figure 21: Commonly reported problems that community members encountered while accessing sanitation facilities (latrines), by proportion of HHs, per camp:[2]

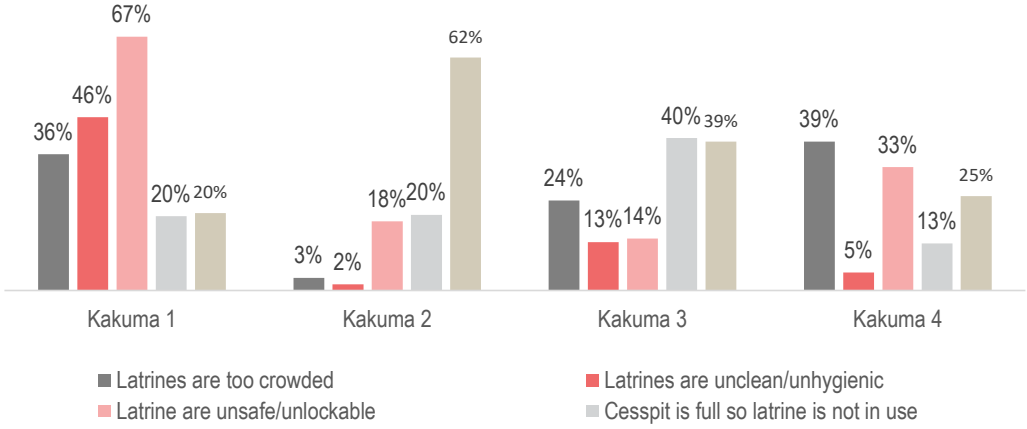
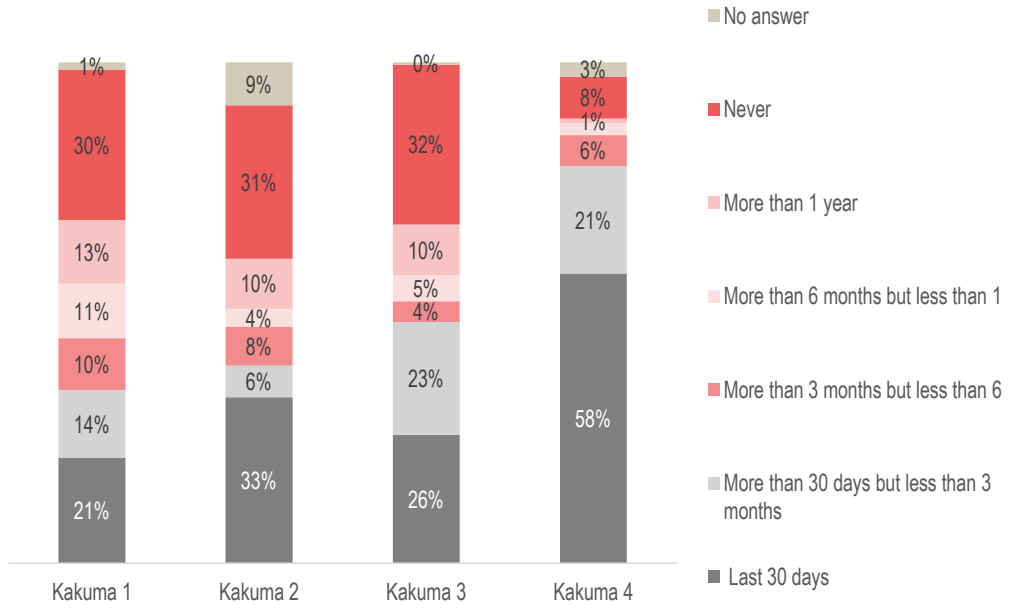


Figure 22: % of HHs that reported having received hygiene promotion messages in the following timelines:

