BREAKING THE SILENCE:

# A Needs Assessment on Child Sexual Assault in Mathare, Kenya

Bringing Smiles Foundation

*Everyone deserves a smile!*

# A Needs Assessment on Child Sexual Assault in Mathare, Kenya

***NEEDS ASSESSMENT REPORT***

***2025***

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**Bringing Smiles Foundation**

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# List of Abbreviations

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|---|---|
| ACRWC | African Charter on the Rights and Welfare of the Child |
| BSF | Bringing Smiles Foundation |
| CHPs | Community Health Providers / Promoters |
| CPD | Continuing Professional Development |
| CPIMS | Child Protection Information Management System |
| CPS | Child Protection Services |
| CRC | UN Convention on the Rights of the Child |
| CSA | Child Sexual Assault |
| CPVs | Community Protection Volunteers |
| DCS | Department of Children Services |
| FGDs | Focus Group Discussions |
| GPS | Global Positioning System |
| ISPN | Integrated Survivor Pathway Network |
| KES | Kenyan Shillings |
| KIIs | Key Informant Interviews |
| KNBS | Kenya National Bureau of Statistics |
| M&E | Monitoring and Evaluation |
| MSF | Médecins Sans Frontières |
| MoUs | Memoranda of Understanding |
| n | Sample size (Statistical notation) |
| NGO | Non-Governmental Organization |
| OB | Occurrence Book (used for police reporting) |
| P3 | Medical Examination Request Form |
| PSEA | Protection against Sexual Exploitation and Abuse |
| SD | Standard Deviation (Statistical notation) |
| SDG 16.2 | Sustainable Development Goal 16.2 |
| SHOFCO | Shining Hope for Communities (NGO) |
| SLAs | Service-Level Agreements |
| SMS | Short Message Service (Text Messages) |
| SOPs | Standard Operating Procedures |
| VAC | Violence Against Children |
| VACS | Violence Against Children Survey |

# Key Terms and Definitions

| | |
|---|---|
| Child Sexual Assault (CSA) | The central subject of the report, understood broadly by respondents to include contact offenses (rape/defilement, molestation) , emotional coercion , sexual exploitation (trafficking, transactional sex) , and online sexual exploitation/grooming. |
| CPIMS | A national system for formally logging and tracking verified child protection cases to ensure accountability and traceable responses. |
| Informal Settlements (Mathare) | Densely populated urban areas characterized by acute poverty, high population density (approx. 67,000 residents per km2), and inadequate infrastructure, which together amplify children's vulnerability. |
| Minimum Reception Standards | A recommended set of baseline protocols for all first-contact points (police, clinics) to ensure immediate privacy, issuance of a case/OB number, use of a single referral slip, and a 48-hour feedback rule to the survivor. |
| Needs Assessment | A systematic process, like this report, used to document the context, scope, support systems, attitudes, educational needs, and systemic/environmental gaps related to a specific issue (CSA) to set evidence-based priorities for programming, advocacy, and donor engagement. |
| Population Density | The measure of population per unit area, cited as approximately 67,000 residents per square kilometer in Mathare, which is eleven times the Nairobi County average |
| Referral Pathways | The steps a survivor takes from disclosure to accessing continuous services (medical, psychosocial, legal). They are described as fragmented and often breaking down after initial contact. |
| Safe Corridors Programme | A long-term recommendation to convert short-term fixes (lighting, drainage) into a sustained, maintained initiative covering high-risk routes to reduce evening-hour exposure and environmental risks. |
| Stigma | The pervasive social barrier where disclosure is often met with silencing, shame, or victim-blaming, which severely discourages reporting and help-seeking. |
| Trauma-Informed Response | A necessary approach for training professionals (enumerators, teachers, health workers) to understand the impact of trauma, avoid re-traumatization during disclosure or investigation, and ensure a sensitive, non-judgmental response to survivors. |
| Underreporting | The systemic issue where the vast majority of CSA cases never reach official records despite widespread community awareness, resulting in only a fraction of the true crisis being documented. |

# Executive Summary

The 2025 Bringing Smiles Foundation (BSF) Needs Assessment set out to redefine what child protection means for a child growing up in Mathare not in theory, but within their daily realities. Its purpose was to **document the context, scope, support systems, attitudes, educational needs, and partnership opportunities related to child sexual assault (CSA) in Mathare;** diagnose systemic and environmental gaps; and set evidence-based priorities for BSF's programming, donor engagement, and advocacy, aligning with *Kenya's National Plan of Action for Children (2023–2027), the Children Act 2022, and SDG 16.2.*

## KEY FINDINGS:

**Recognition Without Resolution:** 85.9% of respondents recognized CSA in Mathare, and 77.7% knew of incidents in their own neighborhoods. Mathare's estimated 260,000 residents include 60% under 25 years, with children under 15 comprising nearly one-third, or approximately 110,000—equivalent to filling over 40 primary schools. With a density of 67,000 people per square kilometer—eleven times Nairobi County's average—70% of streets lack lighting, intensifying environmental risks in unsafe drainage and flooded areas. **Yet fewer than 19% knew how to report formally, and 57% faced barriers such as stigma, fear of reprisal, or the cost of follow-up.** Reporting largely occurs through peers, women's groups, or religious leaders—a symptom of weak institutional trust. As one community leader noted: ***"We know where harm happens; we just don't believe the system will protect the child."***

**Structural and Economic Drivers of Risk:** Environmental and economic conditions intensify exposure. 62% of households cited poor lighting as a safety risk, 51.8% reported unsafe drainage and flooding, and 73% live in single-room dwellings of 10–12 m² shared by up to eight people. In these spaces, privacy and supervision collapse. Poverty compounds this: 67% of households earn below KES 10,000 monthly, an estimated double the Nairobi County poverty rate, leaving children unsupervised for 6–8 hours daily. The physical and economic environment together create conditions where abuse becomes predictable rather than exceptional, with girls aged 10-14 at highest risk.

**Services Under Strain, Stigma, and Erosion of Trust:** Protection systems exist but lack reach, training, and accountability. **Only 24% of reported cases receive structured follow-up, and just 31% of providers have completed child-protection training in the past two years.** Without standardized referral forms, case tracking, or feedback loops, most incidents vanish after initial contact. Resource turnover and dependence on short-term donor projects further weaken consistency. 210 respondents identified stigma as the main deterrent to disclosure, with families often pursuing informal mediation through elders or chiefs, prioritizing reconciliation over justice. Survivors who report formally encounter insensitive handling, delays, or intimidation. Only 35 respondents could name a functioning safe space—proof that even where courage exists, infrastructure does not. Despite these deficits, 90% of residents expressed willingness to participate in protection initiatives, and 230 community members volunteered to co-lead local actions, showing partnership potential amid educational gaps in legal awareness and abuse recognition.

## CRITICAL NEEDS:

**Infrastructure and Environmental Safety:** Targeted improvements including well-lit corridors, secure sanitation blocks, and strengthened drainage systems (62% cite poor lighting; 51.8% report unsafe drainage)

**Reporting and Referral Pathways:** Trusted, child-friendly reporting desks linked to CPIMS to restore confidence in statutory processes (fewer than 19% know how to report & only 24% of cases receive follow up)

**Continuity of Care:** Coordinated case management, sustained psychosocial support, standardized referral protocols, and at least one 24-hour shelter per zone (only 24% of cases receive follow-up)

**Capacity and Legal Literacy:** Consistent, accredited training for teachers, health workers, and administrators to institutionalize child protection principles (only 31% trained in past two years)

**Systems Coordination and Accountability:** Joint planning mechanisms between BSF, Department of Children Services, and county forums, supported by quarterly data dashboards and joint case reviews

## RECOMMENDATIONS:

**Rebuilding Community Confidence:** Launch structured dialogues through schools, faith groups, and local committees to increase awareness of formal reporting pathways from 19% to at least 70%, supported by visible, named focal persons in every major cluster.

**Strengthening Systems and Capacity:** Train 80% of teachers, health workers, and administrators in trauma-informed response. Log every verified case in CPIMS within 48 hours of reporting to ensure traceable responses.

**Expanding Survivor and Caregiver Support:** Establish at least one 24-hour safe space per zone. Launch livelihood and psychosocial programs for 500 caregiver households annually, targeting 20% reduction in neglect and school dropout.

**Institutionalizing Sustainability and Accountability:** Publish annual Mathare Child Protection Dashboards consolidating CPIMS and community data. Transition local protection desks and committees into county frameworks under formal agreements to ensure continuity beyond project cycles.

## IMPLICATIONS & WAY FORWARD:

The evidence from Mathare reveals a community that is neither unaware nor unwilling, **but unsupported by the systems meant to protect it**—the problem is not ignorance, but absence of infrastructure, coordination, and consistent investment, with resilience outweighing neglect as 9 in 10 residents express readiness to act. If implemented with urgency and discipline, **these measures could halve unreported CSA cases within two years** and establish a community-anchored protection model replicable across Nairobi's informal settlements, informing national child protection strategies.

# 1. Introduction & Background

## 1.1 Introduction & Background

**Crammed into just within 3.0 square kilometers, Mathare, one of Nairobi's oldest and largest informal settlements, is home to an estimated 260,000 residents, applying Nairobi's urban growth rate of 3.8% per year, as per the 2019 Kenya Population and Housing Census. With a density of 67,000 residents per square kilometer, Mathare is eleven times more crowded than the Nairobi County average,making it one of the densest urban settlements globally. This density is a daily lived reality that translates into stretched infrastructure, fragile social systems and amplified risks for this community. We anchor on the 2019 census baseline for Mathare (206,564) and apply a 2025 projection (~260,000) for narrative context. Higher NGO spot estimates (~500,000) are treated as upper-bound due to informal-settlement enumeration limits; all rates in this report use the baseline/projection pair consistently.**

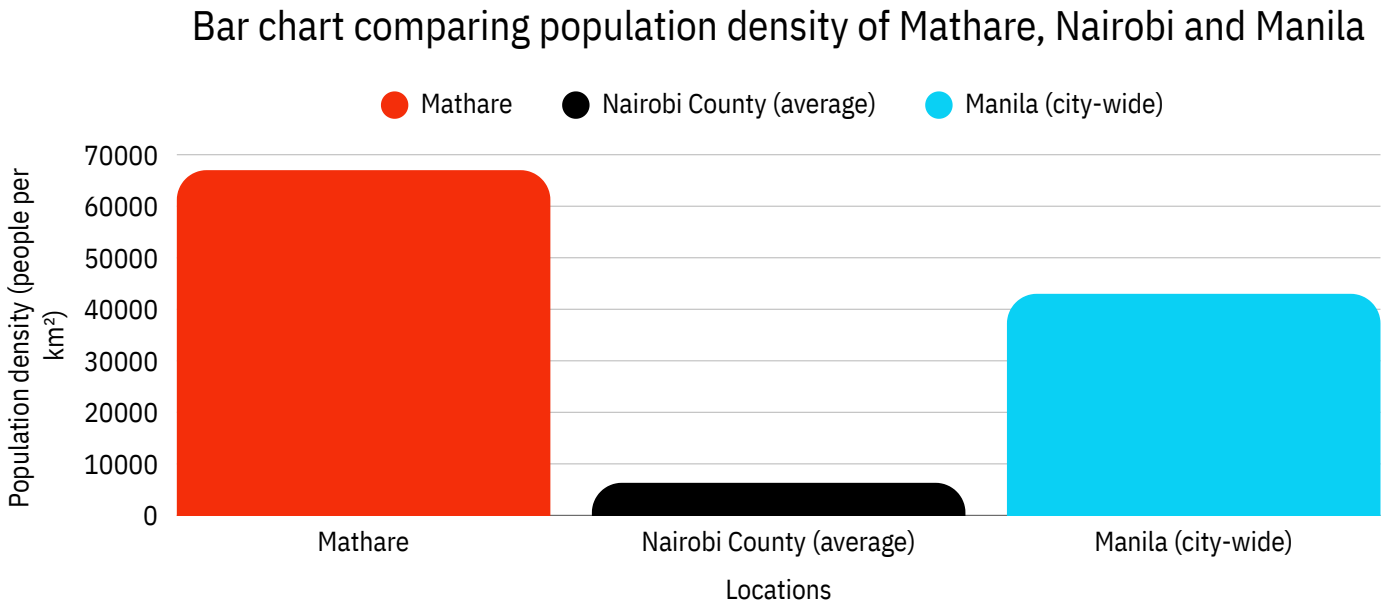



*Figure 1: Mathare's density (~67,000 people/km²) compared to the density of Nairobi County as a whole and that of Manila (KNBS 2019; BSF 2025 projection; international city stats, public sources).*

**Census data show that 60% of the population in Mathare is under 25 years, with children under 15 years comprising nearly one-third of residents (KNBS, 2019). Applying this ratio to the 2025 estimate demographically suggests that approximately 110,000 children live in Mathare today. To better visualise this, Mathare's children alone would fill the enrolment capacity of more than 40 primary schools in Kenya combined. A figure that is higher than the total populations of some of the rural counties in this country.**

**The average household size in Nairobi is 3.1 persons (KNBS, 2019), but in informal settlements such as Mathare, families of five to eight individuals commonly share a single room of less than 12 square meters (Amnesty International, 2021; UN-Habitat, 2020). For the children in Mathare, this means growing up in environments where supervision is limited, risks are heightened, privacy is absent and protective structures weakened by the sheer pressure of numbers. These physical and demographic realities form the foundation of the child protection emergency in this community. The scale of risks faced daily by its children are undeserved, urgent and impossible to ignore.**

## 1.2 Child Protection Context

**To better contextualize child protection in Mathare, this report acknowledges the scale and character of violence against children nationally and grounds it in the settlement's lived reality. National data from the 2019 Violence Against Children Survey (VAC) show that nearly one in five children in Kenya experience sexual violence before turning eighteen. Scaled to Mathare's child population, this translates to approximately 14,000 survivors of sexual abuse today.**
**While these figures already point to a national crisis, they only capture fragments of what communities like Mathare really endure.**

**Mathare specific realities show an even deeper crisis. The baseline data provided in this report will make it clear that Mathare's child protection challenges are not hypothetical. They are present, visible and urgently demand interventions that go beyond national averages to address the lived experiences of children in this community. The Mathare Needs Assessment conducted by Bringing Smiles Foundation (2025) confirmed that child sexual abuse is a recurring reality that is not isolated or occasional in this settlement. Key informants including parents, teachers, religious leaders, health providers, both government and non-government stakeholders and children themselves consistently described frequent cases, often involving perpetrators familiar to the child, relatives, neighbours and in some instances, authority figures. Abuse occurs in homes, classrooms, alleyways and community spaces, cutting across what should be children's most trusted environments.**

**According to Kenya Police Service crime records, fewer than 1,500 cases of defilement and sexual assault are reported nationwide each year. BSF's assessment, however, reveals how this number is starkly at odds with the prevalence revealed by surveys and community reporting, unmasking an invisible crisis of underreporting. The assessment highlighted the many reasons cases never reach official records. Fear of retaliation, stigma, normalization of abuse and crucially, lack of trust in authorities are some of the few reasons that came to disclosure.**

**Interviews with teachers and community leaders revealed that families often settle cases informally, sometimes accepting money or gifts to remain silent. Teachers spoke of children withdrawing quietly from class after incidents. Survivors and their families feared reprisals or further victimization if they reported to the police. Community health providers described cases where survivors were turned away for lack of medical supplies, or where investigations were dropped due to corruption or lack of follow-up. Community leaders admitted families often chose silence rather than confrontation with authorities. These findings confirm that the official statistics only reflect a fraction of the true crisis in Mathare.**

**The Mathare Needs Assessment (BSF, 2025) further reveals multiple overlapping risk factors that exacerbate children's vulnerability. Poverty forces parents and caregivers into long hours of informal work, leaving children unsupervised for extended periods. Overcrowding, with entire families sharing single-room dwellings erodes privacy and increases children's exposure to abuse within homes and communal spaces.**

**Schools, intended as protective environments, are overstretched. Teachers reported struggling with high student-to-teacher ratios and inadequate resources, which limited their ability to detect or respond to abuse. Dropouts and absenteeism, driven by poverty and family pressures, further push children into unsafe environments such as casual labour or street life.**

Health and social services were consistently identified as inadequate. Interviews revealed that only a handful of NGOs provide counselling or medical referrals for survivors and no dedicated safe shelters exist within Mathare. This lack of accessible, child-friendly services leaves survivors unsupported, perpetuating cycles of trauma and silence. Despite moderate visibility of NGO-run services, public provision remains thin and inconsistent, with weak referral continuity — hence the persistent gaps documented in our Findings.Police units lack specialized training, and child protection committees are either inactive or poorly resourced. Cultural stigma and victim-blaming attitudes continue to silence survivors, leaving the majority to navigate trauma without support.

