Barriers and Facilitators to Accessing Humanitarian Services for Persons with Disabilities in Kyaka II Refugee Settlement.

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ASSOCIATION OF REFUGEES WITH DISABILITY(ARD)

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Acronyms and Abbreviations

i. **ARD** – Association of Refugees with Disability
ii. **CPC** – Child Protection Committee
iii. **FGD** – Focus Group Discussion
iv. **GBV** – Gender-Based Violence
v. **HI** – Humanity & Inclusion
vi. **IASC** - Inter-Agency Standing Committee
vii. **KII** – Key Informant Interview
viii. **LNOB** – Leave No One Behind
ix. **MAG** – Men's Action Group
x. **MHPS** – Mental Health and Psychosocial Support
xi. **MTI** – Medical Teams International
xii. **NFI** – Non-Food Item
xiii. **NGO** – Non-Governmental Organization
xiv. **OPD** – Organization of Persons with Disabilities
xv. **OPM** – Office of the Prime Minister
xvi. **RWC** – Refugee Welfare Council
xvii. **SRHR** – Sexual and Reproductive Health and Rights
xviii. **VSLA** – Village Savings and Loan Association
xix. **VHT** – Village Health Team
xx. **WASH** – Water, Sanitation and Hygiene
xxi. **WGQs** – Washington Group Questions

Executive Summary

This report presents the findings of an assessment examining barriers and facilitators affecting access to humanitarian services for persons with disabilities in Kyaka II Refugee Settlement in Uganda. The assessment was commissioned by the Association of Refugees with Disability (ARD) to generate practical, evidence-based insights to inform disability-inclusive programming, coordination, and advocacy in a context of declining humanitarian resources. The report is intended to guide humanitarian agencies, implementing partners, government stakeholders, coordination bodies, and Organisations of Persons with Disabilities in strengthening inclusive service delivery and accountability mechanisms within the settlement.

The assessment adopted a qualitative research design to capture lived experiences and service access dynamics among persons with disabilities. Data were collected through focus group discussions (FGDs) with men, women, and youth with disabilities across multiple zones of the settlement. These discussions were complemented by key informant interviews (KIIs) with community leaders, implementing partners, sector actors, and service providers. The qualitative approach enabled the assessment to explore both structural barriers and practical facilitators affecting access to humanitarian services across sectors.

Findings reveal that persons with disabilities experience persistent and overlapping barriers across major service sectors including health, WASH, food and cash assistance, education, protection, shelter, and livelihoods. The most prominent barriers were physical and environmental, including long distances to service points, inaccessible terrain, lack of ramps, and disability-unfriendly infrastructure. These factors significantly restrict independent mobility and limit consistent access to services

Institutional and procedural barriers were also widely reported. Participants described long queues, limited service days, understaffed facilities, weak referral systems, and administrative requirements that do not accommodate disability-related needs. Communication barriers—particularly the absence of sign language interpretation and accessible information formats—further excluded persons with hearing, visual, and intellectual impairments. In addition, attitudinal barriers such as stigma, lack of prioritisation, and disrespectful treatment at service points undermined dignity and, in some cases, discouraged individuals from seeking services altogether.

Despite these challenges, several facilitators that improve access were identified. Community-based structures—including Refugee Welfare Councils, Village Health Teams, volunteers, and Organisations of Persons with Disabilities—play a key role in information sharing, referrals, and accompaniment to services. Supportive staff practices, the availability of assistive devices, outreach approaches, and proximity of some services were also identified as enabling factors. However, these facilitators

were uneven across zones and often relied on individual initiative rather than systematic institutional arrangements.

Intended users of this report include humanitarian agencies and operating partners, coordination bodies, Government stakeholders and sector leads, and Organisations of Persons with Disabilities. It provides actionable recommendations to strengthen reasonable accommodation, accessible communication, and disability inclusion as a core quality standard of humanitarian response in Kyaka II.

1. Introduction

1.1 Background and Rationale

Kyaka II Refugee Settlement, located in Kyegegwa District in western Uganda, is one of the country's major refugee-hosting settlements. The Uganda National Population and Housing Census 2024 reports that Kyaka II Refugee Camp hosts 90,021 people living in 21,411 households, reflecting a large and diverse population with sustained humanitarian needs. Out of 90,021 people, about 20,300 of them live with disabilities; inclusive of both physical and mental disabilities . To support this group of people, humanitarian assistance in the settlement is delivered through multi-sector coordination involving government and partner agencies. Assistance is delivered through a coordinated structure involving government institutions, international agencies, humanitarian partners, and community-based mechanisms. At the national level, refugee affairs are managed by the Office of the Prime Minister of Uganda in partnership with the United Nations High Commissioner for Refugees, which together oversee protection and service coordination in refugee settlements across Uganda. Within the settlement, services are organized through sector-based programs—such as health, protection, education, and livelihoods—implemented by humanitarian partners under the supervision of the settlement administration and local authorities in Kyegegwa District. Refugees with disabilities are identified during registration and through community outreach systems, including refugee leaders and Village Health Teams, and are categorized as persons with specific needs to ensure prioritization in assistance programs. Service delivery is further supported by health facilities such as Bujubuli Health Centre III and by refugee-led and community-based organizations that help provide psychosocial support, referrals, and livelihood support, thereby ensuring that persons with disabilities can access essential services within the settlement; however, access to this assistance has persistently remained limited.

A survey conducted in 2025 highlighted that thousands of refugees with disabilities had been excluded from food aid; a condition that was continuously worsening, attributed to a drastic reduction in funding. In this study, 42% of households with children with disabilities and 35% of people with disabilities were excluded from all food aid. Food, among other needed humanitarian assistance, is an essential human need without which any human being won't live. Besides food, refugees with disabilities still face limited access to proper tailored education, shelter, clothing, and health care (as many aren't aware of the existing medical services).

