MULTI-SECTOR NEEDS ASSESSMENT

Kalobeyei Integrated Settlement, Turkana county, Kenya, October 2020

BACKGROUND

As of September 2020, a total of 39,623[1], mostly South Sudanese refugees resided in Kalobeyei integrated settlement (Kalobeyei Village 1, Village 2 and Village 3). With continued conflict, instability and food insecurity causing new displacement in South Sudan[2], in addition to reduced humanitarian funding in Kalobeyei integrated settlement[3], there is a need to strengthen the available information on humanitarian needs and access to assistance and services in the villages. 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 conducted in October 2020 across the three villages of Kalobeyei by REACH Initiative in close collaboration with the Norwegian Refugee Council (NRC) and in support of humanitarian operational partners in Kalobeyei integrated settlement. It provides an analysis of needs across the following sectors; education, protection, food security, health and nutrition, water, sanitation and hygiene (WASH) and livelihoods.

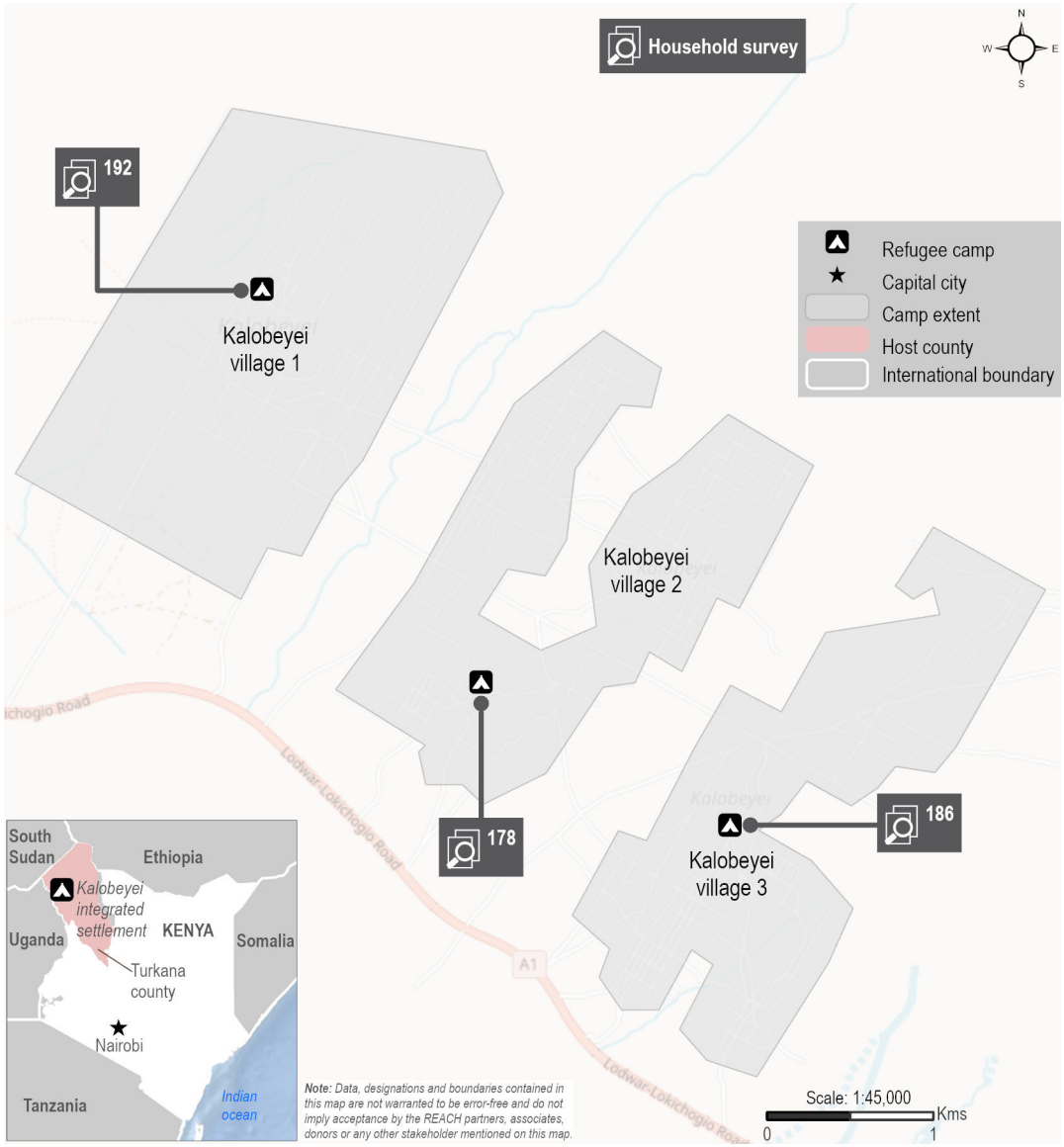
METHODOLOGY

This assessment was conducted through household (HH) level interviews from 6 to 16 October 2020 in Kalobeyei integrated settlement. A total of **556 HHs** from the three villages were interviewed (192 in Kalobeyei village 1, 178 in village 2 and 186 in village 3).

The sample was selected through probability random sampling at individual village level to fulfill a 95% confidence level and 7% margin of error and was calculated based on the HH population of each village. The confidence level is guaranteed for all questions that apply to the entire surveyed population of each village. 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 village samples. The data was aggregated at the overall Kalobeyei integrated settlement 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. 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.