This convergence of high prevalence, systemic underreporting and chronic service gaps make Mathare's reality uniquely urgent. While Kenya has one of the strongest legal child protection frameworks on paper, from the Constitution of Kenya 2010, to the Children's Act (2022), the Sexual Offences Act (2006) to global commitments such as being party to the UN Convention on the Rights of the Child (CRC), the African Charter on the Rights and Welfare of the Child (ACRWC) and an aligned commitment to Sustainable Development Goals (SDG 16.2), which calls for an end to all forms of violence against children, their protections are staggered, collapsing under the weight of local realities,as will be demonstrated by the finding in this report.

## 1.3 Purpose, Objectives and Scope of the Assessment

This assessment therefore, was undertaken to bring to light the realities of Child Sexual Abuse (CSA) in Mathare, document its scale and provide evidence that is necessary to drive the urgent interventions. Its purpose is to deliver credible, community-grounded data that can guide targeted programs, strengthen child protection systems and inform both policy and advocacy at local and national levels.

This assessment was designed to:

1. Document the prevalence and patters of child sexual abuse in Mathare.
2. Expose the risk and protective factors shaping children's vulnerability.
3. Evaluate the availability, accessibility and quality of existing services.
4. Amplify community perspectives, including barriers to disclosure and reporting.
5. Inform pilot interventions, advocacy efforts and policy reforms.

## 1.4 Scope and Limitations

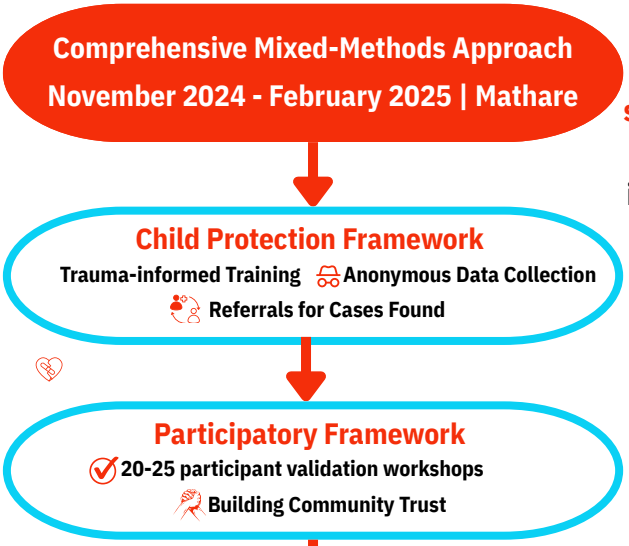
The focus was on children aged 0–18 living in Mathare, with data drawn from household surveys, interviews, and focus groups involving children, families, service providers, and community leaders. While the findings provide a detailed and localized picture, limitations must be acknowledged. Underreporting due to stigma, fear, and distrust of authorities likely means that prevalence figures remain conservative. Resource and time constraints also limit generalizability beyond Mathare. A detailed account of methodology, including data sources and collection tools, is presented in a chapter herein.

This assessment was conducted under strict ethical standards. Every safeguard was deliberate. Data collection was conducted in full alignment with Kenya's Data Protection Act (2019) and BSF's Child Protection Policy. Informed consent and confidentiality agreements were secured at every stage and no personal identifiers were collected. Survivors' voices were treated with dignity, ensuring ethical integrity while protecting data credibility. These safeguards are central to BSF's professional approach and provide confidence that the findings which follow are both ethically sound and a reliable reflection of Mathare's urgent child protection realities.

# 2. Methodology

## 2.1 Assessment Framework and Approach

This needs assessment, conducted by Bringing Smiles Foundation between November 2024 and February 2025 in Mathare, Kenya, adopted a **mixed-methods design** to address the sensitive issue of child sexual assault (CSA). The design combined household and student surveys to measure prevalence and awareness, key informant interviews (KIIs) with teachers, healthcare providers, and local leaders to identify barriers, and focus group discussions (FGDs) to explore community attitudes. Environmental mapping with GPS across sub-areas such as Mlango Kubwa and Mathare 4A, together with engagements with local leaders, identified safe and unsafe spaces. Validation workshops further refined interpretations. This combination balanced numerical evidence with lived experiences—an essential approach in Mathare, where stigma and distrust often conceal abuse.




The methodology was guided by complementary frameworks. The **socio-ecological model** structured analysis across individual, family, community, and institutional levels. The **INSPIRE framework** informed the identification of prevention and service strategies. The **Violence Against Children Survey (VACS) framework** guided the adaptation of core prevalence items, which were translated into Swahili and Sheng and refined through cognitive interviews and pilot testing. A **participatory framework** ensured community engagement, with **validation workshops** of 20–25 participants fostering trust and accountability. Together, these frameworks provided a structured yet adaptable foundation.

Ethical safeguards were integrated throughout. Enumerators received trauma-informed training, same-gender matching was applied for sensitive interviews, and a two-track safeguarding protocol was used: survey responses remained anonymous, while participants were separately offered referral cards with hotline linking them to support services. If a child disclosed imminent risk during an interview, enumerators paused the session and activated a safeguarding log (separate from survey data) to initiate mandatory reporting under the Children Act (2022).

Triangulation across data sources strengthened validity: surveys and mapping quantified prevalence and risk environments; KIIs and FGDs added depth; and workshops confirmed the findings with community stakeholders. Visual 1 illustrates the integrated assessment design. This approach ensured methodological rigor, community involvement, and ethical protection, supporting reliable program planning for diverse audiences.

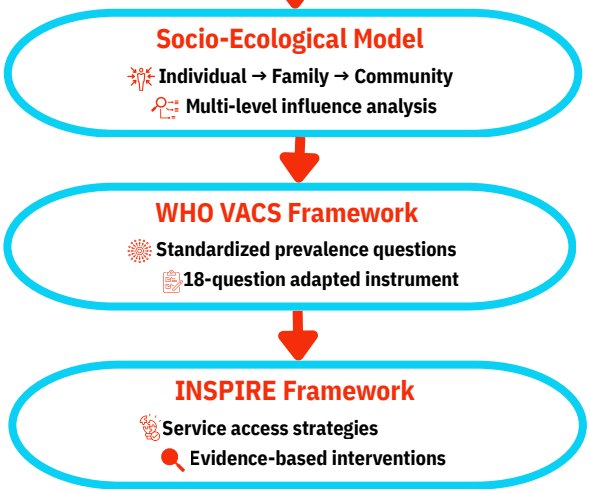



*Figure 2: Integrated Assessment Framework Flowchart*

## 2.2 Data Collection Methods, Tools, and Instruments

### Methods Used

**Data were collected between November 2024 and February 2025 in Mathare using four complementary methods:**

- **Household and student surveys: 350 households and 160 students were interviewed using anonymous, confidential survey instruments to estimate CSA prevalence and identify at-risk groups.**
- **Key informant interviews (KIIs): 36 teachers, 13 healthcare providers, 7 NGO representatives, 12 local leaders, 2 police officers, and 6 religious leaders were engaged, providing expert perspectives on barriers, referral pathways, and community needs.**
- **Focus group discussions (FGDs): Six FGDs were conducted with 6–10 participants each, including youth and service providers, exploring stigma, attitudes, and help-seeking behavior.**
- **Observations and mapping: GPS-enabled transect walks across Mlango Kubwa, Hospital Ward, Mabatini, and Mathare 4A identified unsafe areas (e.g., poorly lit alleys, abandoned structures) validated against resident input.**

### Tools and Instruments

**Survey instruments were adapted from the WHO Violence Against Children Survey (VACS). An 18-item CSA module was translated into Swahili and Sheng, back-translated for accuracy, and refined through cognitive interviews (n=12) and pilot testing in Mathare (n=30). Surveys for adolescents aged 13–17 were conducted via confidential pen-and-paper self-completion, administered privately with same-gender enumerators nearby to provide clarification if needed. Completed forms were sealed in envelopes and later double-entered by BSF staff into Google Forms for aggregation. Younger children (<13) were not directly asked about CSA; caregivers provided proxy responses regarding household safety.**

**Interview guides contained 10–15 semi-structured, open-ended questions tailored for each respondent group (teachers, health providers, NGOs, leaders). Focus group protocols used 5–7 guiding questions to encourage open discussion, moderated by trained facilitators. Observation tools included GPS-enabled devices and structured checklists, which were validated with 10 local leaders before field deployment.**

### Implementation Details

**Data were collected by a team of eight enumerators fluent in Swahili and Sheng, supervised by two field coordinators. Enumerators received four days of training on trauma-informed interviewing, safeguarding protocols, mandatory reporting procedures, crisis intervention, and referral pathways. Training included role-plays, mock interviews, and ethics refreshers.**
**To reconcile anonymity with Kenya's Children Act (2022) obligations, a two-track safeguarding protocol was applied: (a) surveys remained anonymous and unlinked to identities; (b) participants were separately offered referral cards with hotline to connect to caseworkers. If a child disclosed imminent risk during an interview, enumerators paused the survey and initiated referral.**
**Survey responses were collected on confidential paper forms in the field (paper was chosen in locations where carrying electronic devices posed security or community-acceptance risks). Completed paper forms were then double-entered by trained BSF staff into Google Forms for consolidation and cleaning. Digital files were stored in Google Workspace with two-factor authentication, restricted sharing, and daily backups; master analytic files contain no direct personal identifiers. Audio recordings from KIIs and FGDs were uploaded to restricted folders for transcription and then deleted from devices.**

| Data Collection Method | Sample Size | Key Participants | Primary Purpose |
|---|---|---|---|
| **SURVEYS** | | | |
| **Household Surveys** | 350 households | Elders, Adults, Young Adults, Non-school going children | Prevalence, awareness, risk factors |
| **Student Surveys** | 160 students | School children | School risks, help-seeking |
| ***Sub-Total*** | ***510 surveys*** | | |
| **INTERVIEWS** | | | |
| **Teachers** | 36 teachers | Guidance counselors, teachers | Barriers, support needs |
| **Healthcare Provider** | 13 providers | Nurses, clinical officers, CHPs | Service gaps, medical response |
| **NGO Representatives** | 7 staff | Active Child Protection NGOs | Coordination, interventions |
| **Local Leader** | 12 leaders | Chiefs, elders | Informal justice, attitudes |
| **Police Officers** | 2 Officers | Child protection unit, GBV Desk | Enforcement, reporting |
| **Religious Leader** | 6 Leaders | Pastors, Church Leaders | Moral frameworks, trust |
| ***Sub-Total*** | **76 Interviews** | | |
| **Focus Groups** | | | |
| **Parent Groups** | 2 (12-20) | Mothers and fathers | Stigma, family responses |
| **Youth Groups** | 2 (12-20) | Adolescents | Peer dynamics, barriers |
| **Service Provider Groups** | 2 (12-20) | Mixed providers | System coordination |
| **Sub-Total** | 6 Focus Groups (36-60 people) | | |
| **Observations** | | | |
| **GPS Mapping** | 4 areas | Environmental scan | Physical risks, unsafe spaces |
| **VALIDATION** | | | |
| **Community Workshops** | 20-25 people | Mixed stakeholders | Confirm findings |
| **TOTAL PARTICIPANTS** | **642-671** | **All Mathare stakeholders** | **Comprehensive assessment** |

*Table 1: Comprehensive Data Collection Methods and Sample Distribution Across Mathare (November 2024 - February 2025)*

## 2.3 Sampling Strategy and Participant Details

### Target Population and Sampling Frame

**The study focused on households with children aged 0–18 years living in Mathare, Nairobi. Based on the 2019 Kenya Census (≈20,000 households), projected to 2025 using a 2% annual growth rate and adjusted for recent demolitions, the estimated population was ~22,000 households. The sampling frame was developed across four sub-areas—Mlango Kubwa, Hospital Ward, Mabatini, and Mathare 4A—through community mapping and consultations with local leaders.**

### Sample Size Determination and Justification

**Sample size was calculated at a 95% confidence level with a 5% margin of error, assuming an expected prevalence of 22.75% for child sexual assault (CSA). This midpoint estimate was based on evidence from Nairobi's informal settlements and national data (see Table below).**

| Study / Source | Population | Measure | Prevalence (%) | Notes |
|---|---|---|---|---|
| Sarnquist et al. (2014) | Adolescent girls (10–16), Nairobi slums | Annual sexual assault | 20% | Localized, adolescent-specific |
| No Means No Worldwide (2023) | Adolescents, informal settlements | Pre-intervention rape | 24.6% | Contextually similar slum settings |
| IOSR Journal (2023) | Kibera, mixed ages | Lifetime CSA prevalence | 27% | Higher lifetime estimate |
| Mulia et al. (2023) | Kibera, mixed ages | Lifetime CSA prevalence | 38.5% | Upper-bound estimate |
| Kenya VACS (2019) | National sample, females | Lifetime CSA prevalence | 15.6% | Lower-bound national reference |

*Table 2: Evidence Base for Prevalence Assumption (22.75%)*

**From these studies, the initial base sample was 270 households. Applying a design effect of 1.3 for stratification yielded ~351 households. Allowing for a 10% non-response rate, the planned target was ~390 households.**

### Achieved Sample and Analytic Implications

**Fieldwork successfully surveyed 350 households (plus 160 students). While slightly below the planned figure, this sample remains statistically robust. After adjusting for the design effect, the achieved sample provides an effective size of ~269 households, yielding a 95% confidence margin of ±5.0 percentage points. This level of precision is acceptable for a community-level needs assessment and provides reliable estimates of CSA prevalence and associated risk factors.**

| PARAMETER | VALUE | SOURCE/JUSTIFICATION |
|---|---|---|
| Target Population | 22,000 households | 2019 census (20,000) × 2% annual growth × demolition adjustment |
| Confidence Level | 95% | Standard for rigorous research |
| Margin of Error | 5% | Acceptable precision for needs assessment |
| Expected Prevalence | 22.75% | Midpoint from Nairobi studies (20-27% range) |
| Base Sample Size | 270 households | Statistical calculation |
| Design Effect | 1.3 | Stratified sampling adjustment |
| Design-Adjusted Sample | 351 households | 270 × 1.3 |
| Non-response Adjustment | 10% | Based on pilot testing |
| Planned Target Sample | 390 households | Rounded for field implementation |
| Final Achieved Sample | 350 households | Actual Households reached |

*Table 3: Sample Size Calculation Justification*

## Sampling Methods by Participant Type

**Household surveys (n=350) were proportionally allocated across the four sub-areas of Mathare—Mlango Kubwa, Hospital Ward, Mabatini, and Mathare 4A—using 2019 census projections to 2025. Within each sub-area, systematic random sampling was applied: enumerators selected a random starting point and then visited every nth household, with n determined by area size and population density. Proportional allocation ensured representation of each sub-area, and respondent selection within households reflected the eligible population without enforced quotas.**

