4/23/2025

Vulnerability Risk Assessment for Refugees in Kyangwali Refugee settlement

DERF - Danish Emergency Relief Fund

COMMUNITY INTEGRATED DEVELOPMENT INITIATIVES(CIDI)

1.0 Introduction

1.1 About Community Integrated Development Initiatives (CIDI)

CIDI is a not-for-profit organization founded in 1996 and registered with the Non-Governmental Organisation (NGO) Board under the Ministry of Internal Affairs of Uganda in 1999. CIDI operates under registration certificate No. 2715 and Reference No. S-5914/2868. CIDI currently implements programmes that cover 25 districts in Uganda. The head office is located in Kampala. CIDI's Vision is to have "Communities enjoying a decent life free of hunger, poverty and disease". The Mission is "Enhancing sustainable community resilience through, improved income, Nutrition and Food security, Water and Sanitation, Health Promotion and Policy advocacy. CIDI's has a strategic goal that focus on improved access to clean and safe water, hygiene and sanitation services for the target poor communities in Uganda as well as to have "increased capacity of the disempowered local communities to be their own advocates in bringing about positive change in their lives".

1.2 About the project

In Mach 2025, CIDI in partnership secured funding from the Danish Emergency Relief Fund (DERF) for a 6 months project code named; "Emergency WASH Assistance for DRC refugees in Kyangwali - Uganda". The project is being implemented in Bukinda Zone -Kyangwali Refugee settlement. Through this project, CIDI plans to improve health outcomes for 1000 vulnerable people with reduced incidence of water borne disease. The intervention will the dignity and confidence of 100 girls enabling them managing their menstruation without stigma and boosting their self-confidence. The project is aims at ensuring that refugee councils have capacity to voice and engage for improved protection and de-escalation of violence and WASH service delivery among the communities they represent. CIDI is very ware of the composite vulnerabilities that Refugees face as people who are displaced from their localities. The project intends to focus on Extremely vulnerable individuals.

It's against this background that CIDI sought to undertake a Vulnerability Risk Assessment.

1.3 Goal and objectives of the study

Identify the most vulnerable populations and the potential Risks that they face In Kyangwali Refugee Settlement.

1.3.1 Specific objectives

1. Map out the key vulnerable and persons of special needs categories in the area and the risks that the refugees face.

2.Establish the access levels of Water and Sanitation and Health Services

3. Establish access to social and Psyco social support services and the available coping mechanisms

4. Make conclusions and recommendations

1.4 Methodology

The methods that were adopted for the study were consistent with both the basic principles of research and analysis. The approach for the study was largely qualitative and quantitative analysis Primary Data was collected using a semi structured questionnaire. Key Informant Interviews were

conducted with the refugee welfare council, Office of the Prime Minister and UNCHR to enable triangulation of information.

i) Inception meeting

Prior to commencement of the study, an inception meeting was held with the staff of CIDI at Kyangwali and Refugee settlement and other entry meetings were held with the Office of the Prime Minister (OPM) and UNHCR as well as Refugee Welfare Council Block leaders.

ii) Documentation review:

Detailed review of literature and relevant documents was undertaken to generate information related to existing regulations, strategies, policies, and laws/legal frameworks and guidelines.

iii) Key Informant Interviews (KIIs):

Key Informant Interviews (KIIs) were conducted with OPM and UNHCR and the coordination agencies on the status of services in the settlement.

iv) Questionnaire:

Structured Questionnaires were administered with in Bukinda Village in Kyangwali Refugee settlement.

V)Data analysis and reporting

The Data tools were checked and cleaned for completeness before being entered into a database for analysis. Further cleaning was conducted after the data was entered into the database. The Descriptive statistical and narrative interpretation analysis, triangulation was done and a report was compiled using the sub-themes of analysis.