LOCATIONS OF DATA COLLECTION



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KEY FINDINGS

- Findings indicate that Kalobeyei villages have severe needs across multiple sectors, with the most severe needs appearing to be in food security sector where almost two-thirds **(60%) of HHs were found to have either a poor or borderline food consumption score (FCS)[4].** In addition to this, **62% of HHs were using either emergency, crisis of stress level livelihood-based coping strategies, which indicates that their FCS would be lower were they not engaging in these unsustainable coping strategies.**
- COVID-19 seems to be having an impact across sectors, including protection, livelihoods, and food security; A third of the HHs (33%) reported that they had borrowed some money from family, friends, traders, etc. at the time of data collection. Of these, **16% reported that they had borrowed the money due to COVID-19 related challenges. In addition,** some HHs reported having a HH member who had lost their job as a result of COVID-19. Among HH members not registered as refugees or asylum seekers, the **top reported reason for not registering was delays in registration due to COVID-19.**
- There are several key indicators that suggest that HHs are struggling to access WASH services: About half (55%) of HHs in Kalobeyei villages reported that they were unable to access enough water in the 30 days prior to data collection. **Forty four percent of HHs (44%) reported that members of their HH experienced challenges while fetching water. Of these,** 73% suggested that lack of enough water at their water point was the main challenge encountered. **Sixty-six percent of HHs (66%) reportedly did not observe all the five critical hand washing occasions[5]**, which exposes these HHs **to a risk of disease transmission. A relatively high proportion of HHs in Kalobeyei village 3 (35%) reported that at least one member of their HH did not have access to or use a latrine.**
- Security is a concern for some refugees in Kalobeyei: **9% of HHs reported that the safety and security situation in the camps was either poor or very poor** in the six months prior to data collection, while **90%** reported that the safety and security situation was good or very good.
- The access to health and nutrition was seemingly good: 94% of HHs reported being able to access a functioning health facility when they encountered a health issue and 61% of HHs reported being able to access nutrition services when needed.
- Across the three villages, the proportion of **female-headed HHs was higher than that of male-headed HHs.** Eighty-one percent of HHs (81%) in Kalobeyei village 1, 70% in village 3 and 61% in village 2 were headed by women.
- **Across the three villages, a small yet considerable proportion of HHs with school-aged children reported having girls and/or boys in their household who were not attending school at the time of data collection (18% and 14%, respectively), mostly due to the perceived security concerns on the way to school for younger children in particular.**

DEMOGRAPHICS

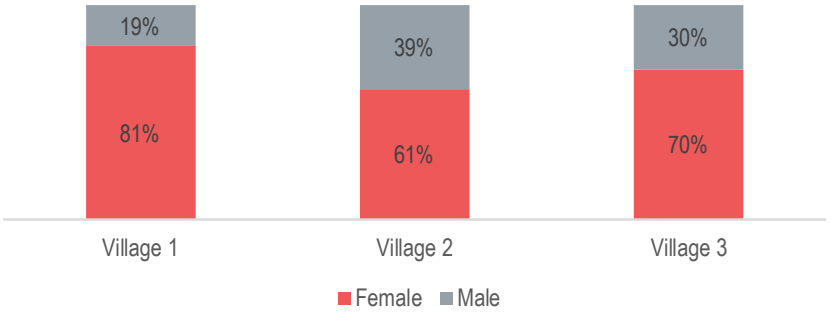
The majority of HH survey respondents were women **(70%)**, and almost all respondents **(94%)** were younger than 50 years.

The population pyramid shows the aggregated demographics for all the three villages. The results indicate that Kalobeyei's population pyramid is skewed towards the younger segments of the population, with a higher proportion of HH members under the age of 18, followed by adults between the ages of 18 and 59, and a minority of HH members aged 60 or older.

The average HH size was found to be approximately 6, of which approximately 4 are under the age of 18.

Proportion of HH members by age and gender:

Gender of the head of household:



A slightly higher proportion of **female-headed HHs than that of male-headed HHs was reported in the three Kalobeyei villages.**

About two-thirds of HHs **(66%)** reported **their country of origin to be South Sudan.** Of these, 79% reported their state of origin in South Sudan to be Eastern Equatoria.

A high proportion of HHs **(91%)** had reportedly **lived in Kalobeyei integrated settlements for less than 5 years.**