**Student surveys (n=160) were conducted in 2–4 schools per sub-area. Schools were identified in consultation with local education officials, and within selected schools, classes were randomly sampled. Within each class, students aged 13–17 years were randomly chosen, with attention to balancing gender where feasible.**

**Key informant interviews were conducted purposively with stakeholders based on relevance to child protection. The achieved sample included 36 teachers (with guidance or counseling roles prioritized), 13 healthcare providers (nurses, clinical officers, CHPs), 7 NGO staff from active child protection organizations, 12 local leaders, 2 police officers (Child Protection Unit and GBV desk), and 6 religious leaders.**

**Focus group discussions (n=6; 6–10 participants each) involved parents, adolescents, and service providers. Parents and adolescents were separated by gender to ensure open discussion of sensitive issues. Service provider groups included mixed participants (health, education, NGO, justice actors).**

**Environmental observations were carried out during GPS mapping across the four sub-areas. Unsafe areas—including poorly lit alleys, abandoned buildings, and informal hangouts—were identified through community input and recorded with GPS coordinates. Figure X presents the distribution of household clusters and school sites included in the study.**

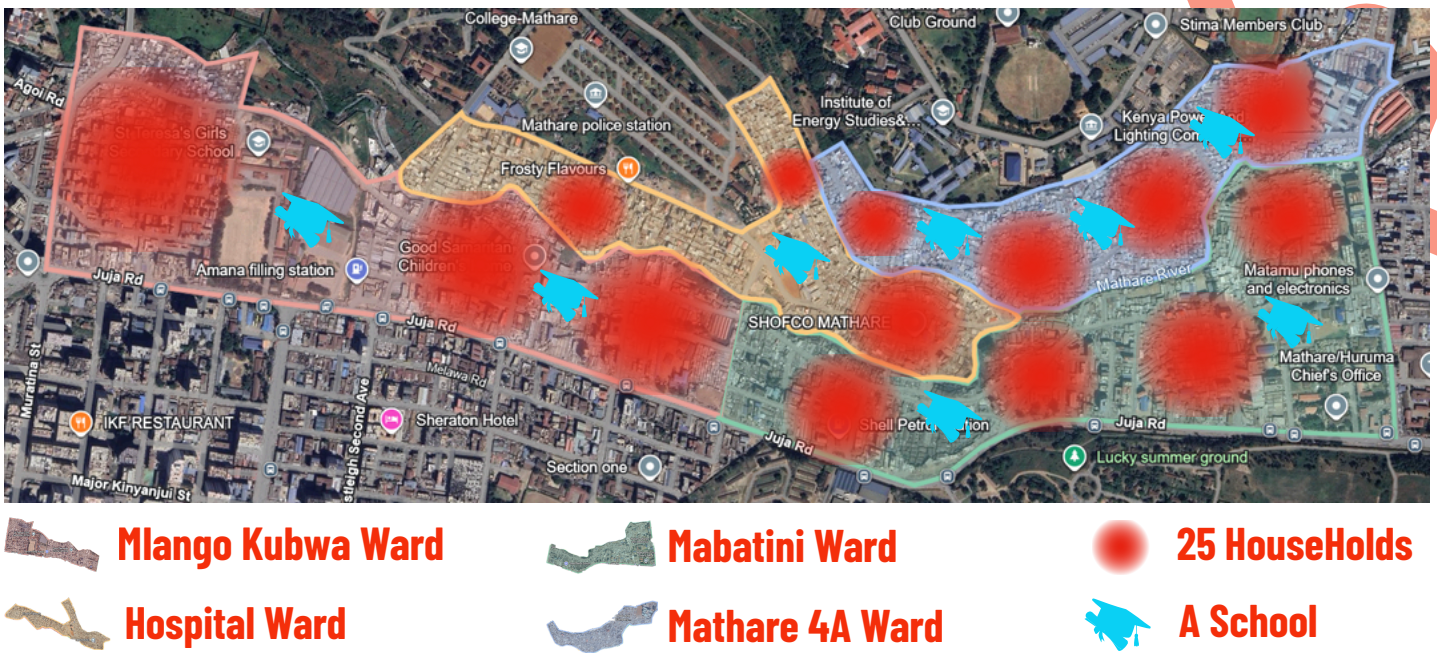



*Figure 3: Sampling Strategy Map*

## Quality Assurance and Bias Mitigation

**To reduce bias, non-responding households were revisited up to three times at different days/times before replacement with the next eligible household along the systematic route. Data collectors (n=8), fluent in Swahili and Sheng, were trained in standardized protocols and supervised in the field. Supervisors conducted daily debriefs, spot-checks, and back-checks on at least 10% of completed surveys. Completed forms were reviewed nightly for consistency and completeness. This approach minimized non-sampling error and enhanced reliability.**

## 2.4 Ethical Considerations and Safeguarding

### Informed Consent and Assent Procedures

**All participants provided informed consent, tailored to age and context. For participants under 18, written parental or guardian consent was obtained first, followed by verbal child assent, explaining the study's purpose—to understand child sexual assault risks—and potential emotional risks in Swahili or Sheng. Children could withdraw at any time, even without parental consent. For ages 16–18, both parental consent and independent assent were required under Kenyan law, respecting their autonomy.**

### Anonymity and Data Security

**Survey data were collected on paper forms and later transferred into Google Forms by the BSF team. Paper forms were stored in locked cabinets, accessible only to authorized staff, and will be destroyed after three years. Digital data were stored on Google Drive with two-factor authentication and daily backups, aligned with ISO 27001 principles of access control and encryption. No personally identifying information was retained, preserving participant anonymity.**

### Participant Safeguarding and Support

**Eight enumerators received four days of trauma-informed training led by child protection specialists. Protocols included sensitive questioning techniques, mid-session well-being checks, and the option to end interviews if distress arose. A counselor was available on-site during data collection. All participants received referral information for psychosocial and legal services within 24 hours.**

### Disclosure Management and Mandatory Reporting

**Procedures complied with the Kenyan Children Act. Anonymous survey responses remained confidential, but if a child disclosed ongoing abuse during direct interaction, enumerators followed a separate safeguarding protocol: pausing the interview, connecting the child to immediate protection services, and documenting the referral in a log unlinked to survey data. This ensured both anonymity and legal compliance.**

## 2.5 Data Analysis Approach

### Quantitative Analysis

**Survey data from 350 households and 160 students were analyzed using survey-weighted descriptive statistics to reflect stratification by sub-area. Prevalence estimates include 95% confidence intervals. Cross-tabulations tested associations between age, gender, and reported incidents, with chi-square tests ($p<0.05$). Missing data (~5%) were addressed through multiple imputation with auxiliary variables, avoiding the bias of mean substitution. Effect sizes were reported alongside p-values to highlight practical significance.**

### Qualitative Analysis

**Interviews and FGDs were transcribed and coded thematically. A codebook, derived from study objectives and emergent themes, guided the process. Two researchers double-coded 20% of transcripts, achieving $\kappa=0.85$ reliability. While Excel was used for coding due to accessibility and team training, reliability checks and structured procedures ensured rigor comparable to specialized software.**

### Validation and Integration

**Triangulation compared survey prevalence with qualitative insights to cross-check findings. For example, quantitative reports of unsafe areas were reinforced by FGD discussions of stigma and fear. Validation workshops with 20–25 community stakeholders reviewed de-identified findings to confirm accuracy and contextual relevance.**

## 2.6 Quality Assurance and Validation

**Validation followed a multi-level process. Triangulation compared survey results (350 households, 160 students) with qualitative insights from interviews and FGDs to check for convergence. Internal peer review had two researchers independently code 20% of transcripts, with discrepancies discussed until consensus was reached.**

**Community validation workshops (June 2025) involved 12 Mathare leaders who reviewed anonymized findings in Swahili; feedback confirmed cultural appropriateness and contextual accuracy.**

**Technical checks included:**
**(i) completeness reviews (≥95% of questions answered),**
**(ii) outlier screening (±2 SD, retained if contextually plausible), and**
**(iii) cross-referencing with national and regional CSA studies to assess external consistency.**

**Together, these processes confirmed that while stigma may have constrained disclosure, the patterns observed are credible and fit wider evidence.**

## 2.7 Limitations and Constraints

**Several limitations must be acknowledged:**

**First, the achieved sample (350 households) fell short of the statistically ideal 386–389 households, due to non-response and field constraints; this may slightly increase the margin of error.**

**Second, stigma around child sexual assault almost certainly led to underreporting, as seen in comparable Kenyan studies, meaning actual prevalence may be higher than reported.**

**Third, timing during the school term limited student participation, while demolitions displaced some households during fieldwork.**

**Fourth, despite back-translation, subtle differences in Swahili/Sheng may have affected comprehension, and a male-heavy data collection team may have influenced disclosure from girls.**

**Finally, resource constraints (four-month field period, modest funding) limited the breadth of interviews with service providers.**

**Mitigation steps included trauma-informed training, geographic spread across four sub-areas, and validation workshops to ensure contextual credibility. Despite limitations, the assessment provides conservative but reliable prevalence estimates, and strong qualitative insights into barriers, risks, and service needs in Mathare.**

# 3. Findings: Community Demographics and Environmental Context

*Note: Unless otherwise stated, **bases** exclude missing responses; where respondents could choose multiple items, **counts may exceed n**. Quotes are **anonymized, translated in verbatim** and **coded by respondent type and sub-area** (e.g., "Local leader, Mabatini").*

## 3.1 Population Overview

**Understanding the population profile of Mathare is essential to contextualizing child protection vulnerabilities and the prevalence of child sexual assault (CSA). Mathare is one of Nairobi's most densely populated informal settlements, with both official census data and community-based surveys painting a picture of overcrowding, youth-heavy demographics, and limited socio-economic opportunities.**

### 3.11 Overall Population Size and Density

**According to the 2019 Kenya Population and Housing Census, Mathare Sub-County recorded a population of 206,564 people (106,522 males and 100,028 females). Covering an estimated 3 km², this translates to a population density of approximately 68,941 persons per km², placing Mathare among the most densely populated urban areas in the world. Alternative estimates, often cited by NGOs and local leaders, suggest a population closer to 500,000 residents. The disparity reflects challenges in accurately enumerating informal settlements, where transient migration, unplanned housing, and informal tenancy systems complicate population counts. We therefore present the census baseline alongside the 2025 projection used in the Introduction, and we compute all rates against those denominators for internal consistency.**

### 3.12 Age Distribution

**Census data indicates that Mathare's population is strikingly young:**

- **0–9 years: 46,226 children**
- **10–19 years: 35,712**
- **20–29 years: 55,112 (largest single age cohort)**
- **30–39 years: 37,967**
- **40–49 years: 19,538**
- **50+ years: 13,057 combined**

**In total, nearly 40% of residents are below the age of 18, underscoring the vulnerability of children and adolescents in this environment. This youth-heavy demographic, combined with limited adult supervision and high unemployment, creates conditions where risks of CSA and other protection concerns are magnified.**

### 3.13 Household Demographics

**Although official census data provides broad statistics, community-level surveys conducted for this assessment shed further light on household and educational dynamics. Among 350 survey respondents 43% were self-employed, 30% unemployed, 15% students, and only 8% formally employed. Out of those, 48% had lived in Mathare for more than 5 years, 39% were born and raised there, and only 10% had arrived within the past 5 years. 23% had completed secondary school, 23% had some secondary education, 21% had completed primary education, and 11% had no formal education and the rest had reached university level. These figures highlight both the long-term settlement patterns of most households and the education and employment deficits that shape daily vulnerabilities.**

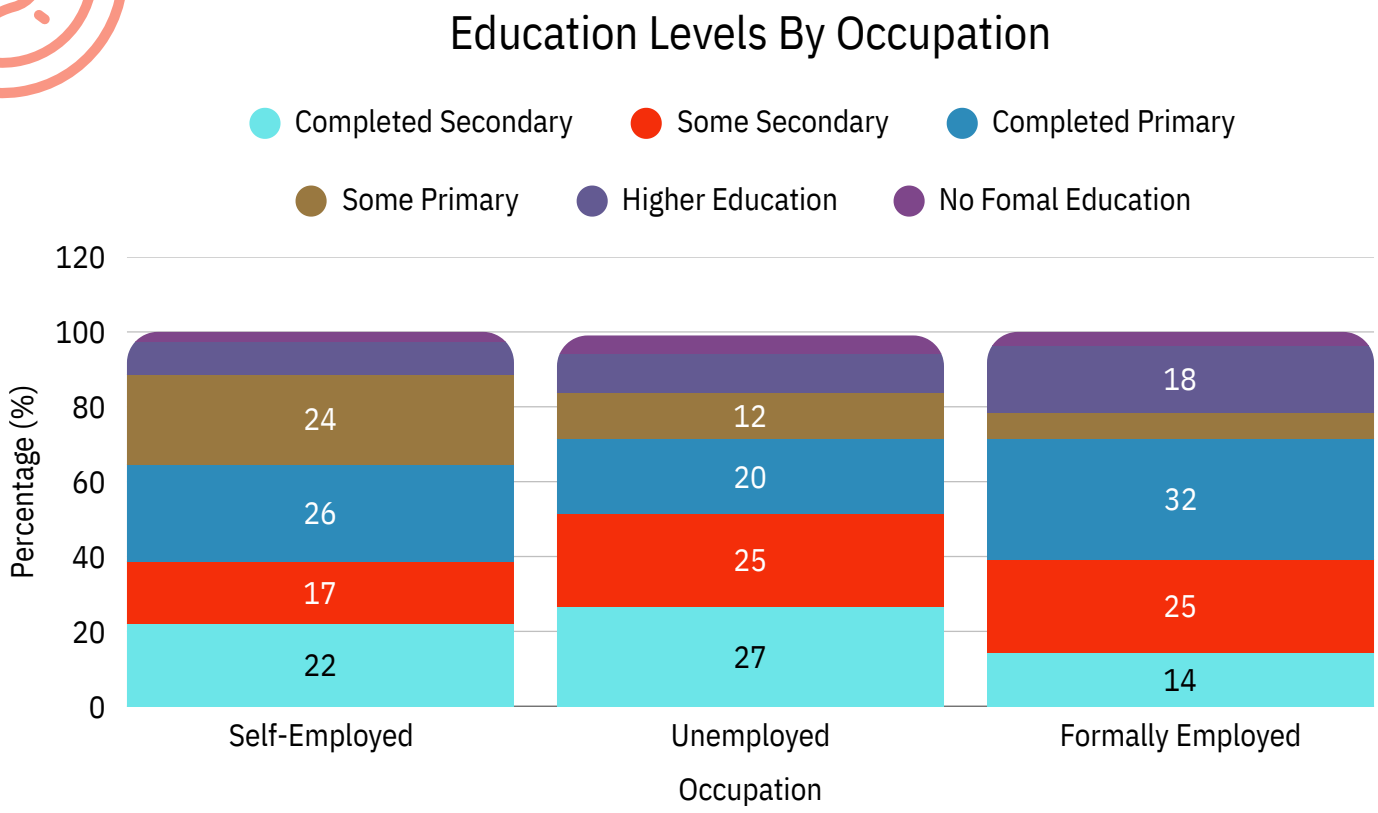



*Figure 4: Education Levels by Occupation of Respondents*

## 3.14 Sub-Areas and Population Concentration

**Mathare is divided into approximately 13 villages, including Kosovo, Mabatini, Bonde, Mathare 4A and 4B, Mradi, and Mlango Kubwa. Community survey rankings indicate that Bonde (207 mentions), Kosovo (84), and Mabatini (82) are perceived as especially vulnerable zones for children. High population densities in these areas strain local infrastructure and heighten risks of neglect, abuse, and exploitation.**

## 3.15 Implications for Child Protection

**The demographic profile of Mathare demonstrates why CSA is both pervasive and underreported in this community. A youth-heavy population combined with overcrowding, high unemployment, and low education attainment places children at elevated risk. The density of residents within limited geographic space increases unsupervised interactions in alleys, schools, and homes, amplifying vulnerabilities.**