Kyaka II Refugee Settlement hosts a diverse refugee population (possessing individuals with a wide range of backgrounds, experiences, and social demographic characteristics; with significant humanitarian needs, including a substantial number (approximately 20,300) of people with disabilities. While humanitarian services through actors like OPM, UN, Humanity and Inclusion (HI), among others; in sectors such as health, WASH, food and cash assistance, education, protection, shelter, and livelihoods are available within the settlement, access to these services is persistently partial. For many persons with disabilities, exclusion is shaped not only by individual

impairments but also by structural and social conditions that systematically limit participation. These include inaccessible physical environments, limited inclusive communication, stigma and discrimination, poverty, and service delivery processes that are not designed to accommodate diverse needs. As a result, persons with disabilities may face difficulties reaching service points, obtaining information in appropriate formats, navigating procedures, and receiving assistance in a timely and dignified manner.

Recent reductions in humanitarian funding have further strained service delivery and intensified existing access barriers. The United States of America through USAID, cut funding towards many humanitarian assistance programs. As a major funder towards humanitarian assistance in the Uganda Country Refugee Response Plan, in 2024 the US provided funds amounting to 72% of food security, 68% of health and nutrition, 67% of shelter and NFIs, and 39% of protection among others. These funds have long been halted / stopped following the closure of USAID. This has partly contributed to service scale-downs, reduced staffing, limited outreach, and increased reliance on cost-sharing; which have shifted the burden of access onto households, disproportionately affecting persons with disabilities, who have limited livelihood options, higher dependency needs, and fewer coping mechanisms when services become less accessible. Across all refugee settlements in Uganda, Kyaka II inclusive, these shifts are particularly harmful because access to servicesamong persons with disabilities often depends on outreach services, tailored accommodation, accessible communication, and predictable, continuous support. When these enabling conditions are reduced or withdrawn, persons with disabilities are more likely to miss critical services, experience delays, or be excluded entirely, further deepening inequities and protection risks.

Against this backdrop, this assessment was commissioned to move beyond assumptions and document, from the perspectives of persons with disabilities themselves, the key barriers and facilitators shaping access to humanitarian services in Kyaka II. The evidence generated is intended to inform disability-inclusive programming, strengthen coordination among humanitarian actors and government structures, and support practical adjustments that can improve equitable access even within constrained resource environments.

1.2 Objectives

1.2.1 General Objective

The overall objective of this assessment was to examine the key barriers and facilitators affecting access to humanitarian services for persons with disabilities in Kyaka II Refugee Settlement, in order to generate evidence that can inform disability-inclusive programming, coordination, and advocacy.

1.2.2 Specific objectives

- Identify the key barriers limiting access to humanitarian services for persons with disabilities in Kyaka II.
- Document existing facilitators and good practices supporting service access for persons with disabilities across sectors.
- Provide actionable recommendations to strengthen disability inclusion, systems coordination, and advocacy.

1.3 Key Areas of Inquiry

Guided by the study objectives and the terms of reference, the assessment focused on the following key areas of inquiry:

- Awareness, availability, and utilization of humanitarian services among persons with disabilities.
- Physical and environmental barriers affecting movement to and within service delivery points.
- Economic barriers, including transport costs, user fees, and indirect costs associated with accessing services.
- Institutional and procedural barriers, such as eligibility requirements, referral systems, staffing levels, and waiting times.
- Communication and information barriers affecting access to service-related information, particularly for different impairment types.
- Attitudinal barriers, including stigma, discrimination, and treatment by service providers and gatekeepers.
- Sector-specific access challenges across health, WASH, education, protection, food and cash assistance, shelter, and livelihoods.
- Existing facilitators, community support mechanisms, and enabling practices that support access to services.
- Participation, accountability, and feedback mechanisms available to persons with disabilities and their perceived effectiveness.

2.0 Methodology

2.1 Study Design

The assessment adopted a qualitative study design, using Focus Group Discussions (FGDs) as the primary data collection method. A qualitative study design is a research approach used to explore and understand people's experiences, perceptions, and social realities through non-numerical data such as interviews, observations, and narratives. This approach was selected to capture in-depth insights into the lived experiences of persons with disabilities and to enable participants to describe, in their own words, the barriers and facilitators shaping access to humanitarian services. It was particularly appropriate for exploring dynamics of exclusion, discrimination, and power relations within service delivery systems that are often missed by quantitative methods, while also creating a participatory space for shared reflection and validation of experiences.

16FGDs were conducted among women, men, and youth with disabilities to ensure safe and inclusive participation and to capture differences in experiences across gender and age groups. In the focus group discussions (FGDs), participants represented a range of disabilities, including physical disabilities, visual impairments, hearing impairments, and psychosocial disabilities. 7 KIIs were also conducted to obtain in-depth insights from individuals who had specialized knowledge, experience, or direct involvement in humanitarian assistance for refugees with disabilities to better understand systems, practices, and contextual factors influencing access to services among the study population herein. The qualitative design enabled exploration of complex, interlinked access challenges that are not easily captured through quantitative methods, particularly in a context where barriers are shaped by social, environmental, and institutional dynamics.

2.2 Study Area and Population

The assessment was conducted in Kyaka II Refugee Settlement, located in Kyegegwa District, western Uganda. Kyaka II hosts a large and diverse refugee population, including persons with disabilities with varying functional difficulties. Humanitarian services in the settlement are delivered through multiple actors across sectors such as health, WASH, education, protection, food and cash assistance, shelter, and livelihoods, with service points distributed across zones. The geographic spread of the settlement, combined with uneven infrastructure and terrain, has important implications for physical access to services, particularly for persons with disabilities.