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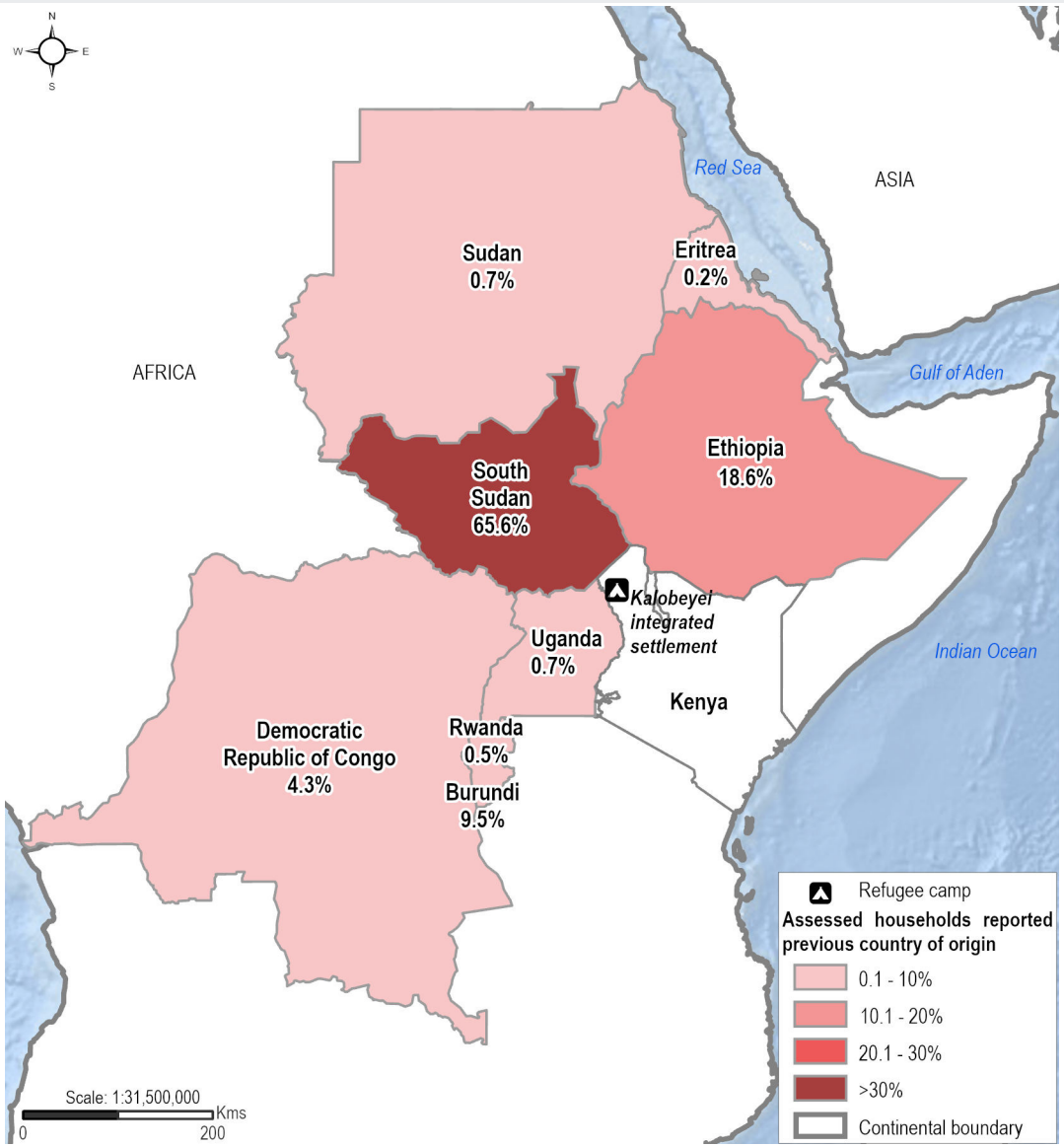
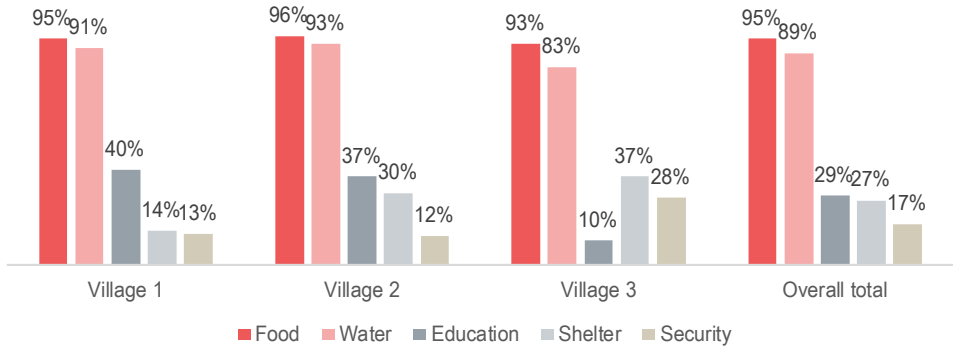
REPORTED COUNTRIES OF ORIGIN



HUMANITARIAN ASSISTANCE

The top three reported HH needs across the three villages were food, water and education respectively.

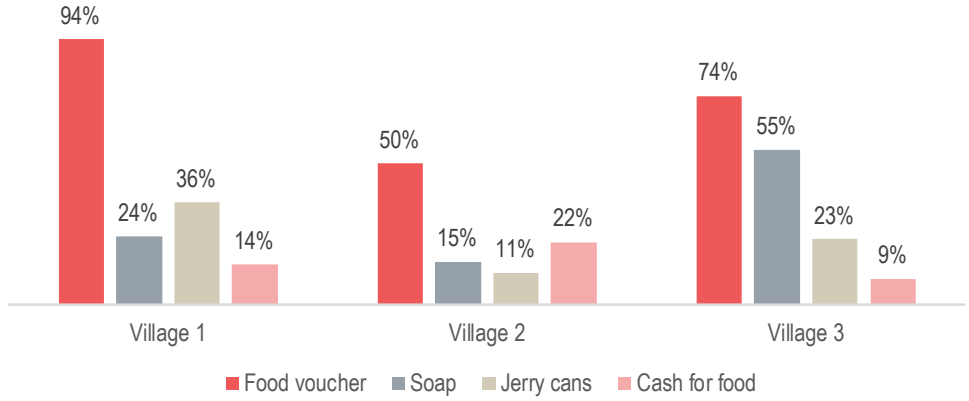
Most commonly reported priority needs in the 30 days prior to data collection:[6]



A high proportion of HHs (92%) across the three villages reported that they had received humanitarian assistance in the three months prior to data collection. Among these, 86% of HHs in Kalobeyei village 1, 75% in village 3 and 72% in village 2 reported that **they were not satisfied with the assistance received mainly because it was not enough.**

Food vouchers were the most commonly reported assistance received by HHs in the three months prior to data collection. In addition, In Kalobeyei village 3, a considerable proportion of HHs (55%) reported having received soap.