**"Children are everywhere in Mathare, but adults are too overwhelmed to supervise them. This is why abuse finds space."**
**~ Community Elder, Mabatini**

## 3.16 Baseline & Projection

**For consistency across the report, we anchor on the 2019 census baseline for Mathare (206,564) and apply a 2025 projection (~260,000) used in the Introduction. Higher NGO spot estimates (to ~500,000) are treated as upper-bound due to enumeration challenges in informal settlements. All rates in this chapter use the baseline/projection pair consistently.**

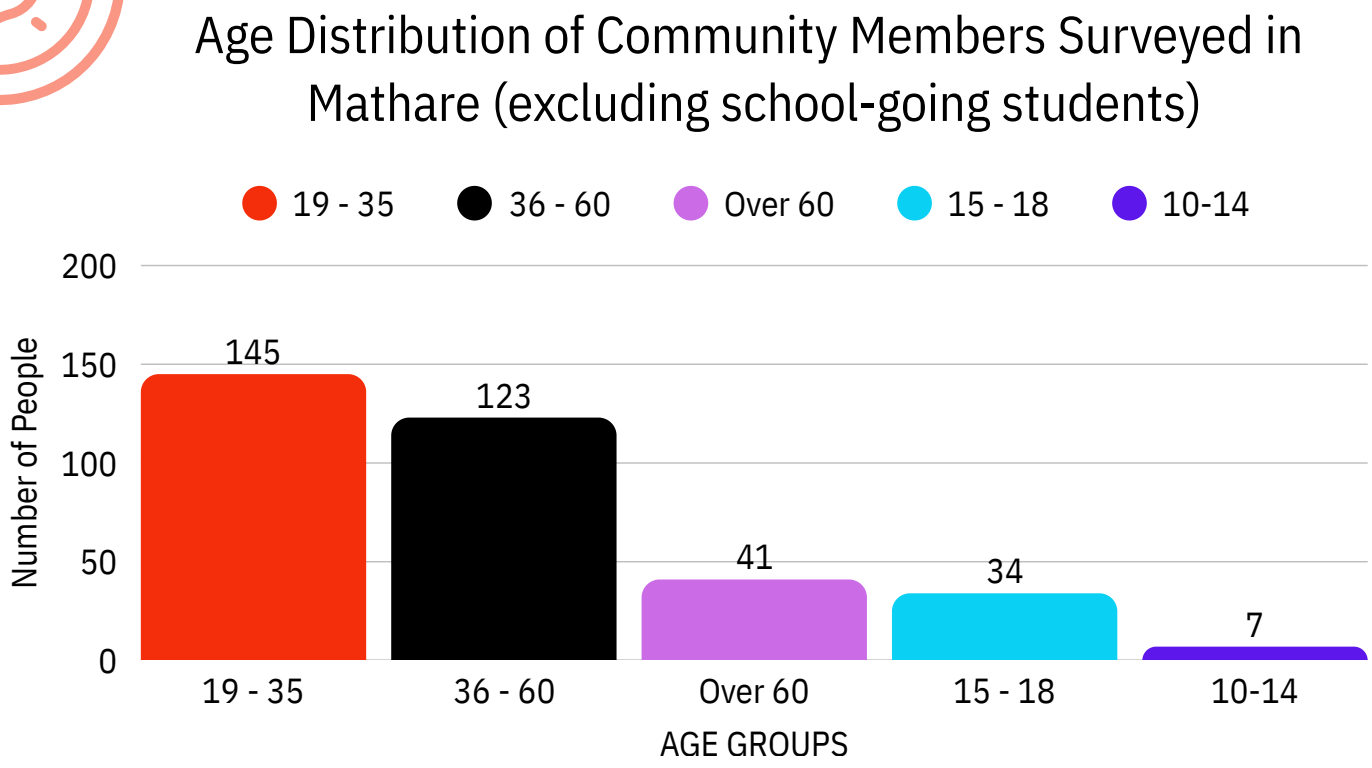



*Figure 5: Age Distribution of Respondents for Community Survey, Excluding the Student Survey*

## 3.2 Community Infrastructure

**The physical and social infrastructure of Mathare directly shapes the safety and well-being of children. While the settlement is characterized by high population density and vibrant community life, it is also defined by inadequate schools, overstretched health facilities, limited safe spaces, and poor public utilities such as street lighting and sanitation. These gaps exacerbate children's vulnerability to abuse, neglect, and exploitation.**

### 3.21 Educational Facilities

**Mathare hosts a mix of public and informal schools, many run by community groups, churches, or NGOs. While exact numbers vary, the Kenya Ministry of Education estimates dozens of community-based schools operating alongside a handful of formal primary institutions. In the community survey, education and awareness emerged as the most pressing need (52 mentions), highlighting parental concern for both access to quality schooling and integration of child protection topics into curricula. Teachers interviewed in this assessment admitted that while schools are critical sites for prevention, many educators lack formal training in identifying and responding to CSA.**

### 3.22 Healthcare Facilities

**Healthcare services are present but limited in scope and unevenly distributed. Organizations such as MSF and SHOFCO run clinics that are widely recognized by community members, while public health facilities remain under-resourced and difficult to access. Survey findings show that 159 respondents rated healthcare for survivors as easily accessible, but a combined 125 said it was somewhat accessible, not accessible, or they were unsure. Interviews with local leaders reinforced these concerns: 56% said survivors are referred to NGOs for treatment, while others noted an outright absence of formal medical response. This reliance on NGO provision reflects both community resilience and the gaps in government service delivery.**

## 3.23 Housing and Public Spaces

**Housing in Mathare is overwhelmingly informal, with structures built from corrugated iron sheets and mud walls. Survey respondents identified unsafe housing and overcrowding as major contributors to child vulnerability. Local leaders also pointed to inadequate lighting in alleys and pathways, which exposes children to risks when moving between school, markets, and homes. Community members consistently ranked crime, poor lighting, and overcrowding as the top environmental factors undermining child safety: 150 respondents cited high crime rates, 81 poor lighting, and 77 overcrowding.**

## 3.24 Community Centers and Safe Spaces

**While NGOs and religious groups have established some community halls and child-friendly spaces, these are insufficient relative to need. Survey data showed that only 35 respondents mentioned safe spaces or shelters as part of the community response to CSA, highlighting both scarcity and lack of awareness. Religious leaders noted that while churches and mosques could provide safe spaces, most lack structured programs or resources.**

## 3.25 Infrastructure and Child Protection

**The absence of reliable infrastructure not only reduces opportunities for education and healthcare but also increases exposure to harm. Poorly lit streets create conditions for CSA at night, overcrowded schools and homes strain supervision, and limited safe spaces mean that survivors often have nowhere to go after abuse is disclosed. Community members frequently highlighted sanitation and road conditions as additional risks, with stagnant drainage and narrow pathways complicating both safety and service delivery.**

> **"The environment itself works against children — when housing is unsafe, clinics are far, and schools are overcrowded, protection becomes impossible."**
> **~ Community Health Provider (CHP)**

**Visibility does not equal sufficiency: while NGO clinics and community halls are recognized, public provision remains thin and uneven, and referral continuity is weak — themes elaborated in Chapter 5.**

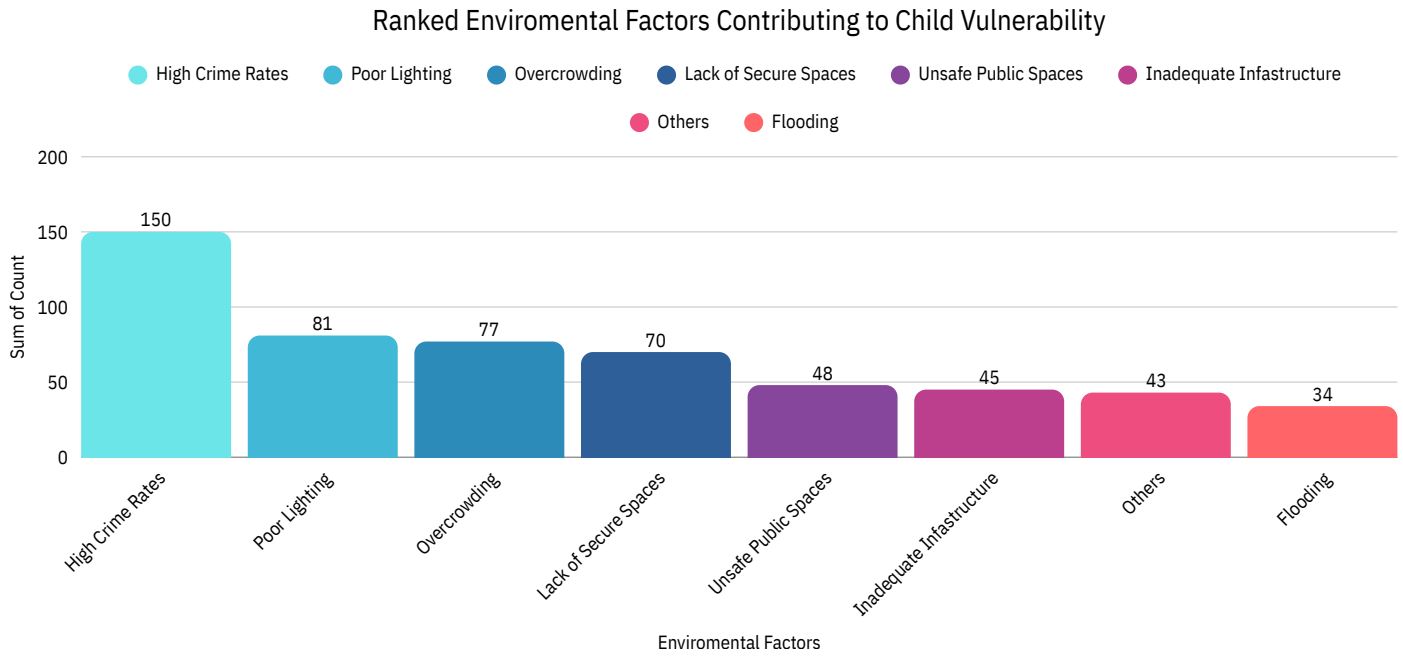



*Figure 6: Ranked Enviromental Factors contributing to Child Vulnerability*

## 3.3 Environmental Risks

**Mathare's environmental context significantly amplifies child vulnerability, intersecting with issues of safety, health, and displacement. Both survey results and stakeholder interviews highlight recurring risks such as crime, poor lighting, flooding, and exposure to drugs and alcohol — all of which create conditions where children are more susceptible to sexual abuse and exploitation.**

### 3.31 Crime and Insecurity

**The community survey identified high crime rates as the single most important environmental factor contributing to child vulnerability, mentioned by 150 respondents. This was followed by poor lighting (81 mentions), overcrowding (77), lack of secure housing (70), and unsafe public spaces (48). Local leaders echoed these concerns, noting that poorly lit alleys and overcrowded housing blocks become hotspots for predatory behavior at night. CHPs confirmed that insecurity restricts children's movement, particularly in the evenings, when most cases of abuse occur.**

### 3.32 Flooding and Poor Sanitation

**Mathare lies along the Mathare River floodplain, with significant portions of the settlement situated within the 30-meter riparian zone. Seasonal flooding displaces families, damages housing, and creates temporary homelessness, all of which increase risks for children. UN-Habitat reports that nearly 30% of the settlement lies within flood-prone areas, exposing residents to annual hazards. Survey respondents also cited inadequate infrastructure (45 mentions) and flooding (34 mentions) as environmental vulnerabilities. Poor sanitation and clogged drainage systems exacerbate these risks, contributing to waterborne disease and undermining safe play and learning environments for children.**

### 3.32 Substance Abuse and Idleness

**Both interviews and survey responses frequently linked drug and alcohol abuse with increased child risk. CHPs reported substance abuse in households and communities as a driver of CSA, noting that children in environments with alcoholism are particularly vulnerable. Open-ended survey responses also cited idleness among youth and drug use in public spaces as pressing community concerns. This aligns with focus group observations that unoccupied youth in overcrowded settlements often engage in risky behavior, exposing younger children to exploitation.**

### 3.33 Risks During Vulnerable Times

**Community members consistently emphasized that risks to children peak at particular times of day. Survey results show that 224 respondents ranked nighttime as the period of highest vulnerability, followed by evenings (124), daytime (70), and early morning (52). These patterns reflect both environmental and social factors: children are often unsupervised at night due to parents working late, while poor lighting and insecure streets create opportunities for abuse.**

### 3.34 Safety Concerns and Reporting

**When asked about broader safety issues, 165 survey respondents reported concerns about conducting fieldwork in Mathare, compared to 76 who said no and 16 who were unsure. These perceptions illustrate a climate where insecurity and environmental risks are normalized, further discouraging disclosure or reporting of CSA**

> **"We all know the dangerous corners — but the children still pass there because they have no choice."**
> **~ Local Leader, Mlango Kubwa**

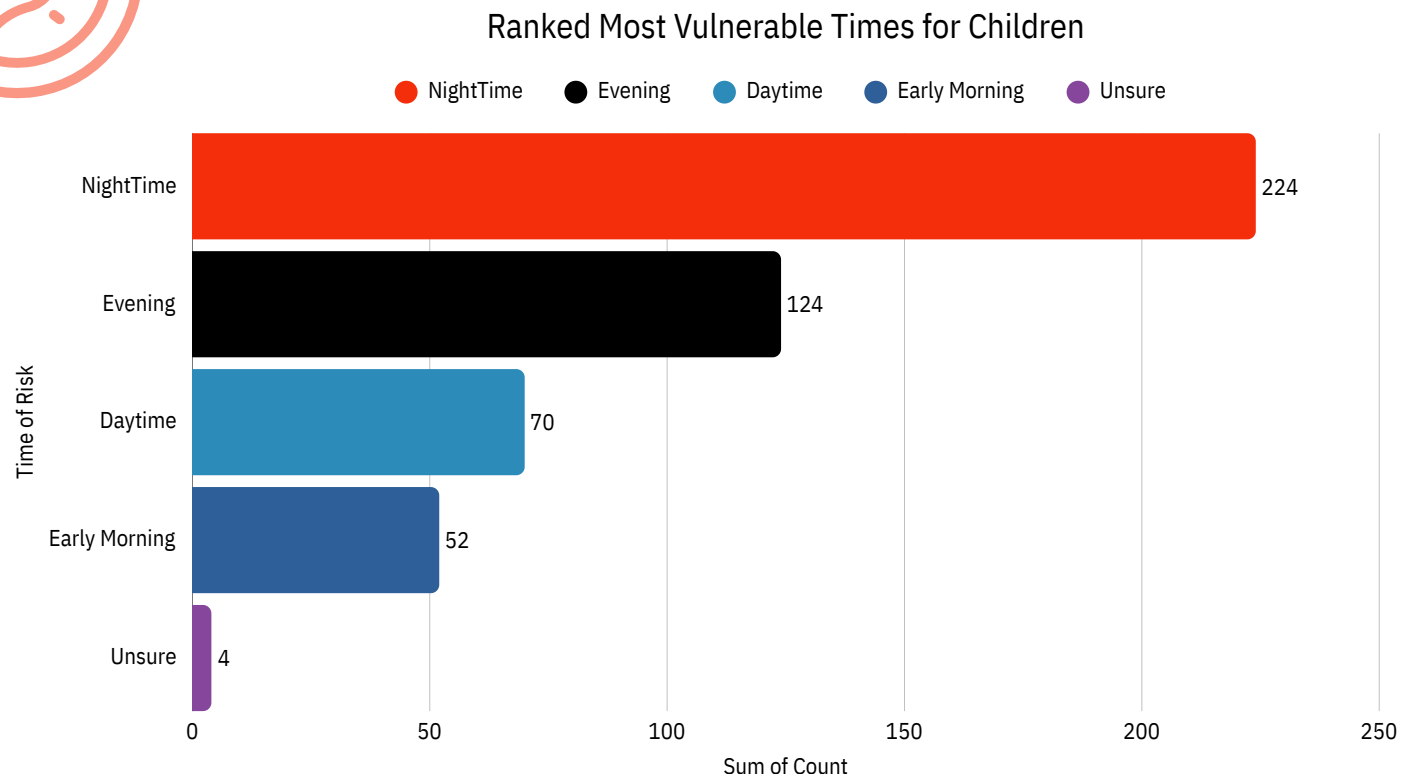



*Figure 7: Ranked Most Vulnerable Times for Childern*

***Environmental risks in Mathare — from crime, flooding, and unsafe housing to substance abuse and poor lighting — form a backdrop of daily hazards for children. These risks intersect with CSA vulnerabilities, creating high-risk times and spaces where abuse is most likely to occur. The normalization of insecurity, combined with inadequate infrastructure and services, means that many risks remain unmanaged, leaving children exposed. Any effective child protection strategy must therefore integrate environmental risk mitigation — including improved lighting, safe housing, flood control, and youth engagement — alongside direct CSA interventions.***