2.0 RESULTS AND FINDINGS

2.1 INTERVIEWE CHARACTERISTICS OF THE RESPONDENTS

Table 1; Interviewee characteristics

		Frequency	Percentage
Village	Barnabe Uwamungu	1	0.44%
	Bukinda	224	99.11%
Respondents category	ORDINARY	142	65.74%
	PERSON WITH SPECIFIC NEEDS	74	34.26%
Sex	FEMALE	163	72.44%
	MALE	62	27.56%
Age group	15 - 19 Yrs	18	8.00%
	20 - 24 Yrs	43	19.11%
	25 - 29 Yrs	44	19.56%
	30 - 34 Yrs	37	16.44%
	35 - 39 Yrs	27	12.00%

	40 - 44 Yrs	17	7.56%
	45 - 49 Yrs	11	4.89%
	50 Yrs Plus	28	12.44%
	Grand Total	225	100.00%

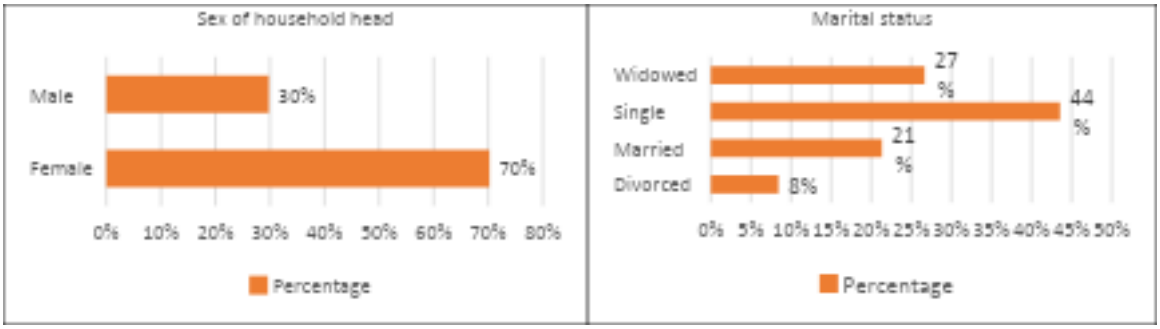
The interview data indicates that the vast majority of respondents (99.11%) were from the village of Bukinda, with only one respondent (0.44%) from Barnabe Uwamungu. Most participants were classified as ordinary respondents (65.74%), while 34.26% were persons with specific needs. In terms of gender distribution, females represented a significant majority at 72.44%, compared to 27.56% males. The age distribution showed a relatively balanced spread across different age groups, with the largest proportions in the 25–29 years (19.56%), 20–24 years (19.11%), and 30–34 years (16.44%) age ranges. Older age groups, including those 50 years and above, accounted for 12.44% of the sample.

2.2 HOUSEHOLD CHARACTERISTICS

Figure 1; Household characteristics

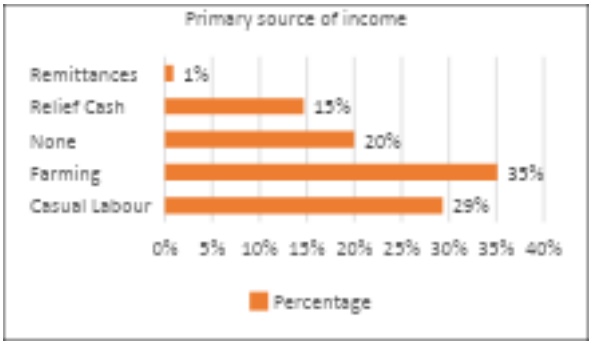
A majority of respondents (67.11%) had lived in the area for 1 to 6 months, while 31.11% had been there for less than a month. Only 1.78% had stayed between 6 months to a year, indicating that most residents were recent arrivals. All 225 respondents (100%) identified as refugees, confirming the survey's focus on displaced or resettled populations.

Figure 2; Sex of the household head and marital ststus



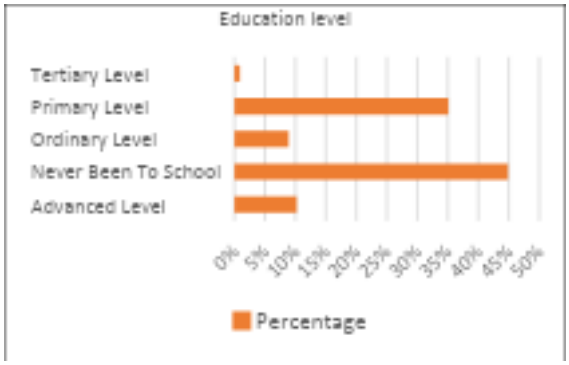
Female-headed households made up a significant majority at 70.22%, while male-headed households accounted for 29.78%.