Of those HHs reporting having received humanitarian aid in the three months prior to data collection (92%), the most commonly reported types of assistance received:[6]



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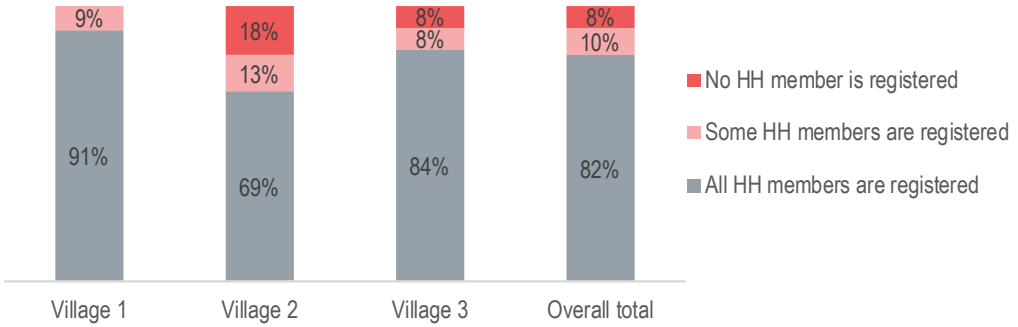
PROTECTION

REGISTRATION AND DOCUMENTATION

HH refugee registration status:



Among HHs with all members not registered as refugees or asylum seekers (8%), the **top reported reasons for not registering were delays in registration due to COVID-19, the unavailability of registration** and HHs not being aware of the importance of registration. A relatively high proportion of HHs reported perceiving that members of the community who had not registered as refugees or asylum seekers are not able to access humanitarian assistance including food assistance (94%), free health services (82%) and free education services (82%).

A quarter of the HHs in Kalobeyei village 1 (25%) reported that all members of their HH **did not possess any identification document (ID)**, while a high proportion of **HHs in Kalobeyei village 2 (97%)** reported that at least one member of their HH **possessed at least one ID.** The IDs possessed included the alien IDs issued by the Government of Kenya, Kenyan birth certificates, manifest, proofs of marriage and proofs of registration.

A relatively high proportion of HHs (66%) in Kalobeyei villages reportedly had at least one member of their HH who was born in Kenya. Despite this high proportion of Kenyan born refugees, a considerable proportion of HHs (42%) reported that at least one HH member born in the camps did not have a Kenyan birth certificate. This varied significantly among the villages, for example it was higher in Kalobeyei village 2 (49%) and lower in Kalobeyei village 3 (41%) and village 1 (37%). Almost half (51%) of the HHs that had members without a Kenyan birth certificate in Kalobeyei villages reported that they **did not know the process of applying for a birth certificate, which may be a contributing factor to registration issues in the future.**

PERSONS WITH SPECIFIC NEEDS

Sixty-eight percent of HHs **(68%) in Kalobeyei village 1 and village 3 and 51% in village 2** reported having **at least one HH member with a specific need**. In the three villages, pregnant or lactating women were the most commonly reported persons with specific needs, followed by separated girls and boys. In addition, 8% and 5% of HHs reported having at least one female and male HH member suffering from a chronic illness respectively.

Of HHs with members suffering from chronic illness, most commonly reported chronic diseases:[6]

	Men	Women
Diabetes	6%	17%
Asthma	7%	15%
Heart disease	17%	14%
Cancer	6%	14%

SECURITY

Nine percent **of HHs (9%) reported that the safety and security situation in the camps was either poor or very poor** in the six months prior to data collection. The top reported reason for HHs feeling that their safety and security was poor, was the perceived risk of physical attacks by other refugees.

Among HHs feeling safety and security is poor, the most commonly reported reasons:[6]

Physical attacks by other refugees	52%
Physical attacks by host community	37%
Verbal harassment by other refugees	25%

Seventy-eight percent (78%) of HHs said that they turned to community leaders, 57% turned to the police and 26% turned to Non-governmental organizations officials to get help when they experienced any insecurity incidents[5] in the six months prior to data collection. The majority of HHs **(83%)** reported perceiving that it **generally takes less than a month for security providers to resolve insecurity cases.** Particularly, 66% of HHs who had reported insecurity cases to the community leaders, said that these cases had been resolved in less than one week.

RELATIONS WITH THE HOST COMMUNITY

Eighty two percent **(82%)** of HHs reported that their **relations with the host community were either good or very good** while 8% reported thar the relationship was poor or very poor. In addition, **10%** of HHs reported that they **did not have any relations with the host community**. Of the HHs who reported relations with the host community to be either poor or very poor, 78% reported that the poor relations were as a result of perceived crime conducted by members of the host community and 35% reported the primary reason to be the perceived competition for work opportunities among the host community and refugees.

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FOOD SECURITY

Sixty-five percent of HHs **(65%) in Kalobeyei villages reported that they did not have enough food for all HH members** and findings suggest that the vast majority of HHs was reliant on food assistance. For instance, **95% of HHS reported food voucher assistance while 18% reported in-kind food assistance as their main source of food in the 30 days prior to data collection.**

Findings indicate that food availability may be decreasing with almost two-thirds of the HHs **(64%) reporting that the amount of food supply for their HH had decreased in the 6 months prior to data collection. These findings are reflected in the findings from common food security composite indicators; about two-thirds of HHs (60%) were found to have a borderline or poor FCS[2] and only 3% reported having** a high household dietary diversity score (HDDS)[4] **within Kalobeyei villages** and about two-thirds of HHs (62%) were found to use emergency, crisis, or stress-level livelihoods-based coping strategies.