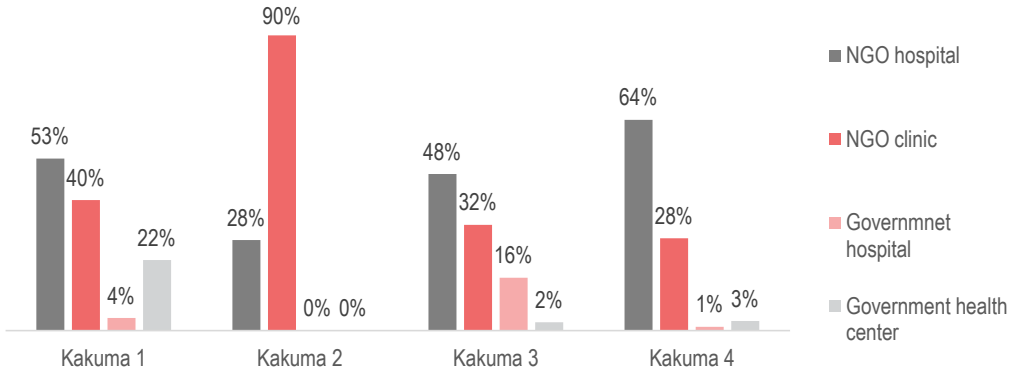


A relatively high proportion of HHs in Kakuma 4 (85%) reportedly received hygiene promotional messages in the 6 months prior to data collection. These HHs might have employed the knowledge gained from those messages to ensure that their sanitation facilities were clean, since only 1 KI in Kakuma 4 reported latrines being unclean as a barrier in accessing sanitation.

HEALTH:

Thirty-seven percent (37%) of HHs reported that at least one member of their HH had a health problem and needed to access health care in the 3 months prior to data collection. Among these, almost half (49%) of HHs reported that community members **sought healthcare from hospital run by a non-governmental organization (NGO)**. In addition, 4% of HHs reported **having paid for health services** such as consultation, treatment or medicines.

Figure 23:% HHs that would visit the following types of health facilities if they experienced a health issue:[2]



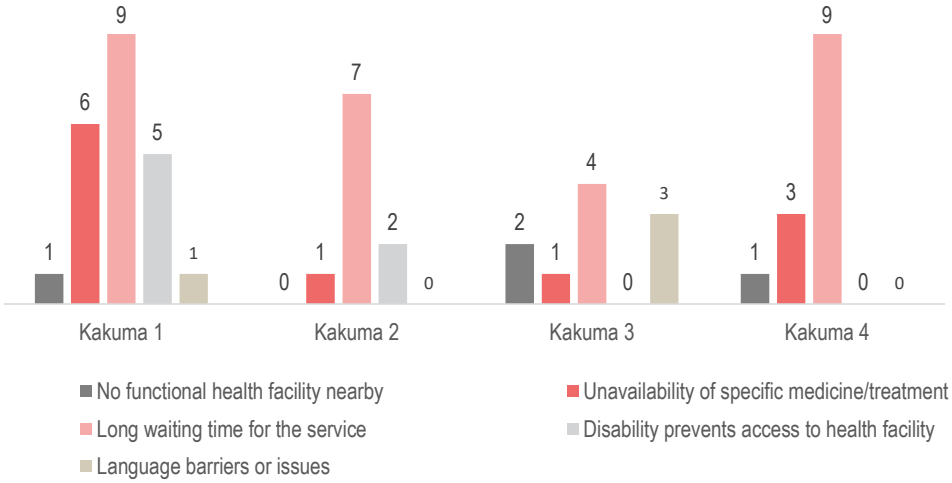
Despite HHs members being able to walk to a nearest health facility to access healthcare, more than half of the HHs (53%) reported that community members perceived the long waiting time to access services as a barrier in accessing healthcare.

Among the HHs that had a member who needed health care but could not access it, almost half (49%) cited the **long waiting time** as the reason they could not access healthcare. Moreover, 24% of HHs that members sought healthcare services reported being dissatisfied, likely because of the long queing time (50%).

Almost all (98%) HHs reported that it took less than one hour for a member from their HH to reach a health facility that is nearest to their home, the majority (96%) of whom walked on foot. This finding is consistent with KIs who reported that it took an average of 35 minutes for most community members to get to the nearest, functional health facility, using the most common mode of transport.

However, almost half (49%) of HHs reported that members experienced challenges in accessing health care. The majority of HHs (86%) and 29/38 KIs reported the **long waiting time as a barrier to accessing healthcare services**.

Figure 24: Commonly reported barriers that community members encountered while accessing healthcare services, as reported by KIs (n=38):[2]



NUTRITION:

Thirteen percent (13%) of HHs reported having at least one member who sought nutrition assistance in the 6 months prior to data collection. Of these, the majority (97%) reportedly received the services.