Figure 3; Primary source of income for the household head



The main sources of income were farming (35.11%) and casual labor (29.33%). A notable portion of households reported having no source of income (20%), while others relied on relief cash (14.67%) and remittances (0.89%).

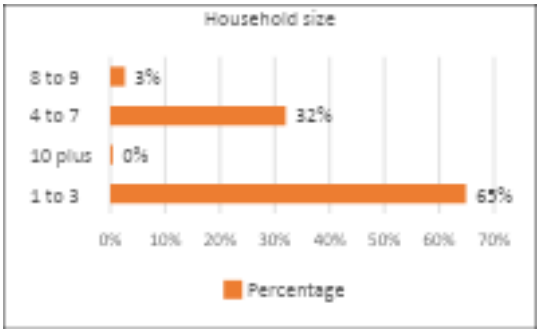
Figure 4; Education level of the household head



Nearly half of the household heads (44.89%) had never been to school. Primary level education was the next most common (35.11%), followed by advanced level (10.22%), ordinary level (8.89%), and

The most reported PSN category was woman-headed households (35%), followed by others (22%), elderly-headed households (11%), and households with persons with disabilities (10%). Child-headed households (4%), those with chronic illnesses (2%), pregnant or lactating women (3%), and unaccompanied or separated children (3%) were also represented.

Figure 5; Household size



Most households (64.89%) had between 1 to 3 members. Another 32% had 4 to 7 members, while larger households (8 to 10+ members) were rare, making up only 3.11%. The largest group of household heads were single (43.56%), followed by widowed (26.67%), married (21.33%), and divorced (8.44%).

Among children under 5 years, a majority of female children (73.81%) are found in households with one girl, while 23.81% have two and only 2.38% have three. Similarly, male children under 5 are predominantly in households with one boy (81.25%), and 18.75% live in households with two boys.

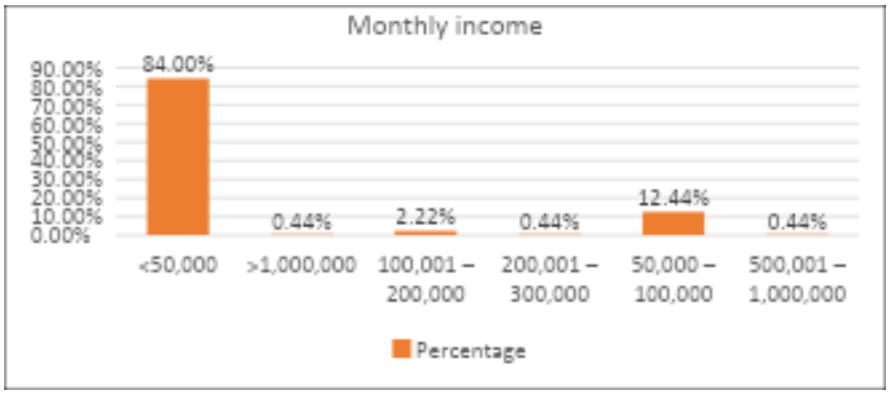
For girls aged 6 to 17 years, 51.39% are in households with one girl, 31.94% with two, and 13.89% with three. A few households have four or even seven girls in this age group. Male children of the same age group show a similar trend: 56.25% are in households with one boy, 28.13% with two, and the rest distributed among three to eight boys per household.

A significant majority of adult females in the 18 to 59 age group (91.86%) are found individually in households, with smaller proportions in households with two or three adult females. The same is true for males, with 98.59% living as the sole male adult in their age category per household.

Among elderly females, 69.23% are in households with one woman, while the rest are spread across households with up to five elderly females. Elderly males show more variation, with 38.46% in single-male households, and others distributed across households with two to eight elderly men.