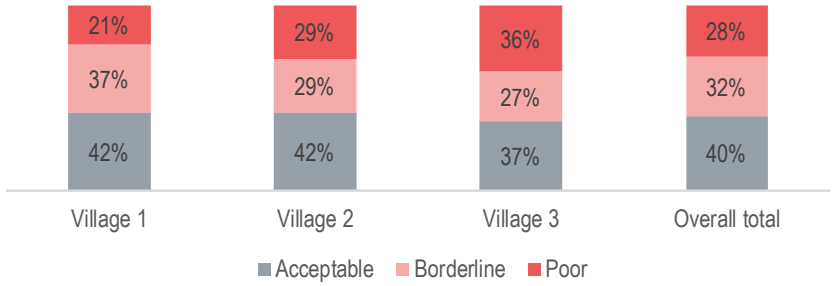
FOOD CONSUMPTION SCORE (FCS):[4]

The FCS measures how well a HH is eating by evaluating the frequency at which differently weighted food groups are consumed by a HH in the seven days prior to data collection. 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. Only HHs with an acceptable FCS are considered to most likely be food secure, while those with borderline and poor FCS are considered more likely to face moderate or severe food insecurity, respectively.

Findings indicate that almost two-thirds **(60%)** of the HHs were **likely to face moderate or severe food insecurity. Findings suggest that HHs in Kalobeyei Village 3 might be slightly more likely to experience food insecurity compared to HHs in Village 1 and 2, however, the differences between villages are small.**

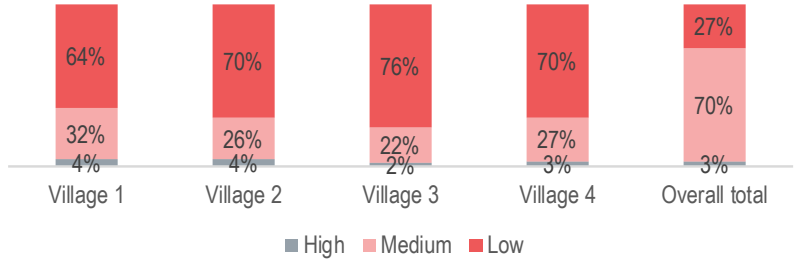
Proportion of HHs per FCS, per Kalobeyei village:[4]



HOUSEHOLD DIETARY DIVERSITY SCORE (HDDS):[4]

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. **Almost all HHs (97%) were found to either have a moderate or a low HDDS, likely suggesting a common experience of food insecurity for HHs in Kalobeyei villages.**

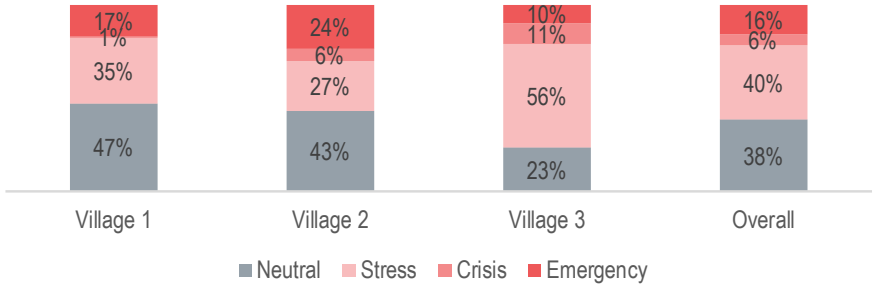
Proportion of HHs per HDDS, per Kalobeyei village:[6]



LIVELIHOOD-BASED COPING STRATEGY INDEX (LCSI):[4]

The LCS is measured to better understand longer-term HH coping capacities. The LCS 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. **Findings indicate that 62% of HHs in Kalobeyei villages were using either emergency, crisis or stress-level livelihood-based coping strategies.**

Proportion of HHs per LCS score, per camp in the 30 days prior to data collection:[6]



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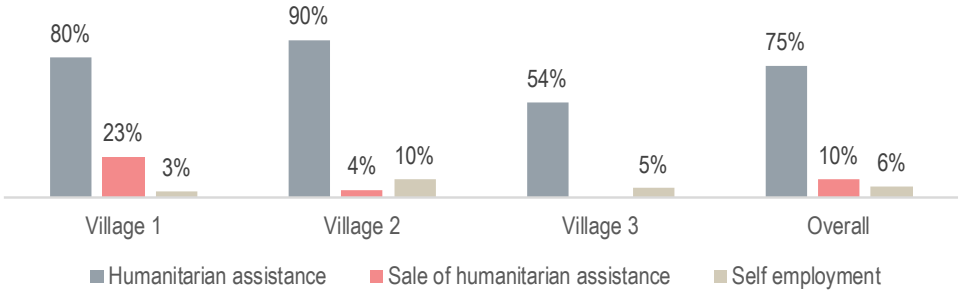
LIVELIHOODS

INCOME:

A higher proportion of HHs in Kalobeyei village 2 (90%) than in village 1 (80%) and village 3 (54%) reported humanitarian assistance as their main source of livelihood in the 30 days prior to data collection. Eighteen percent of HHs (18%) reportedly did not have any source of income in the 30 days prior to data collection, while 9% of HHs reported that at least one member of their HH had earned some form of income in the 30 days prior to data collection. COVID-19 seems to have had an impact on HHs' livelihoods, some HHs reported having a HH member who had lost their job due to COVID-19 related challenges.

Of HHs having some form of income, most commonly reported sources of income in the 30 days prior to data collection:[6]



Ten percent (10%) of HHs reported that at least one member of their HH was operating a business. Of these HHs, **58%** reported that they had **spent their savings to set up the businesses.** An additional **29%** of HHs reported that they had **borrowed money from friends and/or relatives to start their businesses** and **20%** HHs reported that they received grants from the UN to start their businesses. Of the HHs that reported having a business, all HHs reported that the businesses were located inside the camps and **85% reported that they did not have a business permit for their business.**

Thirty-three percent of HHs **(33%)** reported that they **had borrowed some money from family, friends, traders, etc. at the time of data collection.** Of these, **16% reported that they had borrowed the money due to COVID-19 related challenges** and **97%** reported that they had primarily borrowed the money **to buy food.**

VOCATIONAL TRAINING AND EMPLOYMENT:

Fifteen percent **(15%)** of HHs reported having at least one member of their HH who **had attended vocational training in the 6 months prior to data collection**. Of these, 78% and 75% of HHs reported that at least one female and one male HH member respectively had completed the training. A high proportion of the HHs **(76%)** that reported HH members had completed vocational training reported that the skills acquired were sufficient (i.e members could use those skills to earn an income).