The study population comprised persons with disabilities—including men, women, and youth—residing in different zones of Kyaka II Refugee Settlement. Participants represented a range of disability types, including physical, sensory, and other functional difficulties, as well as caregivers of persons with disabilities. Focus Group Discussions were organized by gender and age group to support safe participation and capture differentiated experiences of access, barriers, and facilitators..

2.3 Data Collection Methods

Data for this assessment were collected using qualitative methods, namely Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs), in line with the Terms of Reference. Multiple qualitative tools such focus group discussion, and key informant interview guides; were used to triangulate perspectives from persons with disabilities, community structures, implementing partners, and service providers. This strengthened the credibility, depth, and interpretive value of the findings.

With an average length of 45 minutes each, FGDs were conducted with men, women, and youth with disabilities across multiple zones of Kyaka II Refugee Settlement, including Bukere, Bwiriza, Itambabiniga, Kaborogota, and Seswe. Separate group discussions were held to support safe participation and capture gender- and age-specific experiences. In order to share personal experiences, describe challenges and barriers, discuss perceptions of service quality, and provide suggestions for improving access, participants were anticipated to engage in open dialogue, ask clarifying questions, and reflect on both individual and community-level experiences. This allowed the researchers to capture diverse and nuanced perspectives from persons with disabilities. A structured FGD guide, with open-ended questions, was used to explore barriers and facilitators influencing access to humanitarian services across key sectors, including health, WASH, education, protection, food and cash assistance, shelter, and livelihoods. Participation was equally distributed across participants and those who were reserved, were encouraged to interact with prompts, and probs. Discussions also examined physical, economic, institutional, communication, and attitudinal factors influencing access. Participants were further invited to propose practical solutions for improving inclusion.

In addition, Key Informant Interviews (KIIs) were conducted with purposively selected stakeholders, including community leaders, service providers, and implementing partners; and further participants were identified through snowball sampling to ensure that individuals with relevant knowledge and experience were included in the study. . These included Refugee Welfare Committee (RWC) leaders for persons with disabilities, organisations of persons with disabilities (OPDs), implementing partners, and sector actors involved in service delivery. KIIs focused on service provision practices and inclusion approaches, as well as observed barriers and facilitators. They also explored expected impacts of service reductions and recommendations for strengthening disability-inclusive programming. The KIIs provided critical institutional and operational insights that complemented and contextualised the experiences shared during FGDs

2.4 Sampling and Participants

The assessment employed purposive sampling to ensure inclusion of persons with disabilities with diverse characteristics and lived experiences across Kyaka II Refugee Settlement. Participants were selected based on their direct experience, knowledge, or involvement with persons with disabilities and access to services within the settlement. This included refugees with disabilities or their caregivers, leaders of community structures such as Refugee Welfare Councils (RWCs) and organizations of persons with disabilities (OPDs), as well as members of Village Health Teams (VHTs) and staff from partner organizations working directly with persons with disabilities. Selection criteria prioritized individuals who could provide informed insights on barriers, facilitators, and community dynamics affecting service access, ensuring that the study captured diverse and relevant perspectives from those most familiar with the lived experiences and support systems of persons with disabilities. Sampling deliberately considered gender, age (men, women, and youth), zone of residence, and type of functional difficulty to capture varied access barriers and facilitators across contexts and service sectors. These participant categories were strategically selected because they influence how persons with disabilities are identified, referred, and supported within the settlement, and they play a critical role in strengthening coordination, accountability, and disability-inclusive service delivery.

2.5 Data Analysis

Data analysis followed a thematic analysis approach (a qualitative data analysis method used to identify, analyze, and report **patterns or themes** within data. It involves systematically coding the data, organizing codes into meaningful categories, and interpreting these categories to understand underlying concepts, experiences, or perspectives. This approach is particularly useful for exploring complex social phenomena, as it allows researchers to capture recurring ideas, highlight differences and similarities across participants, and generate insights grounded in the data while maintaining flexibility to adapt to the study context.), drawing on both Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs), in line with the objectives outlined in the Terms of Reference. All transcripts were reviewed in full to ensure familiarity with the data, after which a structured coding process was applied. Initial codes were developed around the core analytical domains of barriers and facilitators, including physical, economic, institutional, communication, and attitudinal factors, while allowing additional issues to emerge inductively from participants' narratives.

Codes were then grouped into broader themes and sub-themes, and patterns were compared across participant groups (women, men, youth) and locations to identify both common and divergent experiences. Findings from FGDs were triangulated with insights from KIIs involving community leaders, organisations of persons with disabilities, and implementing partners to strengthen credibility and contextual

interpretation. This analytical process enabled the report to move beyond descriptive accounts to an interpretive understanding of how and why barriers persist, and which facilitators offer practical entry points for improving disability-inclusive access to humanitarian services.

2.6 Ethical Considerations

Ethical considerations for this study were carefully observed to ensure the protection, dignity, and rights of all participants. Prior to data collection, permission was obtained from the relevant authorities, including the Office of the Prime Minister (OPM), settlement leadership, and partner organizations operating within Kyaka II Refugee Settlement. All participants were informed about the purpose of the assessment, their right to decline participation or withdraw at any point, and how the information would be used. Informed consent was obtained from all participants.. To ensure confidentiality, no personal identifiers were included in transcripts or reporting. Discussions were facilitated in a respectful and inclusive manner, with sensitivity to the vulnerabilities of persons with disabilities. Where participants raised protection-related concerns or distressing experiences, facilitators followed appropriate referral pathways available within the settlement, in line with existing community and partner protocols.

2.7 Limitations

The findings of this assessment are drawn from qualitative data and therefore reflect the lived experiences, perceptions, and narratives shared by participants during FGDs and KIIs. While not statistically generalizable, the findings offer robust insights into systemic access barriers and exclusion dynamics affecting persons with disabilities in Kyaka II Refugee Settlement.