## 3.4 Socio-Economic Challenges

**Beyond demographic and environmental pressures, Mathare's socio-economic realities profoundly shape the safety and protection of children. Poverty, unemployment, substance abuse, and fragile household structures reduce families' capacity to protect children and create environments where exploitation, including child sexual assault (CSA), thrives.**

### 3.41 Poverty and Economic Insecurity

**Survey results revealed that poverty and economic support were cited by 34 respondents as among the most pressing community needs, second only to education and awareness (52 mentions). Households in Mathare rely heavily on informal and unstable livelihoods: 43% of survey respondents reported being self-employed, 30% were unemployed, and only 8% held formal employment. This economic fragility leaves families unable to meet basic needs, heightening children's exposure to transactional exploitation, neglect, and early entry into income-generating activities that place them at risk of abuse. Interviews with local leaders and community health providers underscored this link, noting that household stress and economic desperation often push children into unsafe environments.**

**"When there is no food in the home, children are sent out to find work or favors, and that is where predators find them."**
**~ Community Health Promoter (CHP)**

## 3.42 Education and Limited Opportunities

**Although education is highly valued, access remains inconsistent. While 23% of surveyed respondents had completed secondary education, 11% had no formal education at all. For children, poor school infrastructure, overcrowding, and limited parental resources frequently result in absenteeism or dropout. Teachers interviewed stressed that gaps in education not only limit children's opportunities but also leave them more vulnerable to abuse in the community.**

## 3.43 Substance Abuse and Idleness

**Substance abuse emerged as another recurrent challenge. 16 survey respondents explicitly identified drugs and substance abuse as a pressing need to be addressed, while interviews with CHPs linked parental alcoholism and drug use to neglect and increased CSA vulnerability. At the community level, idleness among unemployed youth was described as a key factor in unsafe environments. Leaders noted that unsupervised youth often gather in alleys and open spaces, engaging in drug use and predatory behavior.**

## 3.44 Family Stress and Parenting Challenges

**Family structures in Mathare are under strain from the combined effects of poverty, overcrowding, and limited support systems. Survey respondents and interviewees alike identified parenting and home environment as an area needing urgent attention. CHPs reported frequent cases of teen mothers lacking adequate support, while NGOs observed that parents overwhelmed by poverty sometimes normalize abuse or silence children to preserve family stability.**

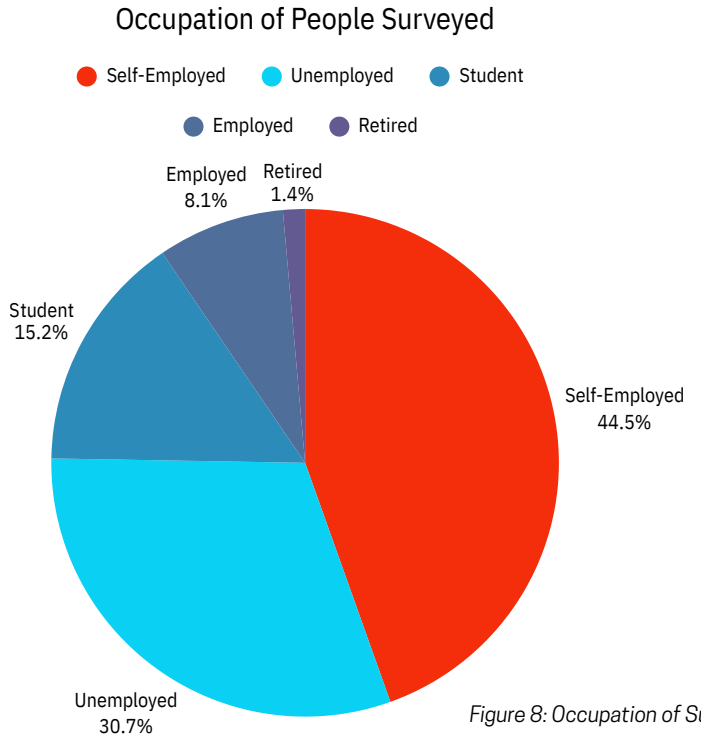



*Figure 8: Occupation of Surveyed Respondents*

***Mathare's socio-economic challenges — poverty, unemployment, substance abuse, and fragile household structures — intersect to create an environment where children are highly vulnerable. While education is recognized as a pathway out of vulnerability, systemic barriers hinder access and continuity. These conditions contribute directly to CSA risks, as children are left unsupervised, driven into unsafe economic activities, or silenced by households struggling with survival. Addressing CSA in Mathare therefore requires not only protection-focused interventions but also integrated socio-economic strategies that tackle poverty, strengthen parenting, reduce substance abuse, and expand educational opportunities.***

# 4. Findings: Scope and Nature of Child Sexual Assault

*Note: Unless otherwise stated, **bases** exclude missing responses; where respondents could choose multiple items, **counts may exceed n**. Quotes are **anonymized, translated in verbatim** and **coded by respondent type and sub-area** (e.g., "Local leader, Mabatini").*

## 4.1 Incidence and Prevalence

**Understanding the incidence and prevalence of child sexual assault (CSA) in Mathare is fundamental for appreciating both the urgency and the scale of the issue. Evidence from the community survey and stakeholder interviews demonstrates that CSA is not an isolated phenomenon but a pervasive and widely recognized problem affecting households, schools, and public spaces across the settlement.**

**Survey data indicates a high level of awareness of CSA as an issue within the community. A significant majority of respondents (85.9%, n=250) reported having heard of child sexual assault before, with only 14.1% (n=41) lacking prior exposure to the concept (Community Survey – Awareness and Knowledge of CSA). Importantly, this awareness translates into acknowledgment of real cases within Mathare: 77.7% (n=233) of respondents confirmed being aware of CSA incidents in their community, while fewer than one in five (18%, n=54) denied such knowledge, and only one respondent preferred not to answer (Community Survey – Awareness and Knowledge of CSA). This indicates that CSA is not only a perceived risk but a lived reality that is widely recognized across Mathare's neighborhoods.**

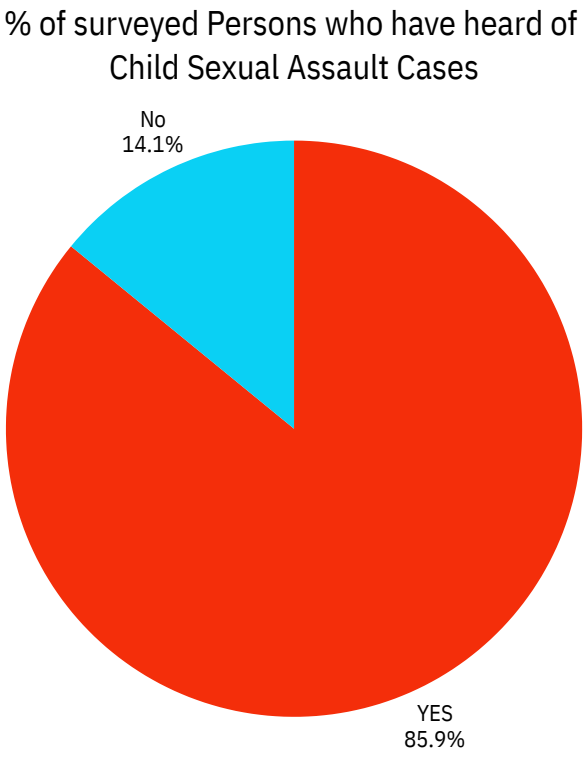



*Figure 9: Percentage of Respondents who have heard of Child Sexual Assualt cases in the area*

**The community also overwhelmingly perceives CSA as a serious social problem. When asked about the magnitude of the issue, 220 respondents described CSA as a "major problem," compared to only 47 who regarded it as a minor concern, and 17 who felt it was not a problem. A very small number (n=5) were unsure (Community Survey – Awareness and Knowledge of CSA). This consensus aligns with insights from interviews: religious leaders emphasized that "CSA happens frequently" in their congregations and neighborhoods, with some noting that "most victims are girls, often abused by familiar persons" (Religious Leaders – Interviews). Similarly, community health providers reported that CSA prevalence was a recurring theme in their work, citing multiple cases of disclosure and medical referral.**

Data from service providers reinforces the impression of widespread prevalence despite underreporting. In interviews with NGOs, 40% of respondents identified CSA prevalence as one of their core concerns, and some described "frequent occurrence" of cases, often brought to their attention through informal community reporting rather than official channels (NGOs – Interviews). Child Protection Officers and local leaders echoed this, describing CSA as "very common but rarely documented" due to stigma and weak follow-up mechanisms. The convergence of quantitative survey findings and qualitative interview narratives underscores the gap between community awareness of incidents and formal reporting rates, suggesting that many cases remain hidden within families or resolved informally at the community level.

Taken together, these findings establish a baseline understanding of CSA prevalence in Mathare. Awareness is widespread, cases are well-known within communities, and there is near-unanimous recognition of CSA as a serious and urgent problem. Yet, the reliance on informal knowledge and the absence of systematic case documentation highlight the limitations of current data. While community members consistently affirm the existence of CSA, the lack of comprehensive reporting mechanisms and official records prevents accurate enumeration of victims. This underscores the importance of situating quantitative findings within a broader narrative: CSA in Mathare is both pervasive and normalized, making it visible to everyone yet inadequately captured in official statistics.

The evidence from this subsection provides the foundation for deeper analysis in subsequent sections. Patterns of abuse, risk factors, and reporting dynamics must be examined to understand not only the scale but also the underlying drivers and barriers. This disconnect between incidence and documentation is at the heart of Mathare's CSA crisis.

> "Everyone here knows a case of a child who was touched, coerced, or abused — but very few will ever reach the police."
> ~ Local Leader, Hospital Ward

Measurement note: *The metrics above derive from community awareness and knowledge of incidents, not case registers. Bases reflect valid respondents per item (e.g., heard of CSA: n=291/350; aware of local incidents: n≈300/350). We report valid n in each figure/table and treat non-response explicitly.*

## 4.2 Patterns of Abuse

The patterns of child sexual assault (CSA) in Mathare reflect both the forms of abuse experienced and the contexts in which they occur. Evidence from the community survey and stakeholder interviews reveals consistent trends: CSA often takes place in private or poorly monitored environments, at vulnerable times of day, and includes a spectrum of abuse ranging from physical assault to exploitation and online harassment.

### 4.21 Forms of Abuse

Community survey findings highlight that contact CSA (rape/defilement, molestation) was the most recognized and reported form, cited by 255 respondents. Emotional CSA, such as coercion, manipulation, or threats within sexual abuse contexts, was also widely acknowledged (n=84). Respondents further identified sexual exploitation, including trafficking and transactional sex (n=57), online sexual exploitation and grooming (n=17), and other forms such as coercion disguised as "boyfriend" relationships or sodomy (n=4). These results show that residents not only recognize severe contact violations but are also aware of less visible or emerging threats.

**Qualitative interviews deepen this picture. Local leaders described frequent cases of coercion disguised as relationships, with adolescents manipulated through so-called "boyfriend" dynamics. Religious leaders emphasized that "girls are the main victims," while focus groups noted incidents of molestation, sodomy, and transactional abuse linked to poverty. NGO representatives added that institutional neglect, such as failures in schools or child care facilities, created additional risks. Taken together, findings suggest that CSA in Mathare spans multiple overlapping forms — physical/contact, emotional/psychological, sexual exploitation, and online — reflecting both traditional and emerging patterns of abuse.**

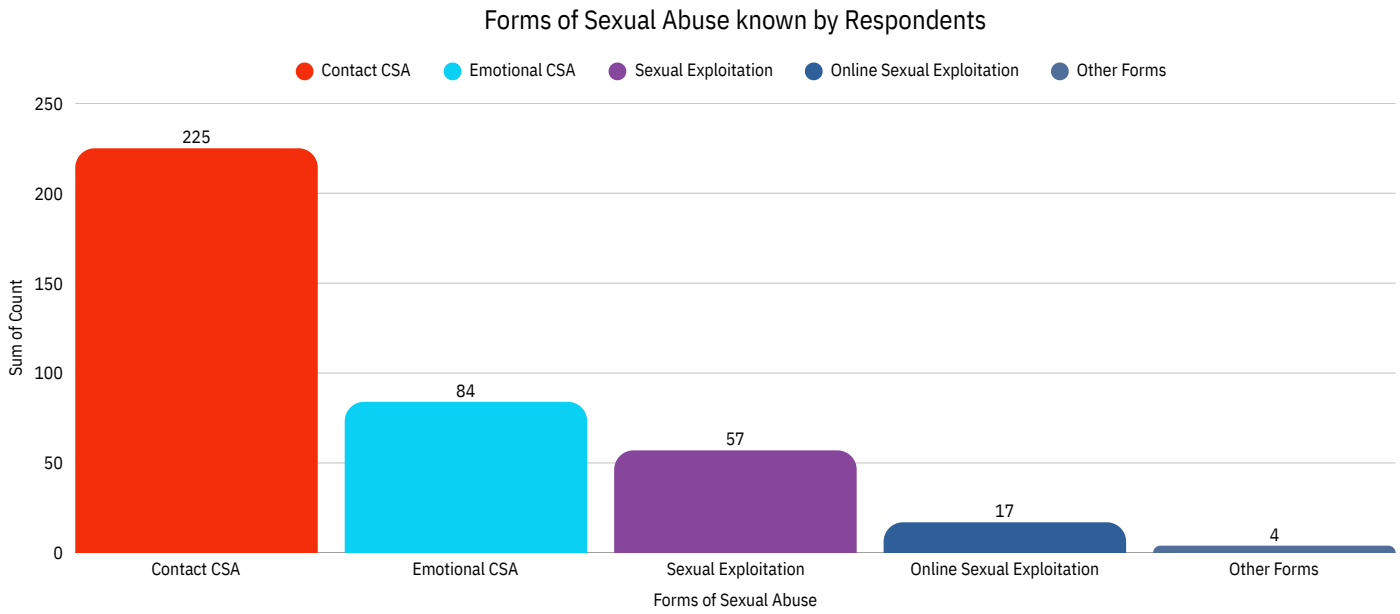



*Figure 10: Forms of Sexual Abuse known by Respondents*

## 4.22 Locations of Abuse

**Where CSA occurs is equally telling. Local leaders most frequently cited community alleys (47%) and homes or compounds (28%) as high-risk locations, with others pointing to streets (19%) and schools (3%) (Local Leaders – Interviews). Focus group discussions echoed these concerns, noting that family members were the most common perpetrators and that homes, compounds, and other private settings accounted for nearly three-quarters of cases. Public spaces such as streets and alleys were also highlighted, particularly in areas with poor lighting and overcrowded housing.**

**Community health providers and NGOs confirmed these patterns, reporting that many cases brought to their attention involved incidents at home or in neighborhood spaces where children lacked supervision. These findings align with environmental risk factors documented in earlier sections: overcrowding, poor housing, and unsafe public areas create conditions where CSA can occur with limited detection or intervention.**

## 4.23 Timing of Abuse

**The timing of abuse further reflects children's vulnerabilities. Local leader interviews revealed that 42.9% of CSA incidents occur at night, often when children are unsupervised or when perpetrators exploit poorly lit environments. Another 28.6% were linked to school holidays, when children spend more time at home or in unsupervised social environments, while weekends were also mentioned as periods of exposure. NGOs echoed these concerns, noting "frequent occurrence" of CSA with no clear seasonal pattern, though some attributed slight reductions to community awareness initiatives.**

Focus groups added nuance, observing that evenings in public spaces and idle hours during school breaks created heightened risks. Such narratives, as the one below, underscore how routine community rhythms — evenings, holidays, and weekends — amplify exposure to abuse.