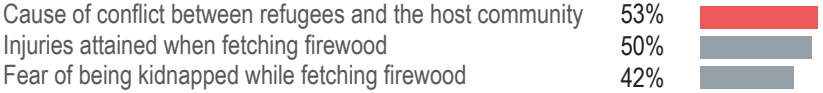
Of the 15% of HHs that reported having at least one member who had attended vocational training in the 6 months prior to data collection, only a minority (9% and 8%) reported that a male and/or female HH member, respectively, had stopped attending the training due to the closure of training centres as a result of COVID-19.

All HHs (100%) reported knowing what is required for one to get formal employment in Kenya. They reported that a person a person is required to apply for jobs, possess skills that match the job they apply for and be able to speak English. In addition to these, as a refugee, one is required to have an alien ID card, proof of registration, a movement pass and a work permit.

ENERGY:

Sixty one percent of HHs **(61%) reported that they mainly used torches** as a source of lighting and **33% of HHs reported solar energy** as their main source of lighting. A high proportion of HHs (83%) reported firewood to be their main source of heat for cooking. Out of these, **91% reported that they encountered challenges while fetching or using firewood.**

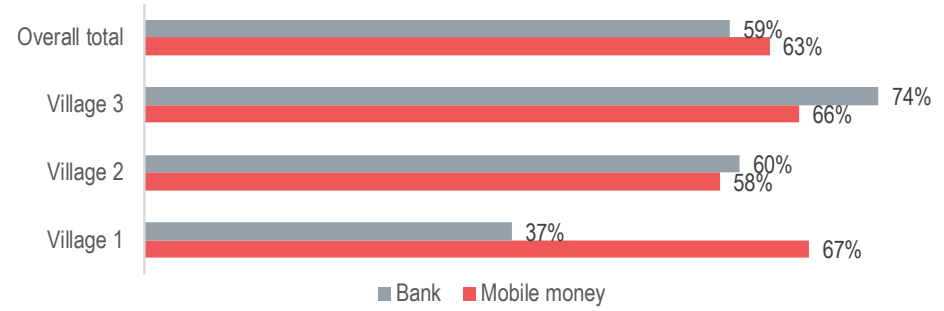
Most commonly reported challenges faced while fetching or using firewood, reported by HHs encountering challenges:[6]



FINANCIAL INSTITUTIONS:

The availability and access to financial institutions is a key part of HHs' livelihoods. Almost two-thirds of HHs **(64%) reported having access to financial institutions**. Those HHs who reported having access to such institutions most commonly reported having **access to mobile money.**

Most commonly reported financial institutions accessed by HHs reporting to have access to financial institutions in Kalobeyei villages:[6]



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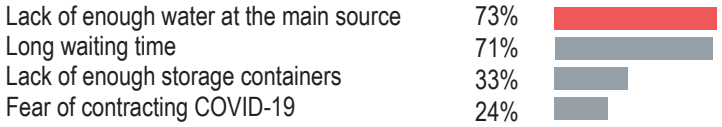
WATER, SANITATION & HYGIENE

WATER:

Forty-five percent of HHs **(45%) reported having access to enough water to meet their HH needs** in the 30 days prior to data collection. Of the 55% of HHs that reportedly did not have access to enough water, **70% fetched water at a far water point and 52% reduced the consumption of water for hygiene practices in order to cope with a lack of enough water. Forty-four percent of HHs (44%) in Kalobeyei villages reported that members of their HH experienced challenges while fetching water.**

Among those HHs, most commonly reported challenges faced while fetching water:[6]



HYGIENE:

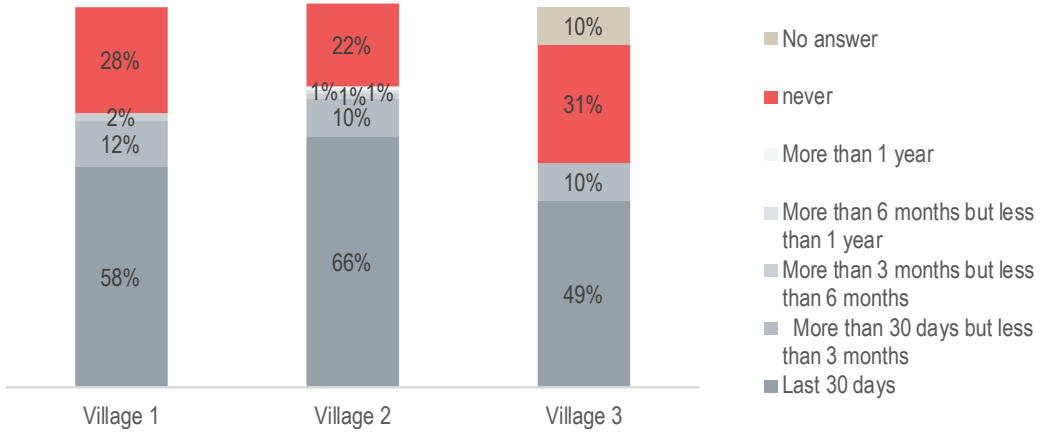
More than half of HHs **(63%) reported having soap at the time of data collection.** These HHs reportedly used the soap for hand washing, bathing, washing utensils and washing clothes, among other uses. Of the 37% HHs that did not have soap at the time of data collection, **68% reported that they were waiting for the next soap distribution and 53% reported that they could not afford to buy soap.**