More so, the study faced several limitations related to the context and timeline. Conducting research in Kyaka II Refugee Settlement posed contextual challenges, including language barriers, varying levels of literacy among participants, and the sensitivity of discussing personal experiences of disability and service access, which may have influenced the depth of responses. Additionally, the dynamic nature of the settlement—with frequent movement of refugees and changes in service provision—limited the ability to capture longitudinal or fully representative perspectives. Time constraints further restricted the number of participants and the duration of field interactions, which may have constrained the breadth of data collection and the opportunity for extended follow-up with participants. Despite these limitations, the study employed multiple qualitative tools and triangulation strategies to enhance the reliability and richness of the findings.

3.0 Findings

3.1 Overview of Services Accessed

Across the FGDs and KIIs, respondents reported engaging with a range of humanitarian services in Kyaka II Refugee Settlement. In line with the IASC guidelines, access experiences were analyzed using the ACAP framework—**Accessibility/physical**, **Communication**, **Attitudinal**, and **Policy/administrative** barriers. The most frequently accessed services included health care, WASH, and food and cash assistance, although many noted declining coverage and predictability. Protection services and education support for children were also mentioned, alongside disability-specific services such as assistive devices, rehabilitation and physiotherapy, and support from OPDs, as well as limited livelihood activities.

Participants described **accessibility/physical barriers** related to distance, terrain, and non-inclusive infrastructure at service points. **Communication barriers** arose where information on services and procedures was not consistently shared in accessible formats. **Attitudinal barriers** were reflected in stigma and dismissive treatment, while **policy/administrative barriers** included rigid registration and service processes with limited accommodation. Overall, intermittent access highlights the fragility of service engagement for persons with disabilities and shows that participation often depends on ad hoc facilitation rather than predictable, rights-based inclusion embedded within humanitarian systems.

3.2 Cross-Cutting Barriers to Access

3.2.1 Physical and Environmental Barriers.

Across the FGDs, and reinforced through KIIs, physical and environmental barriers emerged as the most immediate constraint to service access for persons with disabilities. Long distances to service points, hilly and slippery terrain, muddy roads during rainy seasons, and poorly maintained pathways were reported to significantly limit mobility, especially for wheelchair users and persons with walking difficulties. In several zones, water points, health facilities, and distribution sites were located in valleys or other hard-to-reach areas, effectively excluding some persons with disabilities from independent access.

"Service points are not easy to reach because of the long distances to move and for me I don't walk I need money for transport which is not there." ***FGD- Itambabiniga- YOUTH.***

"Yes, it's hard… it's really hard. The hospitals are very far, like very far from here, and sometimes you don't even have someone to push you or take you. So you just end up not going. Even me, I use crutches, but I can't walk long distances. By the time I reach halfway I'm already tired, so most times I just stay home." **FGD WOMEN -Itambabiniga**

"Bujubuli Health Center IV is located far from many households. People have to walk long distances, which is especially difficult for… those with disabilities." ***FGD WOMEN-BUKERE.***

Participants further cited the absence or poor maintenance of disability-friendly infrastructure—such as ramps, handrails, accessible latrines, and suitable waiting areas. These gaps increase reliance on caregivers or paid support, which is not always available, leading to delayed health-seeking, missed distributions, and reduced use of sanitation facilities. Overall, this barrier was consistently reported across sectors.

3.2.2 Economic Barriers and Indirect Costs of Access

Economic barriers were the second most dominant theme and were described as reinforcing physical exclusion. While many services are nominally free, participants emphasised that indirect costs—transport fares, purchasing medicines due to stock-outs, water user fees, and hiring assistance—often make access unaffordable. Funding cuts have transferred access costs from systems to individuals, increasing household burdens and disproportionately affecting persons with disabilities who have limited livelihood options and higher support needs.

"When I was admitted at the hospital in Bujubuli, I was told to buy medicine and when I said I didn't have money to buy the medicine I was told to leave the bed for another person." ***FGD WOMEN -Itambabiniga***

Across FGDs and KIIs, these costs were directly linked to delayed or foregone service use, particularly in health and WASH. Participants cited inability to pay for transport or medicines as a reason for missing referrals, relying on unsafe water sources, or discontinuing treatment. These pressures were also associated with harmful coping strategies, including begging, selling assets, child labour, and engagement in unsafe income-generating activities.

3.2.3 Institutional and Procedural Barriers

Institutional barriers were frequently cited and described as exhausting and discouraging. Participants reported long queues, reduced staffing, limited-service days, and complex procedures that do not accommodate the functional limitations of persons with disabilities. Persons with disabilities are often required to follow standard processes—standing in long lines, moving between multiple offices, or returning repeatedly—without reasonable accommodation for disability-related needs.

" We face a challenge of long waiting hours at the health facility due to long queues due to few medical workers." ***FGD- MALE- BWIRIZA***

Participants also noted that coordination and information-sharing spaces are not consistently accessible, limiting meaningful participation of persons with disabilities and their representatives. When meetings, feedback forums, or community structures are held in physically inaccessible locations or without inclusive communication, persons with disabilities are effectively excluded from decision-making processes that shape service delivery priorities and resource allocation.

Weak referral systems, particularly in health and protection services, further compound exclusion. Participants described being sent back and forth without clear guidance or follow-up, leading to frustration and eventual disengagement. KIIs confirmed that staff reductions and workload pressures have reduced the system's capacity to provide follow-up, outreach, and case management, with disproportionate effects on persons with disabilities.

3.2.4 Communication Barriers

Communication and information barriers were consistently reported, particularly by persons with hearing, visual, and intellectual impairments. Service information is largely disseminated through verbal announcements, notice boards, or informal word-of-mouth channels, which are not accessible to all impairment groups. The absence of sign language interpretation and accessible formats limits understanding and timely participation.