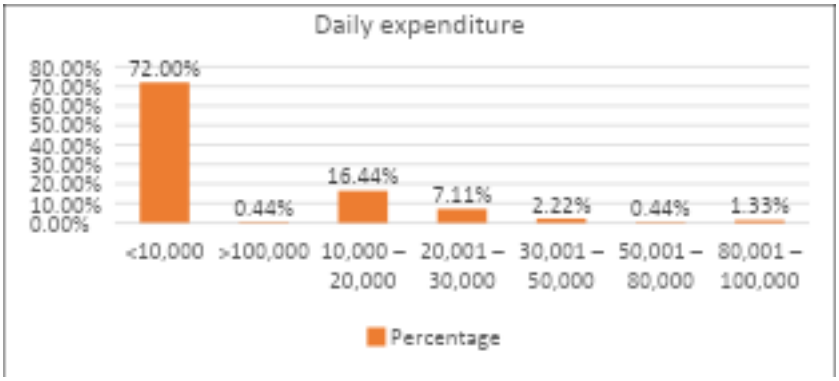
2.3 Household income and expenditures

Figure 6; Household monthly income



An overwhelming majority (84%) of households earn less than 50,000 Ugandan Shillings per month. Only a small fraction earns between 50,000 and 100,000 (12.44%), and fewer still earn over 100,000, highlighting low income levels in the population.

Figure 7; Household daily expenditure

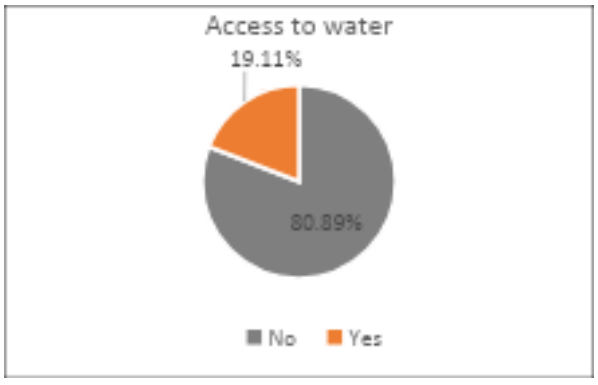


Most households (72%) report spending less than 10,000 Ugandan Shillings daily. Around 16.44% spend between 10,000 –20,000, and only a small number of households spend more than 30,000 per day, indicating generally low daily expenditure in line with low income levels.

3.0 ACCESS TO WASH SERVICES

3.1 Water Access and Usage

Figure 8; Access to water and usage



Most households rely on multiple jerrycans for their daily water needs, with 39.56% initially using a 20-liter jerrycan and 55.11% currently using the same volume. Despite this, a significant majority (80.89%) report insufficient water access, citing reasons such as distant water sources (51%), water scarcity or non-availability (15%), and lack of proper collection containers (23%). This indicates a critical vulnerability whereby access to safe, sufficient water remains a challenge, directly impacting hygiene and health.

Water access

The majority of refugees experience challenges accessing enough water due to distance and insufficient supply leading to a decline in water usage

3.2 Water Consumption Patterns:

Actual water use appears to have decreased from pre-occupation levels, with 55.11% now using one jerrycan's worth daily, reflecting potential resource constraints. The decrease emphasizes the need for improved water supply management and infrastructure to meet minimum hygiene standards.

- Water Scarcity and Accessibility: High dependency on limited water sources: Many households rely on small jerrycans, but actual consumption has decreased, highlighting potential water shortages.
- Distance and safety concerns: Over half of respondents say water sources are too far, and some face safety issues, discouraging regular access.
- Insufficient infrastructure: A lack of proper water collection containers (only 23%) worsens the problem, increasing the risk of contamination and reducing hygiene practices.

3.3 Hygiene and Sanitation:

Access to sanitation facilities shows that approximately 68% of households have latrines, predominantly community latrines (90.20%), though about 31.56% lack any latrine, heightening risks of open defecation and related health issues. Hand washing practices mainly involve water alone (61.78%) or water with soap (34.22%), but soap availability remains limited, with half of respondents having only a small piece in the past week. Soap scarcity compromises hand hygiene, vital for disease prevention, especially in crowded refugee settings.