Thirty four percent (34%) of HHs in Kalobeyei villages reportedly washed their hands during all the critical hand washing occasions[5], **63% reportedly washed their hands during some critical hand washing occasions[5], while 3% reportedly never washed their hands during any of the critical hand washing occasions[5]. HHs who were not aware of all the five critical hand washing occasions**, (96% in Kalobeyei Village 2, 56% in Village 1 and 47% in Village 3) **might be at elevated risk of disease transmission.**

Proportion of HHs that reportedly washed their hands during the following occasions:[6]

Thirty-one percent of HHs (31%) in Kalobeyei Village 3, 28% in Village 1 and 22% in Village 2 reportedly had never received hygiene promotional messaging. Of the HHs that had received hygiene promotional messaging in Kalobeyei villages, 80% had been visited at home by hygiene promoters. HHs across the different villages had received hygiene promotion messaging during different time lines which could have affected the hand washing behaviour of the HHs.

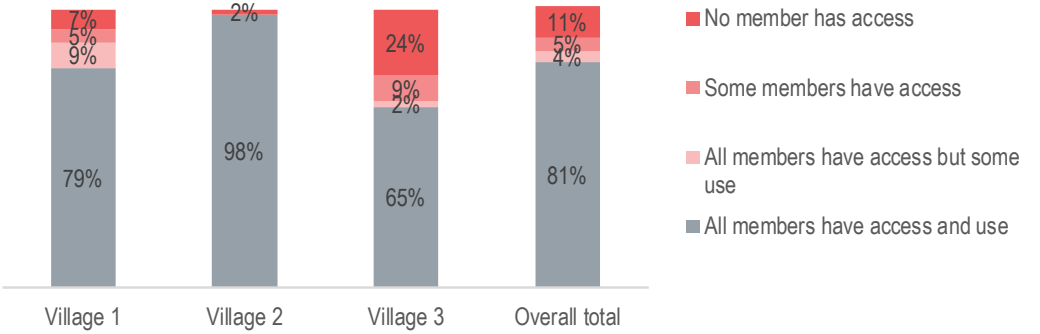
Proportion of HHs whose members received hygiene promotion messages in the following timelines:



SANITATION:

A relatively high proportion of HHs in Kalobeyei Village 3 (35%) reported that at least one member of their HH did not have access to or use a latrine. Among the 19% of HHs across Kalobeyei villages that reported at least one member not having access to/use a latrine, the majority (69%) reported that this was due to a lack of enough latrines, 30% reported that the latrines were not accessible to children below the age of three years which might indicate an elevated risk of infections if feaces are left on the streets and 28% reported that the latrines were unhygienic. Of the HHs that reportedly had a member with access to a latrine, 35% reported that they shared the latrine with members of other HHs. Of the HHs that reportedly shared a latrine, 87% said that the latrines were not gender-segregated.

Reported level of access to latrines, by % of HHs per village in Kalobeyei:



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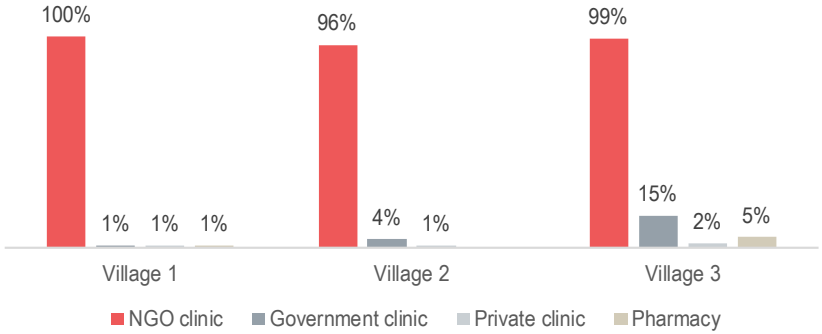
HEALTH

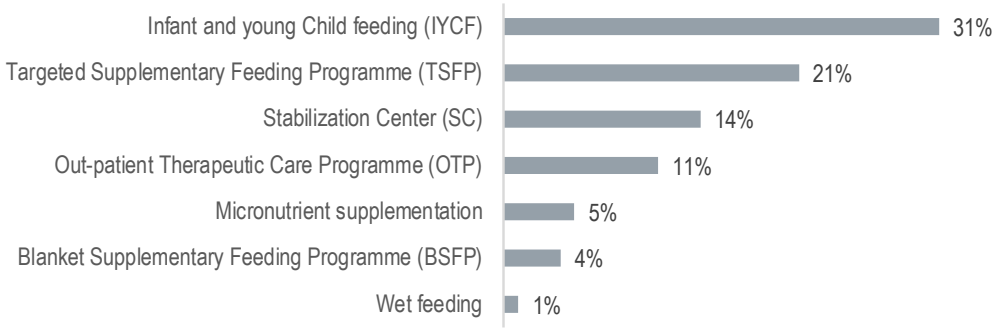
A high proportion of HHs **(94%)** reported that it takes them **less than one hour to reach the health facility that is nearest to their homes.** Almost all HHs **(98%)** reported being **able to access a functioning health facility** when they encountered a health issue. A majority of them, (98%) reported that they would visit an NGO run clinic or hospital. Of the 2% HHs that reported not being able to attend a health facility when they experienced a health issue, most of them reported that there was no medicine or treatment. Of the HHs that reportedly had access to a functioning health facility, **96%** reported that t**hey were not required to pay for health care.**

% of HHs that would visit the following types of health facilities if they experienced a health issue:[6]



Sixty-one percent (61%) of HHs reported being able to access nutrition services when they needed these services. Of the HHs that reported not being able to access nutrition services when needed, 59% reported that they were not aware of health facilities that were offering nutrition services. About half (46%) of HHs in Kalobeyei village 3 reported not being able to access nutrition services when needed.