As a result, some participants reported missing distributions, meetings, or services altogether, or depending on intermediaries who may misinterpret information or exploit them. Language barriers between service providers and refugee populations further exacerbated this challenge in some zones leading to missed services and increased dependency on intermediaries.

3.2.5 Attitudinal Barriers and Stigma

Although less visible than physical barriers, attitudinal barriers were repeatedly raised and carry significant implications for dignity and safety. Participants reported experiences of disrespectful treatment, verbal abuse, stigma, and lack of prioritisation at service points. In some cases, these interactions escalated into intimidation or violence during crowded distributions.

Such experiences contribute to self-exclusion, with some persons with disabilities opting not to seek services to avoid humiliation or harm. KIIs corroborated that stigma and negative community attitudes remain pervasive, particularly where disability awareness among service providers and security personnel is limited. These experiences directly undermine dignity and personal safety.

3.3 Sector-Specific Barriers

Health services were the most affected sector for persons with disabilities. Across FGDs and KIIs, participants reported long distances to facilities, lack of transport, long waiting times, reduced staffing, and frequent medicine stock-outs. Referral systems were described as weak and costly, with some participants required to purchase prescribed medicines or diagnostic services they could not afford. Persons with disabilities requiring physiotherapy, assistive devices, surgery, or specialised care were reported to be disproportionately affected by these constraints.

In the WASH sector, barriers centred on physical accessibility and affordability. Water points were often located in valleys or far from households, making access difficult for persons with mobility impairments. Long queues, breakdown of boreholes, and occasional water user fees further limited access. Latrines were frequently described

as inaccessible, unsafe, or unsuitable for persons with disabilities, increasing risks related to hygiene, dignity, and personal safety.

Food and cash assistance barriers were largely procedural and physical. Participants reported difficulties reaching distribution points, navigating crowds, and standing in long queues without prioritisation. Some persons with disabilities reported missing assistance due to mobility challenges, lack of timely information, or inability to meet procedural requirements. KIIs also highlighted that reductions in cash assistance have intensified dependency and limited households' ability to meet basic needs, including transport to service points.

Barriers in education primarily affected children with disabilities. FGDs cited long distances to schools, lack of assistive devices, stigma and bullying, hunger, and inability of caregivers to meet school-related costs. Reduced teacher numbers and overcrowded classrooms were also reported to limit meaningful inclusion and learning outcomes for children with disabilities.

In the protection sector, participants reported increased insecurity linked to economic stress and limited-service presence. Barriers included difficulty reporting cases due to mobility challenges, fear of retaliation, weak follow-up, and reduced home visits by protection actors. Women and girls with disabilities were reported to face heightened risks of exploitation and abuse, particularly where livelihoods were limited.

Livelihood barriers were predominantly economic and structural. Persons with disabilities reported limited access to skilling opportunities, discrimination, lack of start-up capital, and exclusion from livelihood programmes perceived as physically demanding. Reduced assistance was repeatedly linked to negative coping strategies, including begging, child labour, and engagement in unsafe income-generating activities.

3.4 Cross-Cutting Facilitators

Despite the significant barriers reported, participants across FGDs and Key Informant Interviews identified several cross-cutting factors that facilitate access to humanitarian services for persons with disabilities in Kyaka II Refugee Settlement. These facilitators demonstrate practical entry points for what already works in the settlement and should be scaled and institutionalised within coordination and service delivery systems to reduce reliance on ad hoc support. Overall, the most consistently cited facilitators were linked to community-level support structures, disability-focused organisations, and enabling staff practices, rather than system-wide mechanisms.

Community structures emerged as the most prominent facilitator. Refugee Welfare Committees (RWCs), chairpersons for persons with disabilities, Village Health Teams (VHTs), and informal community volunteers play a critical role in identifying persons

with disabilities, sharing information, making referrals, and, in some cases, physically accompanying individuals to service points. FGDs repeatedly noted that where these actors are active and responsive, persons with disabilities are more likely to be reached, particularly those who are home-bound or have severe mobility limitations. Key informants similarly emphasised that identification and follow-up of persons with disabilities is most effective when mediated through trusted community leadership.

Disability-focused organisations and targeted interventions also facilitate access where they are available. Participants highlighted the role of organisations providing assistive devices, physiotherapy, counselling, and rehabilitation services, noting that these supports directly improve mobility, confidence, and engagement with other services. In several FGDs and KIIs, assistive devices such as wheelchairs, crutches, and CP chairs were described as a precondition for accessing health facilities, water points, community meetings, and livelihood activities. However, these supports were reported to be limited in coverage and inconsistent across zones, pointing to the need for more predictable and coordinated provision.

At the service delivery level, supportive staff attitudes and flexible practices were identified as important enablers. Participants noted that when service providers offer clear explanations, allow persons with disabilities to bypass long queues, provide physical assistance, or conduct outreach and home visits, access improves substantially. Some FGDs cited mobile services and community-based trainings as particularly inclusive for persons with disabilities facing mobility and transport constraints. Importantly, these facilitators were often dependent on individual discretion rather than formalised standards, reinforcing uneven and unpredictable access and underscoring the need to embed them into routine service delivery norms and accountability mechanisms.

3.5 Sector-Specific Facilitators

Facilitators to service access varied by sector and were largely linked to targeted interventions, proximity of services, and the presence of committed frontline actors. In the health sector, participants and key informants consistently highlighted the role of Village Health Teams (VHTs), outreach clinics, and referrals supported by partners such as MTI and HI. Where physiotherapy, counselling, or assistive device support was available, these services significantly reduced exclusion for persons with disabilities, particularly those with mobility and psychosocial impairments.

In the WASH sector, proximity of functional water points, the availability of ramps, and community-led maintenance were cited as enabling factors. Some zones benefited from partner-supported borehole rehabilitation and safer water access, which reduced reliance on distant or unsafe sources. However, these facilitators were uneven across the settlement and often dependent on active partner presence.