Sanitation

Many refugees lack proper sanitation facilities, and those who do often rely on community latrines which can pause privacy concerns

3.4 Sanitation Deficiencies:

- Latrine coverage: While 68% have latrines, a significant number still lack sanitation facilities, which might lead to open defecation and increased health risks.
- Type of Latrines: Most latrines are community-based (90%), which may impact privacy and safety, especially for women and girls.
- Hygiene Practices and Soap Access:
- Hand washing behaviors: Predominantly water only, which reduces effectiveness without soap.
- Soap scarcity: Half of the households had minimal soap in the past week, impairing hygiene, especially critical during disease outbreaks.

Hygiene

Hand washing practices are often limited due to lack of readily available soap. This shows a critical for hygiene education and supplies

3.5 Menstrual Hygiene and Women's Health:

Nearly half of the women and girls (49.10%) use menstrual hygiene products, but a significant 71.49% of those needing pads struggle to access them, mainly due to cost (66%) and availability (20%). Few households have school-going girls receiving adequate pads, increasing vulnerability to reproductive health issues and menstrual-related stigmas. This gap underscores the need for targeted support to improve menstrual hygiene management.

3.5.1 Menstrual Hygiene Challenges:

- Limited access to menstrual products: Nearly half of women and girls who need pads cannot access them, primarily due to cost and availability.
- Impact on dignity and health: Girls may miss school or suffer health issues due to inadequate menstrual hygiene management.
- Health and Protection:
- Limited healthcare access: More than 76% of households cannot access healthcare when needed.
- GBV and psycho-social support: Though reported cases are low, the potential for violence remains, compounded by inadequate psycho-social support for victims.

Menstrual Hygiene

Many women and girls face challenges accessing menstrual products showing a need for increased access and support

Health Access

Refugees often struggle to access healthcare due to distance, lack of resources and inadequate support systems, making them vulnerable to health risks

4.0 Health and Gender-Based Violence (GBV):

GBV

While reported cases are low (3.56%) there is a potential for violence, and access to psychosocial support for victims is inadequate, showing protection concerns

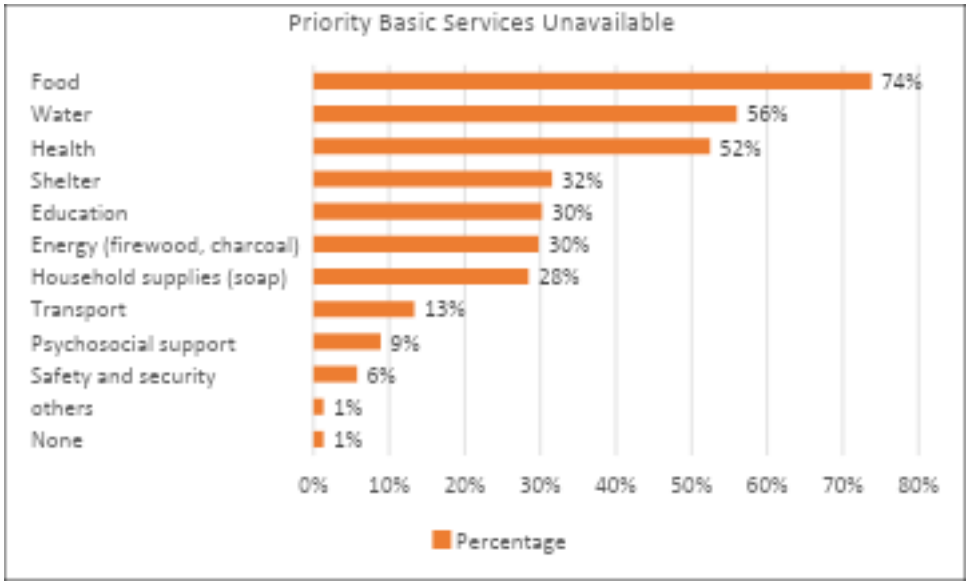
Access to health services is limited, with 76.44% unable to access care when needed. GBV reporting is low (96.4%), but the presence of incidents in the past month indicates ongoing protection concerns. Psycho-social support remains largely inaccessible, with over 91% not receiving any form of assistance, exposing vulnerabilities and mental health risks.

The overlap of limited water access, inadequate sanitation facilities, limited hygiene products, and insufficient health and psycho-social support demonstrates significant vulnerabilities within the refugee population.

These conditions threaten public health, dignity, and safety, emphasizing an urgent need for integrated WASH interventions, improved infrastructure, and support services tailored to the community's needs.