> **"When children are left without activities during holidays, that's when many cases happen — it's like predators are waiting."**
> **~ Focus Group Participant, Mathare 4A**

## 4.24 Community Responses to Disclosures

Patterns also emerge in how communities respond when abuse comes to light. Focus group participants reported that families often resort to informal resolution, including mediation between parents and perpetrators, rather than reporting through formal systems. Religious leaders similarly noted that many cases are "kept in the home" due to fear of stigma, while NGOs documented frequent instances where survivors were redirected to counseling or informal justice mechanisms instead of pursuing legal processes. This reliance on informal, non-legal responses contributes to persistent underreporting, which will be explored further in Section 4.4.

*Patterns of CSA in Mathare reveal a complex interplay of* ***forms, contexts, and timing.*** *Abuse most often takes the form of physical or emotional harm, occurs in homes or community alleys, and peaks at night or during school holidays. Community responses, meanwhile, favor informal mediation over formal justice pathways. These trends illustrate how* ***structural vulnerabilities — overcrowding, poor supervision, unsafe environments, and cultural stigma — shape the everyday risks children face.*** *Understanding these patterns is essential for designing targeted interventions, whether through safer environments, strengthened reporting systems, or awareness campaigns that challenge normalization of abuse.*

## 4.3 Risk Factors and Perpetrators

The vulnerability of children in Mathare to sexual assault is shaped by a combination of individual, household, and community-level risk factors, alongside the profiles of common perpetrators. Evidence from interviews with local leaders, child protection officers, NGOs, and community health providers reveals recurring patterns of risk and identifies the groups most frequently implicated in abuse.

## 4.31 Risk Factors

Children in Mathare face risks rooted in poverty, family stress, and community conditions. Community health providers consistently emphasized five recurring factors: drug and alcohol abuse, economic exploitation, lack of parental care, overcrowded housing, and the prevalence of teenage mothers. Each of these elements reduces supervision and increases opportunities for abuse. For instance, overcrowding in single-room households creates environments where privacy is compromised, while substance abuse contributes to impaired judgment and heightened aggression among adults.

Interviews with Child Protection Officers added further nuance, citing that children with disabilities are disproportionately at risk, as they are often less able to resist or disclose abuse. They also noted that alcoholism within families creates volatile domestic environments where neglect and sexual abuse intersect. Religious leaders pointed to harmful cultural beliefs, such as the perception that "children are not believed when they speak out," which silences survivors and perpetuates vulnerability.

## 4.32 Perpetrator Profiles

**Across interviews with local leaders and child protection officers (n=19), authority figures were most frequently cited as perpetrators of CSA, followed by neighbors and family members. For example, police officers or chiefs were mentioned by 9 of 19 respondents, neighbors by 6 of 19, and family members by 3 of 19 (multi-response allowed). Focus groups added that family members accounted for the majority of perpetrators (7 of 12 group mentions), followed by neighbors/acquaintances (2 of 12) and strangers (1 of 12). NGO representatives underscored the role of institutional neglect, noting that schools and community organizations sometimes failed to prevent or even facilitated abuse.**

**This convergence of findings paints a troubling picture: children are most at risk from those entrusted with their safety — family members, neighbors, and authority figures. Such dynamics exacerbate underreporting, as survivors and families struggle with disclosure due to fear of retaliation, stigma, or betrayal of trust.**

> **"The ones hurting children are not outsiders; they are the people we know and live with."**
> **~ Focus Group Participant, Hospital Ward**

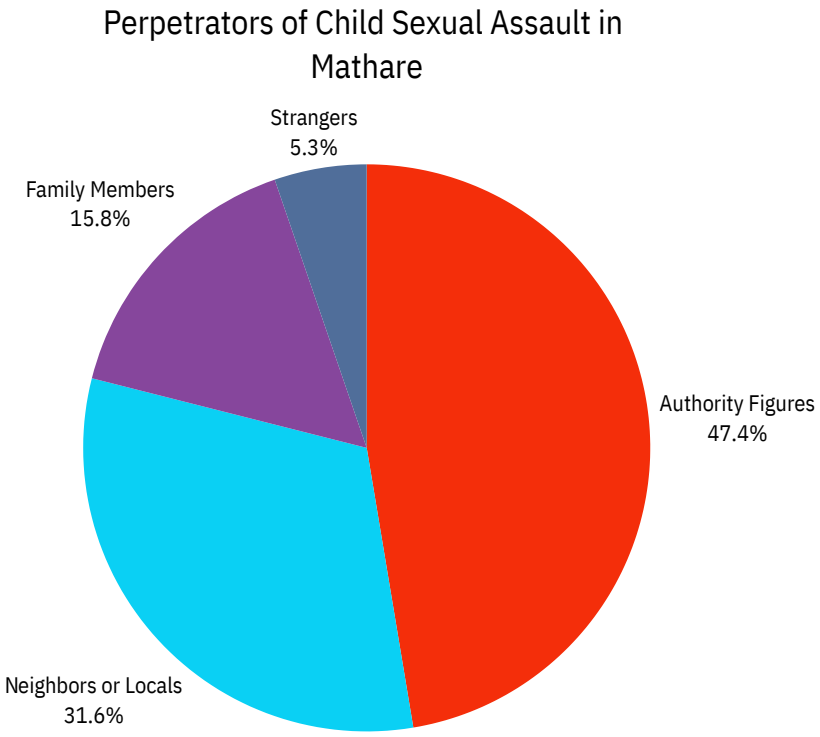



*Figure 11: Perpetrators of Child Sexual Assault in Mathare as per Respondents*

***Risk factors such as poverty, overcrowding, parental neglect, substance abuse, and disability combine to heighten children's vulnerability in Mathare. Perpetrators are frequently familiar individuals within the child's immediate environment, including relatives, neighbors, and even authority figures. These overlapping risks and perpetrator profiles reinforce why CSA is both widespread and underreported: the danger comes from within the very structures meant to protect children.***

## 4.4 Community Awareness and Underreporting

**Despite widespread recognition of child sexual assault (CSA) as a serious problem in Mathare, patterns of disclosure and reporting remain deeply constrained by stigma, cultural beliefs, and systemic barriers. Community survey results and interviews across stakeholder groups illustrate how awareness and underreporting intersect to sustain silence around abuse.**

### 4.41 Awareness Levels

**Survey findings demonstrate relatively strong community knowledge about CSA as a concept. Most respondents reported being comfortable discussing the issue: 199 said they were very comfortable, while 37 were somewhat comfortable. Only 33 described themselves as uncomfortable, 13 very uncomfortable, and 9 neutral (Community Survey – Perceptions and Attitudes). This suggests that CSA is not a hidden or taboo subject in general discourse. However, comfort in speaking about CSA does not necessarily translate into willingness to formally report incidents, especially when families or authority figures are implicated.**

**Knowledge of reporting pathways is similarly uneven. While a majority (78.7%, n=225) indicated that they know how to report a case of CSA, almost one in five respondents admitted they did not (n=49), and 12 were unsure (Community Survey – Reporting and Underreporting). This gap reflects limited penetration of official reporting channels in community life and highlights the risk that awareness of CSA as a problem does not automatically equip families with the tools to seek justice or support.**

### 4.42 Stigma and Cultural Beliefs

**Stigma remains the most pervasive barrier to reporting CSA. In the community survey, 210 respondents confirmed that stigma is associated with reporting, compared to just 64 who disagreed and 26 who were unsure (Community Survey – Perceptions and Attitudes). Attitudinal data further illustrates this: when asked how the community responds to CSA disclosure, 183 respondents described silencing, shame, or victim-blaming responses. Only 33 highlighted supportive actions, while others described mixed reactions, cultural denial, or symbolic gestures with little practical support.**

**Cultural beliefs reinforce this climate of silence. A significant portion of the community (103 respondents) admitted that myths or cultural taboos discourage reporting, compared to 146 who rejected this and 21 who were unsure (Community Survey – Perceptions and Attitudes). Focus groups echoed this theme, noting that survivors are often blamed or pressured into silence by relatives seeking to avoid public shame. Religious leaders similarly reported that CSA is frequently viewed as a "family matter," with abuse by familiar persons minimized or hidden. Such norms not only discourage survivors from seeking help but also normalize abuse as part of everyday life.**

### 4.43 Barriers to Reporting

**When asked directly about reasons for underreporting, respondents identified multiple, overlapping obstacles. The most common were fear of retaliation (162 mentions) and stigma and shame (129 mentions). Other significant barriers included lack of trust in authorities (69 mentions), fear of legal processes (43), lack of awareness on how to report (33), and cultural taboos (25) (Community Survey – Reporting and Underreporting).**

> **"Families fear being judged more than they fear the crime itself."**
> **~ Community Survey Participant, Mabatini**

**Stakeholder interviews provided vivid illustrations of these barriers. Local leaders acknowledged that police refusal to take cases seriously (30.9%) and poor case follow-up (16.7%) often deter families from pursuing justice. Reports of bribery and corruption (11%) and direct threats from perpetrators were also common. Child Protection Officers added that cultural justifications, false "healing" practices, and community pressure frequently prevent cases from moving forward. NGOs underscored that stigma and shame were the single most consistent deterrents.**

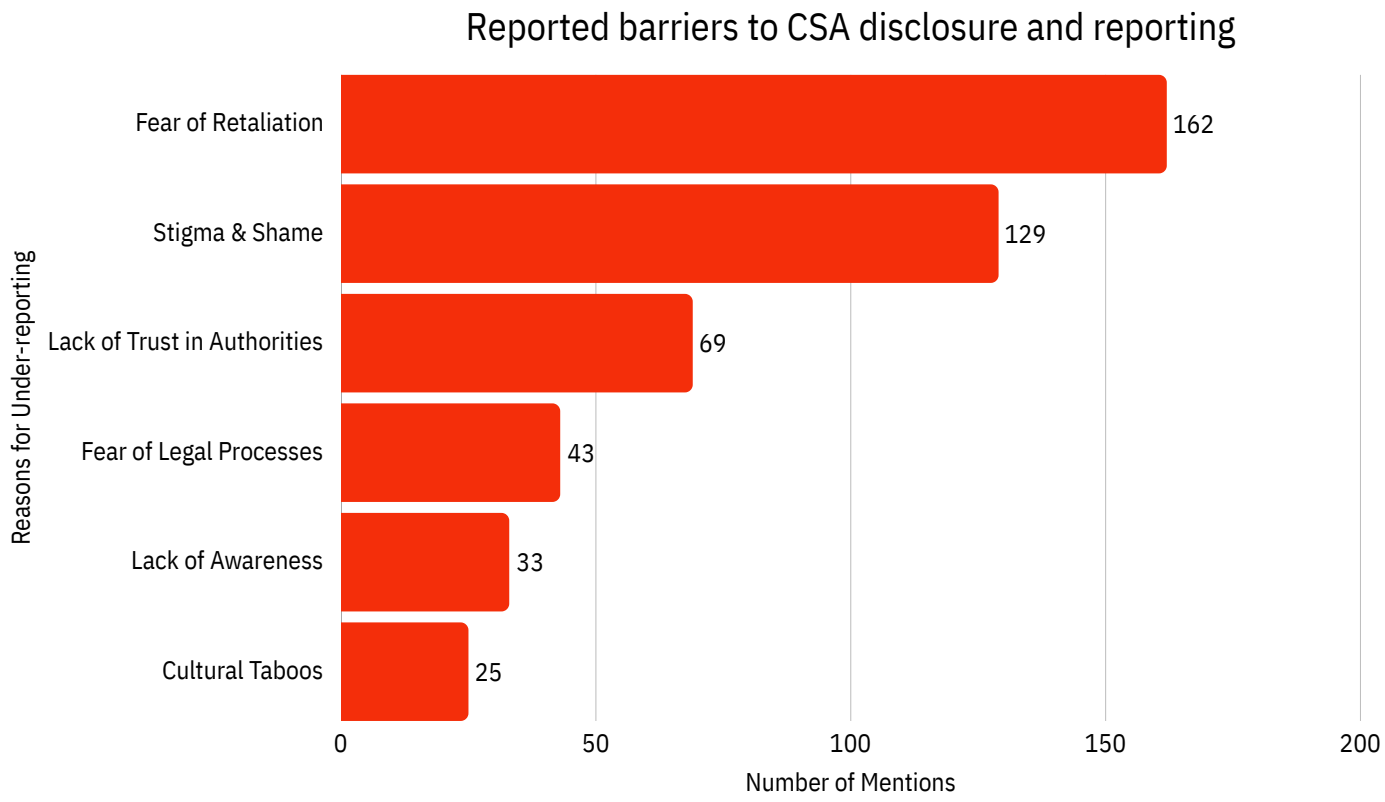



*Figure 12: Reported Barriers to Child Sexual Assault Disclosure and Reporting*

## 4.44 Consequences of Underreporting

**The cumulative effect of these dynamics is profound underreporting. In the community survey, 57% of respondents stated they or someone they knew had faced barriers when attempting to report CSA, compared to 42% who had not (Community Survey – Reporting and Underreporting). NGO representatives described a near-total absence of a "reporting culture," with many cases addressed through informal family or community negotiations. Religious leaders added that disclosures often emerge only during counseling or crisis intervention, rather than through proactive reporting mechanisms. The result is a hidden crisis: while the community broadly acknowledges CSA as a major problem, formal systems receive only a fraction of cases.**

***Community awareness of CSA in Mathare is high, yet underreporting remains the defining feature of the landscape. Stigma, myths, fear of retaliation, and distrust of authorities combine to suppress disclosure, while informal responses further obscure prevalence. This gap between awareness and action reinforces a cycle of silence, leaving survivors without adequate protection and perpetrators without accountability. Addressing these barriers will be essential in bridging the divide between recognition of CSA as a problem and meaningful community or legal responses.***

# 5. Findings: Existing Support Systems and Gaps

*Note: Unless otherwise stated, **bases** exclude missing responses; where respondents could choose multiple items, **counts may exceed n**. Quotes are **anonymized, translated in verbatim** and **coded by respondent type and sub-area** (e.g., "Local leader, Mabatini").*

## 5.1 Healthcare Services

**Healthcare provision for survivors of child sexual assault (CSA) in Mathare represents one of the most immediate and critical needs, yet it remains constrained by gaps in accessibility, capacity, and community awareness. Evidence from both the community survey and stakeholder interviews highlights a patchwork of services, largely concentrated in NGO-supported facilities, with limited government-led provision.**

### 5.11 Accessibility and Awareness

**Survey findings suggest that healthcare services are relatively visible but uneven in their accessibility. 159 respondents described services as easily accessible, while 73 considered them somewhat accessible. However, 41 respondents reported that healthcare was not accessible at all, and 11 were unsure (Community Survey – Access to Support Services). These figures indicate that while a majority can identify some pathway to care, a significant proportion of families continue to face structural barriers that may prevent timely medical intervention.**