For food and cash assistance, facilitators included prior identification of households with persons with disabilities, accompaniment support during distributions, and, in some cases, cash transfers that allowed households to meet transport and basic needs. In education, provision of scholastic materials, books, and limited support for children with disabilities facilitated attendance where available, though gaps remained. Livelihoods facilitators were mainly linked to skilling programmes, savings groups, and small cash or start-up support provided by partners such as ADRA and OPDs, which enabled some households to engage in small businesses despite broader constraints.

Overall, sector-specific facilitators were present but fragmented. Their effectiveness depended heavily on sustained partner engagement, clear targeting of persons with disabilities, and complementary support across sectors, underscoring the need for more coordinated and institutionalised disability-inclusive approaches. These facilitators demonstrate practical, scalable entry points for institutionalising inclusion, underscoring the need to transition from partner-dependent initiatives to coordinated, system-wide disability-inclusive approaches.

3.6 Participation, Accountability and Feedback

Participation of persons with disabilities in decision-making and service feedback mechanisms was described as limited and inconsistent. While some respondents reported being invited to community meetings or mobilisation activities, meaningful participation was constrained by mobility challenges, inaccessible venues, lack of timely information, and communication barriers. Many persons with disabilities indicated that they often rely on caregivers or community representatives to speak on their behalf, which weakens direct representation of their concerns.

Accountability mechanisms were perceived as weak and unreliable. Although formal complaint and feedback channels exist, respondents expressed low confidence in their effectiveness, citing unclear reporting pathways, fear of retaliation, limited confidentiality, and inadequate follow-up. Participants noted that complaints raised at service points or through community leaders rarely resulted in feedback or corrective action, particularly when concerns involved mistreatment, informal charges, or exclusion during distributions. Weak accountability mechanisms further entrench exclusion.

4. Discussion

The findings from this assessment show that barriers to accessing humanitarian services for persons with disabilities in Kyaka II are systemic, cumulative, and mutually reinforcing. Physical inaccessibility, poverty, institutional constraints, communication gaps, and negative attitudes do not operate in isolation; rather, they intersect in ways that progressively exclude persons with disabilities from services that are nominally available. In practice, the presence of one barrier often triggers

others, compounding vulnerability and increasing dependency on caregivers or informal support.

Funding constraints have intensified these dynamics. Reduced staffing, limited outreach, medicine stock-outs, and scaled-down services have effectively shifted the burden of access onto households, many of which lack the financial or physical capacity to compensate. For persons with disabilities, this translates into delayed health-seeking, reduced service utilisation, increased exposure to protection risks, and reliance on negative coping strategies. The findings suggest that without deliberate accommodation, service availability alone does not guarantee equitable access.

At the same time, the assessment highlights that inclusion is achievable, even in a constrained funding environment. Community structures, VHTs, organisations of persons with disabilities, assistive devices, and supportive staff practices consistently emerged as facilitators that reduce exclusion when applied deliberately. However, their impact remains uneven because they are often dependent on individual initiative rather than embedded systems. This underscores the need to institutionalise minimum disability-inclusion standards across sectors rather than relying on ad hoc goodwill.

Overall, the evidence points to a critical shift required in humanitarian programming: from treating disability inclusion as a specialized or optional consideration to embedding it within routine service design, delivery, and accountability mechanisms. Without this shift, existing inequalities are likely to deepen, particularly under continued funding pressure, undermining both protection outcomes and progress toward self-reliance for persons with disabilities. These findings underscore the need to treat disability inclusion as a core quality standard of humanitarian response.

5. Conclusions

This assessment finds that access to humanitarian services for persons with disabilities in Kyaka II Refugee Settlement is constrained by multiple, interlinked barriers that cut across sectors. Physical inaccessibility, long distances, and difficult terrain remain the most immediate obstacles, but these are reinforced by economic constraints, institutional limitations, communication gaps, and negative attitudes. Together, these factors limit independent access to services and increase reliance on caregivers, informal support, or harmful coping mechanisms.

While facilitators such as community structures, VHTs, organisations of persons with disabilities, assistive devices, and supportive staff practices do exist, they are unevenly applied and largely dependent on individual initiative rather than systematic inclusion. In the context of reduced humanitarian funding, the absence of deliberate, disability-inclusive approaches risks deepening exclusion and vulnerability for persons with disabilities. Addressing access challenges therefore requires intentional integration of inclusion measures into routine service delivery, accountability systems, and resilience-building interventions across all sectors. Failure to act risks institutionalising exclusion under conditions of prolonged funding constraints.

6. Recommendations

6.1 Immediate Actions

- **Implementing partners/service providers** should enforce priority access for persons with disabilities at health facilities and distribution points (queue fast-tracking, staff guidance, designated support desks).
- **Sector leads and partners** should improve accessible communication through RWCs, VHTs and home visits, and provide information in appropriate formats for persons with hearing, visual and intellectual impairments.
- **Health and protection partners** should provide transport/referral support for persons with disabilities, especially for referrals, rehabilitation and case follow-up.
- **Accountability focal points and partners** should strengthen complaints and feedback systems to prevent informal charges and exploitation (clear reporting pathways, confidentiality, follow-up).
- **RWCs, VHTs and OPDs**, supported by **partners and donors**, should scale outreach and accompaniment for home-bound and socially isolated persons with disabilities.

6.2 Medium- to Long-Term Actions

- Mainstream disability inclusion standards across all sectors, ensuring that accessibility, reasonable accommodation, and dignity are integrated into routine service delivery rather than treated as add-ons.
- Invest in disability-appropriate livelihoods and skilling, including home-based and low-mobility income-generating options, coupled with start-up capital and financial literacy support.
- Improve physical accessibility of infrastructure, particularly WASH facilities, health centres, and community spaces, through durable ramps, pathways, lighting, and adapted latrines.
- Strengthen inclusive education support for children with disabilities, including assistive devices, school feeding linkages, and targeted protection against dropout.
- Enhance coordination with OPDs and disability leadership structures, recognising them as essential partners in identification, referral, monitoring, and accountability.