5.0 Access to Basic Services

Figure 9: Priority Basic Services Unavailable



A significant proportion of refugees lack access to fundamental services: food, water, and health services. Shelter, household supplies, and education are also insufficient, affecting overall well-being and safety.

Shelter

Many refugees (32%) lack access to adequate shelter, facing challenges with overcrowding, vulnerability to the inadequate living conditions

Food security

Food insecurity is a major concern, with a large proportion of refugees struggling to access enough food, contributing to their vulnerability and hardships

The most critical shortages reported are food (74%), water (56%), health services (52%), shelter (32%), and household supplies like soap (28%). Energy sources (30%) and education (30%) also face notable gaps. Very few respondents (1%) indicated they have no unmet basic needs, highlighting widespread vulnerabilities.

Household supplies

Refugees face shortages of basic supplies like soap, which further compromises their hygiene practices and overall well being

Energy

Access to energy sources is limited affecting lighting, cooking, and other daily activities, creating challenges for refugees

Education

Education opportunities for the refugees is limited, impacting their access to leaning and potential for future development

5.1 Barriers to Access

The main barriers are long distances to service points (76%) and lack of funds (66%). Other issues include feeling unsafe (7%), movement restrictions (3%), and limited availability of supplies (6%). These obstacles substantially hinder access to essential services and heighten risks, especially for women and vulnerable groups.

5.1.1 Information on Water, Sanitation, and Hygiene

A majority (86%) have not received recent info on safe water and sanitation, with NGOs and community leaders as primary sources. However, more than 93% wish to learn about sanitation and hygiene, demonstrating awareness gaps and demand for health education.

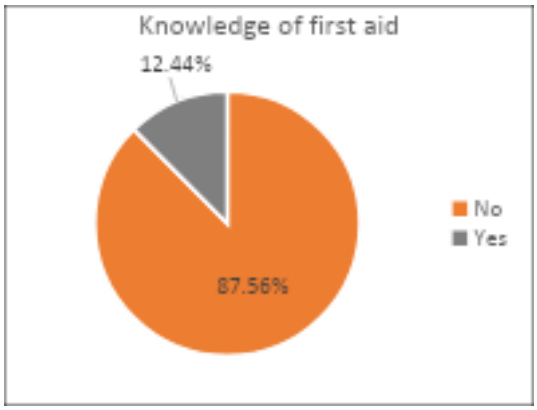
5.2 Common Hazards and Risks

Risks reported include Protection Risks of vulnerable groups especially women and children due gender-based violence often worsened by poor light, exploitation due to extreme vulnerabilities. The Crowded shelters and use of open fires present high fire hazard risks, environmental degradation, disrupts the ecosystem displacing reptiles such as snakes posing snake bite risks. Over crowding within the shelters worsens the hygiene situation. Inadequate access to water poses high risks of water borne diseases, typhoid, respiratory infections, malaria and diarrheal diseases among children. Health emergencies are worsened by inability to access health care service quickly especially at night. Accidents especially of motorcycles were also reported.

5.3 Coping Mechanisms

Most households seek help from community leaders (42%) and friends (31%). Smaller percentages seek assistance from NGOs (15%) or resort to borrowing money (16%) and selling assets (12%). Nearly one-fifth (19%) do not have coping strategies, indicating gaps in support systems.

5.4 Knowledge of First Aid



A vast majority (87.6%) lack first aid knowledge, but over 80% are interested in learning, reflecting a significant opportunity for capacity building to enhance emergency response capacity within the community.

5.5 Experience of Trauma or Violence

About 49% of respondents reported experiencing or hearing violence in the past month, with psychological/emotional violence (42%) and physical violence (43%) being prominent forms. This underscores ongoing protection concerns.

5.6 Violence in Neighborhoods and Households

Only 4.4% of respondents reported hearing violence in their neighborhood recently, while 26.7% experienced violence themselves or among family members in the last month. The prevalent types include physical (43%) and psychological (42%) violence, with sexual violence being less reported (12%).

5.7 Coping Strategies among Women and Men

Both women (70%) and men (70%) mainly cope by talking to others and caring for their families. Substance abuse and conflict are minor coping mechanisms, indicating resilience but also ongoing stress.