**Awareness of organizational support is fairly high: 200 respondents reported knowing at least one organization that supports CSA survivors, compared to 91 who did not. Among the organizations most frequently cited were SHOFCO (34 mentions), MSF (15), Blue House (11), Dreams (6), and Ghetto Foundation (4) (Community Survey – Access to Support Services). The prominence of NGOs underscores their central role in healthcare provision, often filling gaps left by under-resourced public health infrastructure.**

### 5.12 Quality and Capacity Gaps

**Despite this level of awareness, interviews with local leaders revealed persistent weaknesses in the quality and consistency of healthcare response. Over half of respondents (56%) said survivors were primarily referred to NGOs, while 32% reported that there was no formal medical response, and 12% cited inaccessible clinics (Local Leaders – Interviews). This pattern demonstrates a reliance on external actors rather than local facilities, with serious implications for sustainability and equitable access.**

**Community health providers echoed these concerns, ranking healthcare services as one of the most critical but under-resourced areas of response. They pointed to delayed or inconsistent medical attention, long waiting times, and a near-total absence of specialized post-assault care. Gaps in mental health and counseling support were consistently mentioned, alongside limited referral systems that fail to link survivors to follow-up care.**

> **"We see children come for initial treatment, but there is no system to ensure they return or get further support. It ends at the first visit."**
> **~ Healthcare Provider, Mabatini**

## 5.13 Barriers to Access

**Structural and socio-economic barriers further hinder access to healthcare. Survey data identified cost of services (109 mentions) as the single most significant obstacle, followed by fear of discrimination (63), distance to facilities (53), lack of information (52), and complicated processes (32) (Community Survey – Access to Support Services). These findings align with interview data, where survivors were reported to face stigma from healthcare workers and bureaucratic hurdles in referral pathways.**

**In addition, facilities themselves are unevenly distributed across Mathare's sub-areas, meaning that families in more remote or densely populated zones may have limited access to clinics that can provide post-assault care. NGOs such as SHOFCO and MSF were cited as dependable providers, but their services remain limited by funding cycles and capacity constraints.**

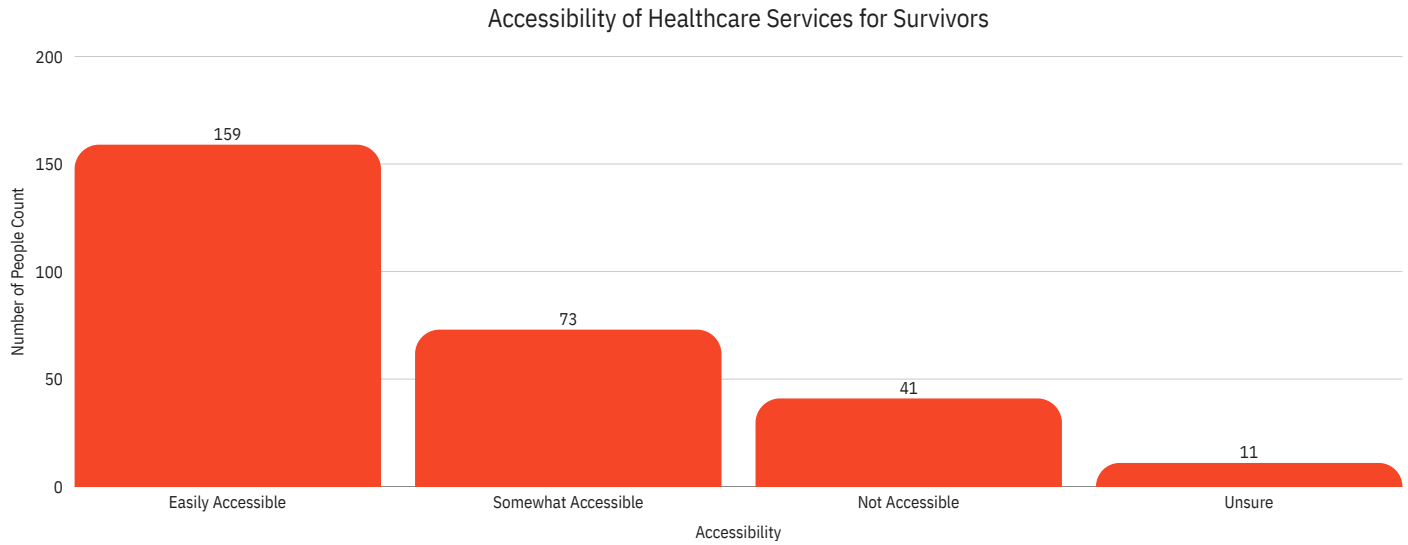



*Figure 13: Accessibility of Healthcare Services for Survivors*

***Healthcare services for CSA survivors in Mathare are characterized by visibility but limited effectiveness. While a majority of residents report knowing where to go in case of abuse, many also describe experiences of discrimination, cost barriers, and gaps in follow-up care. The reliance on NGOs such as SHOFCO and MSF provides essential lifelines but raises concerns about sustainability and equitable coverage across the settlement. These findings underscore the urgent need for strengthened public health infrastructure, improved referral systems, and expansion of trauma-specific medical services to ensure survivors receive comprehensive and sustained care.***

## 5.2 Counseling and Psychological Support

**Counseling and psychological support services are essential for survivors of child sexual assault (CSA), yet they remain among the most underdeveloped and inaccessible components of the response system in Mathare. Evidence from community survey results and stakeholder interviews indicates both an awareness of such services and a recognition of significant gaps in their quality, reach, and sustainability.**

## 5.21 Availability and Awareness

Survey data reflects a mixed picture of availability. 138 respondents stated they were aware of psychological services for survivors and their families, compared to 100 who reported no awareness and 42 who were unsure (Community Survey – Access to Support Services). This suggests that while services exist and are recognized by many, nearly half of the community either lacks awareness or remains uncertain about how to access such support.

The perception of service quality was similarly divided. 73 respondents rated psychological support as being of "acceptable quality," 62 described it as "high quality," but 70 were unsure, and 30 assessed it as "low quality" (Community Survey – Access to Support Services). These variations in perception point to uneven experiences across different providers, with some families benefiting from high-quality NGO programs while others encounter weak or absent support.

## 5.22 Gaps in Provision

Local leaders were especially critical of the availability of psychosocial services. Over 84% reported the complete absence of psychosocial support within their areas, noting that only NGOs provided limited options (Local Leaders – Interviews). This suggests that formal, community-based counseling infrastructure is largely non-existent, leaving a vacuum in the immediate support system for survivors.

NGO interviews confirmed these weaknesses, identifying multiple barriers to effective counseling:

- Victim-blaming (36.8% of mentions) that discourages survivors from seeking support.
- Few trained counselors (31.6%), leading to long waiting times or limited session availability.
- Stigma against counseling (31.6%), with many families perceiving psychological services as unnecessary or inappropriate.

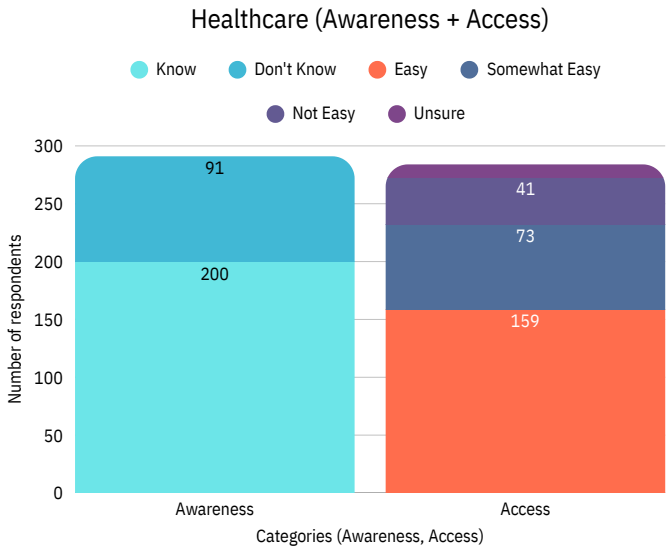
Community health providers highlighted the lack of long-term or specialized trauma services, with most survivors only receiving short-term counseling, if any. They emphasized the absence of child-specific approaches and noted that referral systems between clinics and psychosocial services were inconsistent or ineffective.

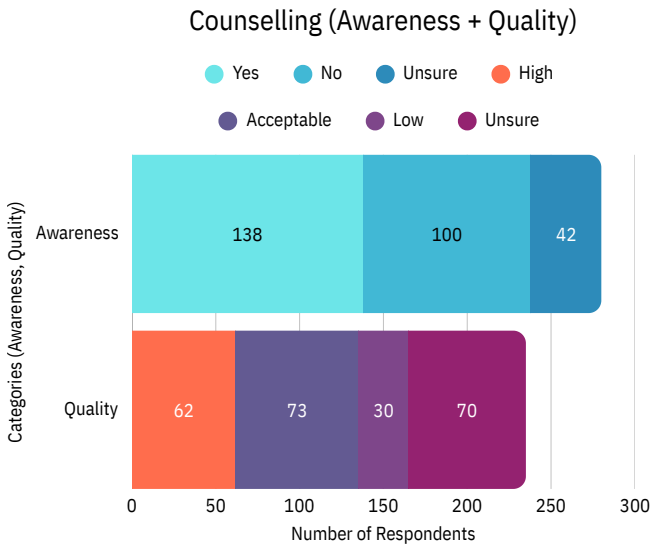
> "There are cases where a child goes through trauma counseling only once, and that is the end — there is no follow-up, no continuous therapy."
> ~ Healthcare Provider

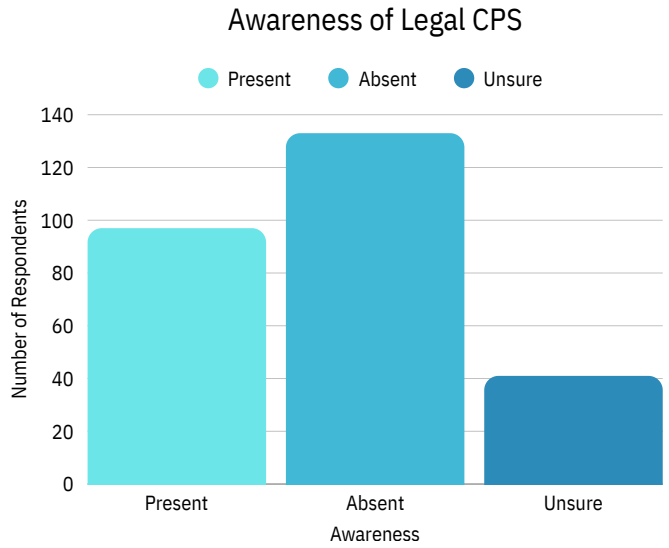
## 5.23 Barriers to Access

Barriers to psychological services mirror those in healthcare more broadly, with cost, stigma, and lack of information emerging as dominant themes. Families often cannot afford repeated counseling sessions, particularly when services are offered by private providers rather than NGOs. Stigma is a powerful deterrent: some families associate counseling with "madness" or weakness, while others fear that seeking therapy will publicly expose the abuse, inviting community shame.

Additionally, limited awareness campaigns mean that many community members do not view counseling as an integral part of recovery. While survey data shows that a majority know such services exist, the lack of visible and accessible entry points leaves many survivors unsupported.



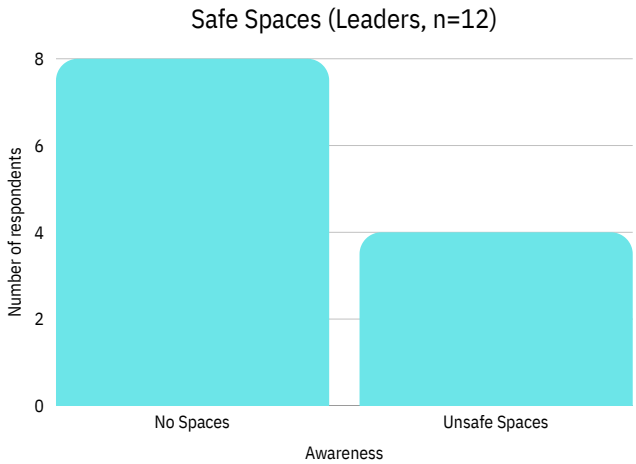




*Figure 14: Community awareness, perceived access, and perceived quality of services (by service type). Healthcare shows relatively higher awareness and moderate access; counseling shows mixed awareness and quality; legal/CPS and safe spaces reflect limited awareness and major gaps.*

***Counseling and psychological support in Mathare remain critically inadequate relative to the need. While some services exist through NGOs and are recognized by segments of the community, coverage is inconsistent, stigma is widespread, and specialized child-focused trauma services are lacking. Survivors and families face significant barriers, including cost, limited availability of trained counselors, and cultural perceptions that discourage therapy. The absence of systematic, long-term psychological care means that even when survivors receive initial support, their healing journeys are often cut short. Addressing these gaps will require investment in sustainable, community-based psychosocial services, stigma reduction, and capacity-building for trained counselors.***

## 5.3 Legal Aid and Child Protection Services

**The effectiveness of legal aid and child protection services in Mathare remains limited, characterized by low awareness, inconsistent availability, and deep community mistrust of formal systems. Both survey data and interviews with leaders, religious figures, NGOs, and child protection officers illustrate a legal landscape where survivors face multiple structural and cultural barriers that prevent them from obtaining justice.**

### 5.31 Awareness and Availability

**Survey findings show significant uncertainty about the existence of legal support mechanisms for CSA survivors. 133 respondents reported that no legal support services were available in Mathare, while 97 acknowledged their existence, and 41 were unsure (Community Survey – Access to Support Services). This suggests that while legal services exist, they are not visible to much of the community, or are perceived as inaccessible.**

**Even when services are technically available, their accessibility is undermined by procedural and economic obstacles. Survey participants identified cost of services (109 mentions), fear of discrimination (63), distance to facilities (53), lack of information (52), and complicated processes (32) as key barriers (Community Survey – Access to Support Services). The weight placed on affordability and information gaps demonstrates how legal aid, even when present, often remains out of reach for the most vulnerable families.**

### 5.32 Challenges in the Justice System

**Interviews with local leaders highlighted widespread failures in police and justice responses. They reported instances where police refused to record cases (33.3%), evidence was lost or tampered with (14.3%), or investigations were delayed indefinitely (4.8%) (Local Leaders – Interviews). Child Protection Officers and religious leaders reinforced these concerns, pointing to police inaction, bribery, and a lack of protective laws or enforcement mechanisms. Religious leaders noted that more than one-third of cases were undermined by corruption and the absence of child-specific protections (Religious Leaders – Interviews).**

**NGO representatives provided further detail, citing bureaucratic hurdles (46%), hidden costs (23%), and outright police inaction (23%) as common barriers. Over half (53.8%) described the legal system as failing survivors through victim-blaming, poor evidence handling, or procedural neglect (NGOs – Interviews).**

> **"Even when a child reports, the system collapses — evidence is lost, families are intimidated, and perpetrators walk free."**
> **~NGO Respondent**

***Referral flow (reported): Disclosure → Clinic/NGO (named providers) → Police/CPS (often blocked by refusal/fees/delay) → Counseling (limited capacity) → Follow-up (rare/inconsistent).***

## 5.33 Lack of Child-Friendly Mechanisms

Another recurring theme was the absence of child-friendly procedures. Religious leaders observed that children were often retraumatized during investigations because there were no specialized desks or trained staff to handle their cases sensitively. Child Protection Officers emphasized that survivors lacked protective measures during reintegration, with children often returning to unsafe homes or dropping out of school after cases collapsed. These structural weaknesses compound community mistrust, reinforcing informal dispute resolution over formal legal channels.