To support sustainability and localisation, these actions should be integrated into routine partner workplans and government-led coordination structures, with OPDs resourced to play a sustained leadership role beyond project cycles.

7. Lessons Learned

- **Humanitarian actors must intentionally design and apply disability inclusion** across all stages of service delivery, rather than assuming it will occur automatically.
- **Humanitarian actors must advocate for institutionalization of practical accommodations**—such as prioritisation, accompaniment, and accessible information—to improve access consistently and at scale.
- **Humanitarian actors should advocate for strengthened community structures** by defining clear roles, strengthening accountability, and linking RWCs, VHTs and OPDs to formal service systems.
- **Humanitarian actors must integrate disability inclusion even under funding constraints**, as failure to do so increases negative coping, protection risks, and long-term dependency.

8. Annexes

8.1 Annex 1: Data Collection Tools

A. BARRIERS & FACILITATORS – MASTER FGD GUIDE

(For Persons with Disabilities; includes cross-sector, resilience/livelihood lens + future cuts lens)

SECTION 1: WARM-UP & SETTING THE SCENE

1. **What are the main services you currently know and use in Kyaka II?** (Health, WASH, Education, Protection, Livelihoods, Food distribution, Cash, Shelter)
2. **In your own words, what does "accessing services" mean for you or your household?**
3. **How has your ability to access services changed over the past year?** (Easier? Harder? Why?)

SECTION 2: BROAD BARRIERS ACROSS ALL HUMANITARIAN SERVICES

2.1 Physical & Environmental Barriers

2.1.1 Are service points (clinics, water points, schools, distribution points) physically easy or difficult for you to reach?

2.1.2 What physical features make access difficult?

- Distance
- Terrain/slopes
- Lack of pathways/ramps
- Inaccessible latrines
- Crowding
- Weather conditions

2.2 Communication Barriers

2.2.1 How easy is it for you to receive and understand information about available services?

- Sign language
- Braille
- Large print

- Verbal explanations
- Use of local languages
- Awareness of service points

2.2 Attitudinal Barriers

2.3.1 How are you treated by service providers? Are there any discriminatory attitudes or stigma toward disability?

2.3.2 Do you feel listened to when you raise concerns?

2.4 Institutional & System Barriers

2.4.1 Do you encounter any rules, procedures, queues, or eligibility requirements that make it difficult to access services?

2.4.2 Are staff enough to serve everyone? (e.g., long queues due to understaffing)

2.5 Economic & Livelihood Barriers

2.5.1 Does lack of money affect your ability to access services (transport, buying food, medical costs)?

2.5.2 How are current food cuts affecting your household?

SECTION 3: SECTOR-SPECIFIC BARRIERS

3.1 Health

3.1.1 What makes it difficult to access health services (OPD, maternal health, chronic illness care, HIV, disability-related services)?

3.1.2 Have you experienced long queues, lack of medicines, or reduced staff?

3.1.3 Next year there will be less health workers in the settlement, according to you what will the consequences of that decrease?

Special focus:

- Maternal & neonatal mortality risk
- Persons with disabilities needing regular care
- Rehabilitation services

3.2 WASH

3.2.1 What challenges do you face when collecting water or using latrines or bathing shelters?

3.2.2 Are these facilities safe (especially at night) and adequate (number, location, status0?

3.2.1 How would **reduced WASH services** affect your health, hygiene, and dignity?

3.3 Protection & GBV

3.3.1 Is there a lot of protection incidents happening in the settlement? Mostly where? And when?

3.3.2 Have you seen an increase in the number of incidents for the past year? Why?

3.3.3 Is it easy or difficult to report safeguarding or protection concerns?

3.3.4 What might happen in the settlement if the number of protection caseworkers reduce?

3.4 Food Security & Livelihoods

3.4.1 How are current food cuts affecting you?

3.4.2 How would **no food distribution next year** affect households with disabilities?

3.4.3 What strategies do you use to cope with reduced food or cash?

3.4.4 What livelihood opportunities are available to you?

3.4.5 How is it to look for a job outside the settlement? With the host community?

3.5 Education

3.5.1 What barriers affect children with disabilities attending school?

3.5.2 If next year there are less teachers paid by UNHCR in schools, what will be the consequences for the children in the settlements? And for children with disabilities?

3.5.3 Does food reduction affect school attendance? Have you heard parents removing their kids from school since the food cuts?

SECTION 4: BROAD FACILITATORS (WHAT HELPS ACCESS)

4.1 What helps you access services?

- Helpful staff
- Community support

- Mobility aids
- Accompanying family members
- OPD support
- RCWs
- Inclusive practices

4.2 What motivates you or makes you feel confident accessing services?

4.3 What helps you stay strong and manage your life today?

- Skills
- Community groups
- Economic activities
- Social networks

SECTION 5: SELF-RELIANCE, RESILIENCE, AND FUTURE RISK

5.1 Exploring resilience in light of service reduction

5.1.1 If humanitarian services are reduced next year, what challenges do you expect?

5.1.2 What coping strategies do you have?

5.1.3 What additional support would help you maintain resilience?

5.2 Food cuts impact

5.2.1 What risks do food cuts create for:

- Children
- Persons with disabilities
- Pregnant/lactating women
- Older persons
- Adolescents
- Persons with chronic illness

5.3 Livelihood & economic empowerment

5.3.1 What livelihood activities are possible for refugees from Kyaka II

5.3.2 What livelihood activities are possible for persons with disabilities in Kyaka II?

5.3.3 What would help you become more self-reliant?

5.3.4 What are the biggest barriers to economic empowerment?

SECTION 6: COMMUNITY PARTICIPATION & ACCOUNTABILITY

6.1 Are persons with disabilitiess involved in decisions affecting service delivery?
6.2 How can your participation be improved?
6.3 How do you prefer to give feedback to agencies?