5.8 Training in Conflict Resolution

Most respondents (80%) have not received training in conflict resolution, but nearly 20% have. This highlights an area for capacity development to promote peace and social cohesion within the settlement.

6.0 Conclusion

The findings reveal significant gaps in access to essential services among refugees in Kwangwali. A majority report being unable to access food (74%), water (56%), health services (52%), and shelter (32%), primarily due to long distances (76%) and lack of financial resources (66%). These barriers exacerbate vulnerabilities and limit daily coping capacities.

Most refugees rely on community help or borrowing to overcome access challenges, but 19% lack alternative solutions. Knowledge of basic health practices like First Aid remains very low (only 12%), yet many (81%) wish to learn, highlighting an opportunity for capacity building. Incidents of violence (39%) and trauma are prevalent, though community awareness of violence within neighborhoods is limited (only 4.4%). Women and men primarily cope by talking to others and caring for their families, but coping mechanisms like substance abuse are minimal, indicating resilience but also unmet psychosocial needs.

These findings connect directly on WASH and basic service gaps, emphasizing how limited access and safety concerns drive coping strategies and barriers. Despite widespread needs, access to information on sanitation, hygiene, and conflict resolution remains insufficient, underscoring the urgent need for integrated support programs that enhance access, safety, health knowledge, and psychosocial well-being in the settlement.

Recommendations:

- ❖ Improve water infrastructure: Establish nearby water points, supply durable collection containers, and ensure safety to reduce distances and risks.

- ❖ Expand sanitation facilities: Increase latrine coverage, especially household latrines, ensuring safety, privacy, and cleanliness.

- ❖ Enhance hygiene promotion: Distribute soap, promote hand washing with soap, and support hygiene education campaigns.

❖ Address menstrual hygiene needs: Provide free or subsidized pads, especially targeting school-going girls, and tackle taboos through awareness.

❖ Strengthen healthcare and protection services: Improve access, expand psycho-social support, and reinforce GBV prevention and response mechanisms.

6.2 Strategies for Addressing Vulnerabilities in WASH and Protection

1. Enhancing Water Access and Efficiency

❖ Establish additional water points closer to households to reduce distance and safety concerns.

❖ Introduce water-efficient technologies (for instance, drip or rainwater harvesting where feasible).

❖ Distribute durable, portable water collection containers and educate households on safe water storage.

2. Improving Sanitation Infrastructure and Usage

❖ Scale up latrine construction, prioritizing household latrines to improve privacy, safety, and dignity.

❖ Implement regular maintenance and cleaning routines for existing latrines to promote usage.

❖ Create community-led sanitation and hygiene promotion campaigns, encouraging shared responsibility.

3. Promoting Hygiene Practices and Access to Supplies

❖ Increase soap distribution regularly, possibly through local supply chains or barter schemes.

❖ Launch hygiene awareness campaigns emphasizing the importance of hand washing with soap at critical times.

❖ Install hand washing stations at key points such as water points, markets, and schools.

4. Addressing Menstrual Hygiene Needs

❖ Distribute free or subsidized menstrual hygiene products to women and girls, especially school-going girls and vulnerable households.

❖ Conduct community sensitization sessions to challenge taboos associated with menstruation.

❖ Support girl-friendly spaces in schools or community centers for hygiene management.

5. Strengthening Healthcare and Mental Health Services

❖ Set up mobile clinics or health outreach programs to improve healthcare access.

❖ Train community health workers on basic health services and GBV response.

❖ Develop psycho-social support networks, including safe spaces for women and youth, and establish referral pathways for GBV survivors.

6. Protection and GBV Prevention

❖ Increase awareness about GBV prevention, reporting mechanisms, and support services.

❖ Engage community leaders to promote a protective environment and challenge harmful norms.

❖ Establish confidential reporting channels and provide specialized support for GBV victims.

Additional Tips

❖ Community Engagement: Involve local groups early in the planning to ensure acceptance and sustainability.

❖ Partnerships: Coordinate with NGOs, government agencies, and community leaders to leverage resources and expertise.

❖ Feedback Mechanisms: Establish channels (hotlines, suggestion boxes) for households to report issues or suggest improvements.