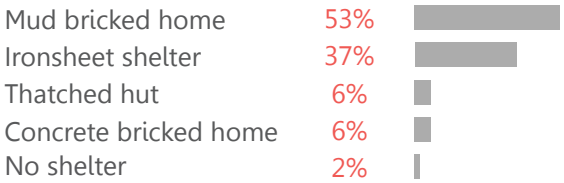
Even so, community members reportedly experienced challenges in accessing nutrition services. Notably, all HHs in Kakuma 2 and 3, and half of the HHs in Kakuma 1 and 4 respectively, reported **waiting for a long time while seeking nutrition services at health centres**. Furthermore, half (50%) of the HHs in Kakuma 1 and Kakuma 4 cited **unavailability of nutrition services** and **facilities offering nutrition services being far,** respectively.

Table 5: % of HHs per camp, per amount of children below 5 years and pregnant/ lactating mothers in their HH, that had reportedly been screened for malnutrition in the six months prior to data collection:

	Children under 5 years			Pregnant/lactating mothers		
	Yes	No	Do not know	Yes	No	Do not know
Kakuma 1	22%	78%		3%	97%	
Kakuma 2	38%	60%	2%	13%	79%	9%
Kakuma 3	22%	78%		17%	83%	
Kakuma 4	22%	78%		9%	91%	

SHELTER

Figure 25: Reported types of shelters by % of HHs:[1]



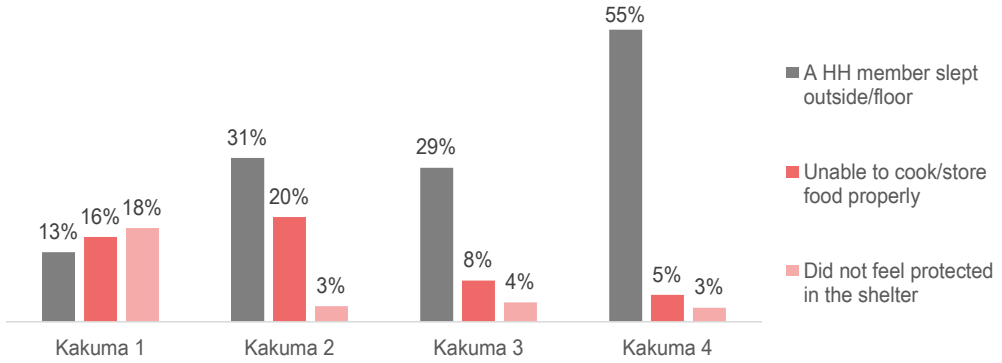
At the time of data collection, 30% of HHs reported being in need of shelter materials. In addition, the majority of KIs (28/38) and reported that shelter/ housing was a top priority need for most community members.

More than half of KIs (21/38) reported that some community members (half or a little less than half) in the camp lived in either an inadequate shelter, a moderately to highly damaged shelter, or no shelter. Furthermore, 21% HHs reported that their shelters had been damaged in the 3 months prior to data collection. Of these, more than half (53%) reported that the roofs of their shelters had been damaged. In addition, the majority of HHs (80%) reported that their shelters were damaged by strong winds.

Moreover, some HHs reported that their shelters had enclosure issues that potentially caused living conditions in such HHs to be uncomfortable. Particularly, 34% of HHs reported having shelters that leaked when it rained. Of these, a higher proportion (61%) of HHs were reported to be in Kakuma 2.

Almost half (17/38) of the KIs and 26% of HHs reported having at least one member who had to sleep outside or on the floor because of insufficient space or insufficient sleeping mats/mattress. In particular, a higher proportion (55%) of HHs and the majority of KIs (10/17) **in Kakuma 4 reported having at least one member who had to sleep outside or on the floor because of insufficient space.** This indicates that community members in Kakuma 4 have higher shelter needs compared to other camps.