Of HHs able to access nutrition services, % of HHs whose members were enrolled for the following nutrition services at the time of data collection:[6]

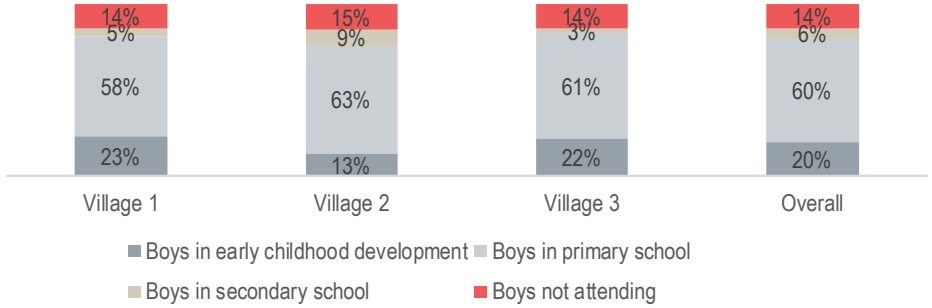


EDUCATION

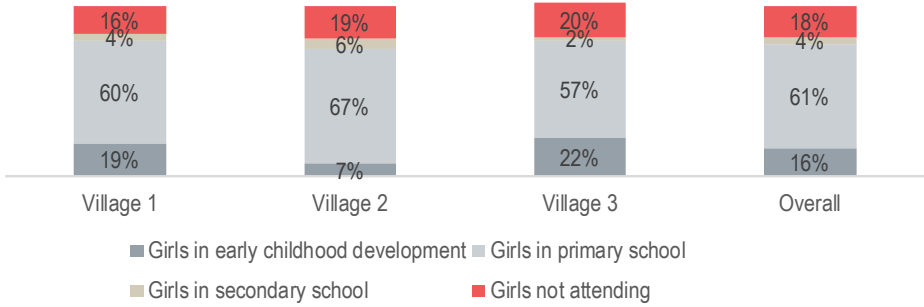
The proportion of girls not attending school appears to be slightly higher than that of boys not attending school across the three villages. The most commonly reported reason given by HHs for their children not attending school were that children were perceived to be too young to attend school, reportedly since schools were too far away for the younger children to travel to.

A higher proportion of children were reportedly attending primary school in comparison with those attending secondary school which indicates that **a considerable number of children are not transitioning to secondary school after completing primary school.** Moreover, 8% of HHs in Kalobeyei Village 2, 4% in Village 3 and 3% in Village 1 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 the inability to pay for school fees and stationary, forced marriage, a preference to work instead of studying, little motivation since those who attended tertiary education are still in the villages and uncertainty about the future due to fear of the villages being closed.

Proportion of school-aged[8] boys reportedly attending school in March 2020, per education level:



Proportion of school-aged[8] girls reportedly attending school in March 2020, per education level:



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CONCLUSION

Findings indicate that HHs in Kalobeyei villages experience humanitarian needs accross multiple sectors , particularly in the food security sector, where almost two-thirds (60%) of HHs were found to **have either a poor or borderline food consumption score (FCS)[4].** In addition to this, **62% of HHs were using either emergency, crisis of stress level livelihood-based coping strategies, which indicates that their FCS[4] might have been lower were they not engaging in these unsustainable coping strategies and suggests an eroded resilience to future shocks.**

Documentation and access to information on how to obtain it, remains a challenge for refugees in Kalobeyei villages. **A considerable proportion of HHs in Kalobeyei villages reported that some or none of their HH members were in the possession of any type of ID**, while a relatively sizable proportion of HHs also reported that some or none of their HH members were registered at the time of data collection. Given the different challenges encountered by unregistered and/or undocumented HH members, including not being able to access food assistance, free health services and free education services, among other services, this might indicate an elevated vulnerability for those who are not registered or undocumented, as they are usually not able to access food assistance and other basic services, such as education and health.

In terms of sanitation, some HHs across the three villages reportedly did not have access to functioning latrines and **some HHs were found to not be aware of all critical handwashing occasions, likely exposing them to elevated risks of disease transmission, particularly in the light of COVID-19.**

Since March 2020, the livelihoods and income of Kenyans has been affected due to regulations to prevent the spread of COVID-19. In particular, **Some HHs in Kalobeyei villages reported that at least one member of their HH had lost their source of income as a result of COVID-19 challenges.**

Overall, findings suggest that HHs in Kalobeyei villages, despite commonly receiving humanitarian assistance, are facing challenges in meeting some of their HH's needs in the different sectors of education, health and nutrition, livelihood, WASH and protection.

About REACH:
REACH Initiative facilitates the development of information tools and products that enhance the capacity of aid actors to make evidence-based decisions in emergency, recovery and development contexts. The methodologies used by REACH include primary data collection and in-depth analysis, and all activities are conducted through inter-agency aid coordination mechanisms. REACH is a joint initiative of IMPACT Initiatives, ACTED and the United Nations Institute for Training and Research - Operational Satellite Applications Programme (UNITAR-UNOSAT).

END NOTES

1. UNHCR Statistics package, September 2020
2. United-Nations Secretary-General High level panel on displacement in South Sudan.
3. UN news about the reduced humanitarian funding in Dadaab, Kakuma and Kalobeyei.
4. For more information on food security indicators (FCS,CSI, HDDS) please see here:
5. Hand washing should happen at 5 critical times i.e. before touching food (eating, preparing food or feeding a child) and after contact with excreta (after using the toilet or cleaning a child's bottom).
6. Households could select multiple answers
7. Insecurity incidents include theft, sexual and gender based violence, domestic violence, etc.
8. School-aged children are children between 4 and 17 years old

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