SECTION 7: RECOMMENDATIONS

7.1 What should humanitarian agencies improve immediately to make services more accessible?
7.2 What long-term changes would better support inclusion, self-reliance, and safety?

B. KEY INFORMANT INTERVIEW TOOL (REVISED FOR FUNDING CUT CONSEQUENCES)

(Tailored to Health, WASH, Education, Protection, Livelihood actors)

SECTION 1: CURRENT SERVICE DELIVERY

1.1 Which services are you currently delivering in Kyaka II?
1.2 What percentage of your beneficiaries are persons with disabilities?

SECTION 2: IDENTIFICATION OF PERSONS WITH DISABILITIES

2.1 How do you identify and track persons with disabilities?
2.2 Do you use Washington Group questions?

SECTION 3: CURRENT BARRIERS REPORTED BY PERSONS WITH DISABILITIESs

3.1 What barriers do persons with disabilities report when accessing your services?

3.2 What attitudinal challenges have you observed within your team or volunteers?

SECTION 4: EXPECTED IMPACT OF SERVICE REDUCTIONS

4.1 With the expected **50% staffing reduction**, what will be most affected?

- Health (maternal, neonatal care)
- WASH (maintenance, safe access)
- Education (teacher-to-learner ratio)
- Protection (case management capacity)
- Livelihoods

4.2 How will these reductions impact persons with disabilities specifically?
4.3 What immediate risks do you foresee?

- Increased mortality
- Malnutrition
- Violence
- Negative coping mechanisms
- School dropout
- Survival sex
- Exploitation

SECTION 5: FACILITATORS

5.1 What practices currently support inclusion?
5.2 Which community structures work well (RCWs, OPDs, volunteers)?

SECTION 6: RESILIENCE & SELF-RELIANCE

6.1 What opportunities exist for persons with disabilities to build livelihoods?
6.2 What support would be required to strengthen their resilience?

SECTION 7: RECOMMENDATIONS

7.1 What urgent measures should agencies take to reduce harm from upcoming service cuts?
7.2 What long-term strategies should be prioritized to protect vulnerable groups?

C. CHILD-FRIENDLY FGD TOOLS

Age groups:

- UASC
- Adolescents (13–17)
- Children (8–12 boys, 8–12 girls)
  Includes future cuts + resilience

1. UASC (Simple, Sensitive)

1. What places help you most (school, clinic, water, safe space)?
2. What is hard about getting help?
3. Who helps you when you need something?
4. Are there places you feel unsafe?
5. What would make life easier for you?
6. If services were reduced, what would worry you the most?

2. Adolescents (13–17)

2.1 What services do you use most?
2.2 What makes it hard for young people to use services?
2.3 Are there places where youth feel unsafe?
2.4 How will losing teachers, health workers, and protection staff affect young people?
2.5 What skills or opportunities would help youth cope with future challenges?
2.6 What is needed to keep adolescents safe and in school?

3. Younger Boys (8–12)

3.1 Where do you like going?

3.2 What is hard about getting water, going to school, or going to the clinic?
3.3 Are there places you don't feel safe?
3.4 How would less food affect your family?

4. Younger Girls (8–12)

4.1 What makes school or water points easy or hard to use?
4.2 Do you feel safe using latrines or going out at night?
4.3 What helps you when things are difficult?
4.4 How would less food or fewer teachers affect girls?

D. DISABILITY-INCLUSIVE PROBES (APPLY TO ALL TOOLS)

After each question, ask:

- How does this affect people with different disabilities (physical, visual, hearing, intellectual, psychosocial)?
- What supports would improve accessibility?
- What difference would staff training make?
- Does the service allow caregivers or assistants?
- Are pathways, buildings, signs accessible?
- How do you get information if you cannot hear or see?

VISION

A respected and dignified community of refugees with disabilities who are empowered and fully participate in decision making processes.

MISSION

Raise awareness about disabilities and advocate for the rights of refugees with disabilities within humanitarian context

VALUES

The values of the organization shall be:

- Transparency and accountability;
- Honesty and integrity;
- Diversity and inclusiveness,
- Professionalism and teamwork

LEGALITY

ARD is a registered Non-Governmental organisation that supports and enables refugees with disabilities to participate in and benefit from all forms of humanitarian assistance extended to refugees in the country. The organisation started as a small support group for refugees in Kampala, in the year 2010, after the members realised that refugees who are PWDs were not being fully included and allowed to participate in humanitarian assistance programmes like other refugees. Moreover, they could not advocate for their rights as individuals and without support. With the backing of Inter-Aid, UNHCR, and RLP, the small group of Refugees with disabilities were encouraged to start a formal group that could engage with the key actors involved in humanitarian assistance in the country.

ARD branches (membership associations) are now operational in the following settlements: Maaji in Adjumani district; Kiryandongo in Kiryadongo district; Kyaka II in Kyegegwa district; Kyangwali in Hoima district; Nakivale in Isingiro district and Rwamwanja in Kamwenge district

FOR MORE INFORMATION

For more information please reach us on the following contacts and address: ARD is located in Najjanankumbi/Near Umeme sub-station (Massanyarazi) Entebbe Road / Telephone numbers: **+256 200 909 832 +256 781 503 951** Email address: **info@ardofuganda.org, pwda2017@gmail.com & jamesmbig8@gmail.com** P.O.BOX 108994, Kampala.

Consortia Partner

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In Collaboration with:

ADF AFRICAN DISABILITY FORUM

IDA International Disability Alliance

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