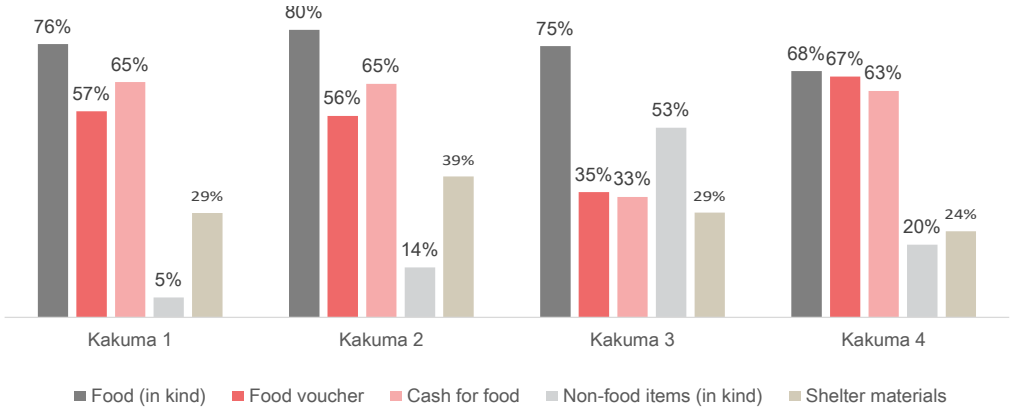
Figure 26: % of HHs reporting issues that HH members faced in terms of living conditions in their shelters, per camp:[2]



HUMANITARIAN ASSISTANCE:

Findings indicate that food security remains to be a priority need for HHs in the Kakuma refugee camps. Despite a considerable proportion of HHs (65%) reporting having received food assistance (in-kind, voucher, or cash for food) in the 30 days prior to data collection, 75%, 55% and 51% of **HHs reported food (in kind), voucher, and cash for food to be the top priority needs** at the time of data collection respectively. Furthermore, 10/28, 8/28 and 7/28 of KIs reported shelter to be a top priority need by most community members in Kakuma 1, 3 and 4 respectively. This indicates that besides food assistance, community members are also in need of shelter assistance.

Figure 27: % of HHs reporting the top priority needs at the time of data collection:[2]



The majority (76%), 56% and 44% of HHs across the four camps commonly reported having received food, water and hygiene assistance respectively (every month), in the six months prior to data collection respectively.

Among HHs that received humanitarian assistance, the majority (88%) reported being satisfied with the assistance received, and the process of delivery of assistance. Among HHs that reported being dissatisfied (12%), the majority (94%) perceived that the assistance **was not enough to meet their HH needs** while 43% perceived that the assistance was of low quality.

CONCLUSION:

- Despite the majority (89%) of HHs in Dadaab refugee camps reporting having received humanitarian assistance in the 6 months prior to data collection, a complete fulfillment of all refugees' needs is far from being achieved. Severe food consumption gaps were reported by both HHs and KIs, with one-third of HHs being found in poor, or borderline FCS. In addition, **over half (55%) of HHs were found to be using stress, crisis or emergency livelihood-based coping strategies**, indicating that their food security situation would likely have been lower were they not engaging in these unsustainable coping strategies and suggests an eroded resilience to future shocks.
- The **protracted drought situation in the Northern parts of Kenya potentially weakened the purchasing power of most HHs.** This potentially led to HHs over-relying on humanitarian assistance, which is an unsustainable source of income. More than half (57%) of the HHs reportedly encountered challenges due to drought. Of these, the majority (71%) of **reported encountering difficulties paying for basic goods due to inflation, thus potentially reducing their ability to access different varieties of food.**
- A considerable proportion of adult males and females could not access jobs, despite having job skills, working experience or vocational training. Among HHs with male (45%) and female (40%) members with skills, vocation training and working experience who were reportedly not using their skills, 49% and 43% respectively, attributed this to there being **few or no jobs opportunities** and **the lack of tools and equipment**.
- Community members who run businesses in the camps encountered some barriers. The commonly reported barriers were **inadequate capital to expand business** and a **lack of documentation**. Thirty-percent (30%) of HHs reported not having access to any financial facility while only 1% of HHs reported having access to community based saving schemes. About two- thirds (33%) of HHs with members running businesses reported **lacking capital to stock up their business, suggesting that businesses could scale up if they had more access to capital.**
- Whereas the majority (98%) of HHs reported having access to clean water, a considerable proportion of HHs encountered challenges in accessing sufficient water, potentially due to drought. All KIs in Kakuma 4, and the majority of them in Kakuma 1 (80%) and Kakuma 3 (75%) perceived that community members could not access adequate water due to drought. The majority of HHs had to **cope with the lack of sufficient water by reducing water consumption for hygiene practices (72%)** or **walking longer distances to fetch water (42%).**
- Despite the fact that community members could access a functioning health facility within walking distance when they were faced with a health problem, **the long waiting time** was commonly reported as a barrier to accessing healthcare. The majority (76%) of KIs perceived the **long waiting time** to be a **barrier to most community members who sought healthcare in the camps.**