*Legal aid and child protection services in Mathare are largely inaccessible, mistrusted, and ineffective. Community perceptions of nonexistence (133 respondents) or uncertainty (41 respondents) reflect not only gaps in communication but also genuine systemic failures. Survivors who attempt to navigate formal pathways encounter financial barriers, corruption, procedural neglect, and stigmatizing practices. The absence of child-friendly mechanisms further undermines trust and perpetuates underreporting. Strengthening the justice response will require investment in affordable legal aid, training for police and judicial staff, and establishment of child-sensitive reporting and protection systems. Without these reforms, the majority of survivors will remain outside formal protection structures, reinforcing cycles of silence and impunity.*

## 5.4 Safe Spaces and Temporary Housing

Safe spaces and temporary housing are critical components of protection for children at risk of or recovering from sexual assault. In Mathare, however, the availability of such facilities is extremely limited, with community members, leaders, and child protection officers consistently highlighting the absence of reliable shelters and reintegration support.

### 5.41 Availability and Capacity

Survey findings show that when asked about community responses to CSA, only 35 respondents mentioned safe spaces or emergency shelters as part of the support system (Community Survey – Community Response). This small number reflects both the scarcity of facilities and the limited awareness of their role in survivor protection. By contrast, far more respondents mentioned symbolic or moral support, underscoring the heavy reliance on informal rather than institutional safety nets.

Interviews with local leaders confirmed this picture. Two-thirds (66.7%) reported that no shelters or rescue homes were available in their communities, while the remainder noted that the few spaces that existed were unsafe or poorly maintained (Local Leaders – Interviews). The consequence is that children often remain in dangerous environments, even after disclosure, because families have nowhere else to take them.

Child Protection Officers added further depth, describing how the absence of safe houses created long-term vulnerabilities. They reported that 44.4% of survivors had no safe houses to access, while 33.3% of children dropped out of school after CSA due to lack of reintegration support. Another 22% highlighted the absence of court-ordered protection or reintegration mechanisms.

> **"A child can disclose, but if there is no safe place for them, they are sent back home to the same danger."**
> **~Child Protection Officer**

## 5.42 Barriers and Community Perceptions

**NGO interviews reinforced these findings, noting that while some organizations such as SHOFCO provide safe spaces, their capacity is small and subject to funding limitations. Families reported that eligibility restrictions often excluded certain survivors, particularly older adolescents or those without parental guardianship. Others expressed mistrust of shelters, fearing stigma or retaliation from the community if it became known that a child had been placed in one.**

**Community survey data also suggests that safe spaces are not widely trusted or utilized. Even when survivors access temporary shelter, barriers such as cost, distance, and complicated procedures frequently deter families. For many, the absence of clear referral systems leaves them unaware of how to access such support in the first place.**

## 5.43 Reintegration Challenges

**A further gap lies in reintegration. Survivors who leave shelters often face challenges returning to school, resuming social life, or reintegrating with families. Without psychosocial support and ongoing monitoring, reintegration can expose children to retraumatization or renewed abuse. Child Protection Officers observed that schools are rarely prepared to receive returning survivors, contributing to long-term exclusion from education.**

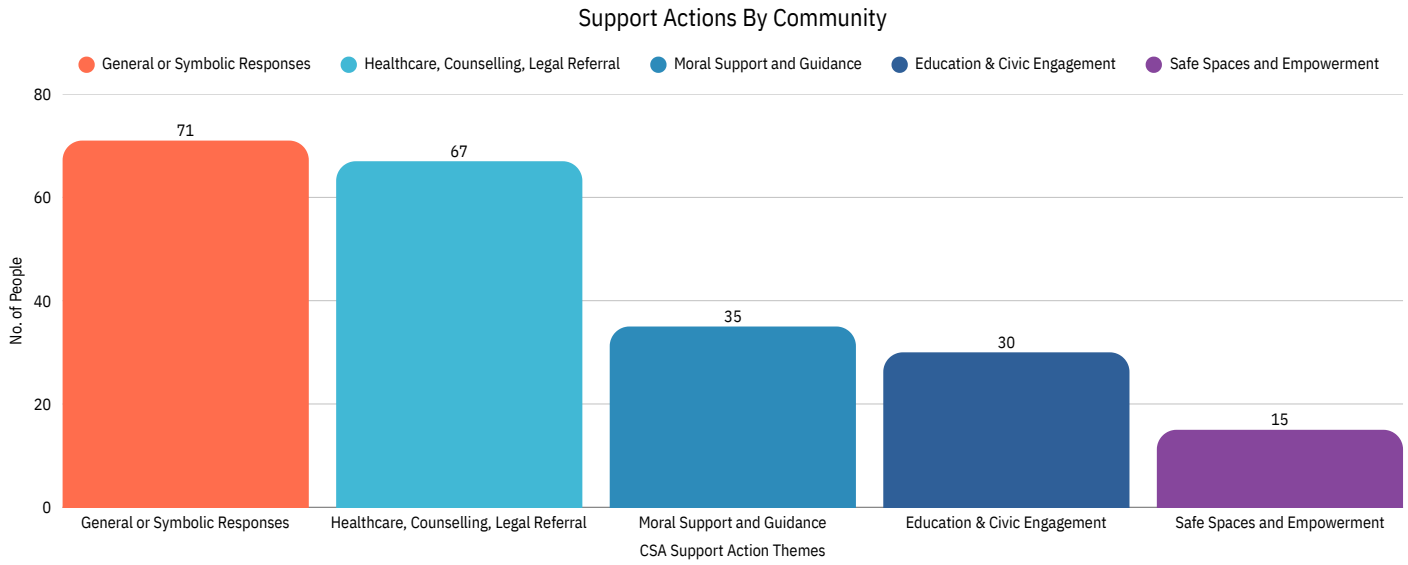



*Figure 15: How the Community Supports survivors*

***Safe spaces and temporary housing in Mathare are largely absent, underutilized, or distrusted, leaving survivors without adequate protection following disclosure. Families frequently rely on informal solutions, returning children to unsafe homes due to lack of alternatives. Existing NGO-run facilities provide vital support but are limited in scale and sustainability. Without substantial investment in safe housing, reintegration support, and community awareness, survivors remain exposed to ongoing harm even after cases are identified. Addressing these gaps will require expansion of shelters, clear referral systems, and stigma reduction efforts to ensure that safe spaces truly function as protective and trusted havens for children.***

# 6. Findings: Community Attitudes, Educational Needs, and Partnerships

*Note: Unless otherwise stated, **bases** exclude missing responses; where respondents could choose multiple items, **counts may exceed n**. Quotes are **anonymized, translated in verbatim** and **coded by respondent type and sub-area** (e.g., "Local leader, Mabatini").*

## 6.1 Attitudes and Beliefs toward CSA and Survivors

**Community attitudes and cultural beliefs in Mathare play a decisive role in shaping how child sexual assault (CSA) is perceived, discussed, and addressed. While survey findings indicate that residents are increasingly open to acknowledging CSA as a social problem, stigma, victim-blaming, and cultural taboos remain powerful barriers that discourage reporting and limit survivor support.**

### 6.11 Openness and Awareness

**Survey results demonstrate a relatively high level of openness around discussing CSA. Nearly two-thirds of respondents (199) reported being very comfortable discussing CSA openly, with a further 37 describing themselves as somewhat comfortable. By contrast, only 46 respondents expressed discomfort, whether uncomfortable (33) or very uncomfortable (13), and 9 reported neutrality (Community Survey – Perceptions and Attitudes). These findings suggest that while CSA is no longer a completely hidden subject, openness does not necessarily translate into collective responsibility or action when cases occur.**

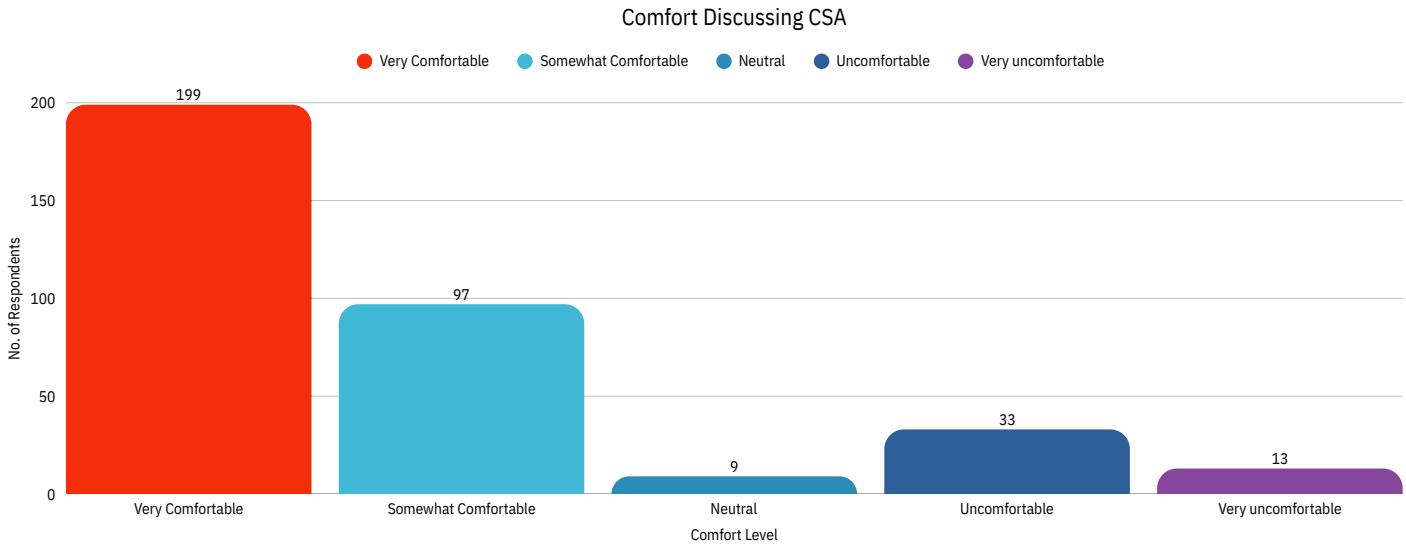



*Figure 16: Comfort Discussing Child Sexual Assault*

### 6.12 Stigma and Victim-Blaming

**Stigma remains one of the most entrenched attitudes shaping community responses. More than two-thirds of survey participants (210) affirmed that stigma is associated with reporting CSA, with only 64 disagreeing and 26 unsure (Community Survey – Perceptions and Attitudes). This stigma manifests in silence, shame, and victim-blaming, as confirmed by responses to how the community reacts when CSA is disclosed: 183 respondents reported that disclosure is typically met with silencing, shame, or blame placed on survivors, while only 33 described supportive responses, 31 identified mixed reactions, and a small minority cited denial or symbolic acknowledgement.**

**Interviews reinforce these findings. Focus groups described CSA as an issue "everyone knows about but no one wants to face," noting that survivors are often accused of "inviting abuse" through their behavior or clothing. Religious leaders similarly admitted that CSA is often seen as a family matter, best handled in private rather than through public reporting. These perspectives normalize abuse, protect perpetrators, and compound survivors' trauma.**

**"Some people even say it is a gift when an older man takes an interest in a young girl."**
**~Community Health Provider (CHP)**

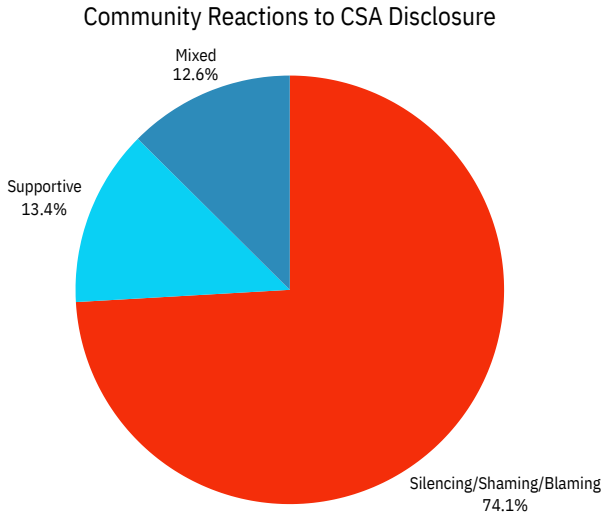



*Figure 17: Community Reactions to Child Sexual Assault Disclosure*

## 6.13 Cultural Beliefs and Myths

**Cultural myths further entrench silence. Survey findings show that 103 respondents acknowledged the existence of cultural beliefs or myths that discourage reporting, compared to 146 who denied such beliefs and 21 who were unsure (Community Survey – Perceptions and Attitudes). These myths include perceptions that CSA should not be spoken about, that discussing sexual violence brings shame on families, or that survivors exaggerate or fabricate experiences. Religious and community leaders acknowledged the persistence of these beliefs, noting that even when children disclose, families may refuse to pursue action to "avoid embarrassment" or protect reputations.**

## 6.14 Impact on Survivors

**The cumulative impact of these attitudes is a climate where survivors are discouraged from disclosure and often retraumatized by the community response. NGOs described frequent experiences of stigma when survivors attempted to access services, with one staff member noting: "Families fear being judged more than they fear the abuse itself." Religious leaders observed that survivors are pressured into silence through both cultural norms and community expectations of forgiveness. Such attitudes not only block access to justice but also deny survivors the empathy and support needed for recovery.**

**"Families fear being judged more than they fear the abuse itself."**
**~NGO Respondent**

*Attitudes and beliefs in Mathare reflect a community that is aware of CSA but constrained by stigma, myths, and entrenched victim-blaming. While many residents are comfortable discussing CSA in general terms, disclosure often results in silencing or blame rather than protection. Cultural norms that prioritize family reputation over child safety reinforce cycles of silence and impunity. Changing these attitudes will be essential for building an environment where survivors can safely disclose abuse, families can seek justice, and communities can collectively confront CSA as a public, rather than private, problem.*

*With 210/300+ residents linking stigma to reporting and only ~33/300 describing supportive reactions, outreach must explicitly shift social norms and protect disclosers; otherwise, even high "comfort discussing CSA" will not convert into case detection or service uptake.*

## 6.2 Educational and Awareness Needs

**A central theme emerging from the assessment is the community's recognition of the urgent need for education and awareness programs on child sexual assault (CSA). While Mathare residents broadly acknowledge CSA as a serious problem, significant gaps remain in understanding children's rights, reporting mechanisms, and survivor support. At the same time, there is strong community willingness to engage in educational initiatives, creating opportunities for targeted interventions.**

### 6.21 Willingness to Participate

**Survey results demonstrate overwhelming readiness among community members to engage in CSA prevention and awareness activities. 253 respondents stated they would participate in programs aimed at preventing CSA, compared to only 18 who said no and 13 who were unsure (Community Survey – Engagement and Participation). This near-universal willingness reflects both the urgency of the issue and a growing openness to community-driven solutions.**

### 6.22 Priority Topics for Education

**When asked about the most important topics for awareness and training, respondents highlighted a broad range of needs such as Children's rights (165 mentions), How to talk to children about sexual abuse (134), Reporting mechanisms (122), Recognizing signs of abuse (118), Legal rights and protections (104), Support services available (94) (Community Survey – Engagement and Participation).**

**These priorities suggest that while the community recognizes CSA as a problem, there is still uncertainty about how to identify abuse, how to communicate with children effectively, and how to navigate reporting and support systems. The prominence of children's rights and legal protections also reflects gaps in civic education, particularly around Kenya's child protection laws.**

**Interviews corroborate these findings. Teachers reported that students often lack even basic knowledge of CSA definitions and rights, while educators themselves expressed the need for training on prevention, early detection, and referral pathways. Religious leaders admitted that churches and mosques rarely integrate CSA awareness into sermons or programs, and several requested evidence-based training to help leaders address the issue responsibly. Community health providers similarly noted low awareness and widespread myths, calling for continuous, structured sensitization campaigns.**

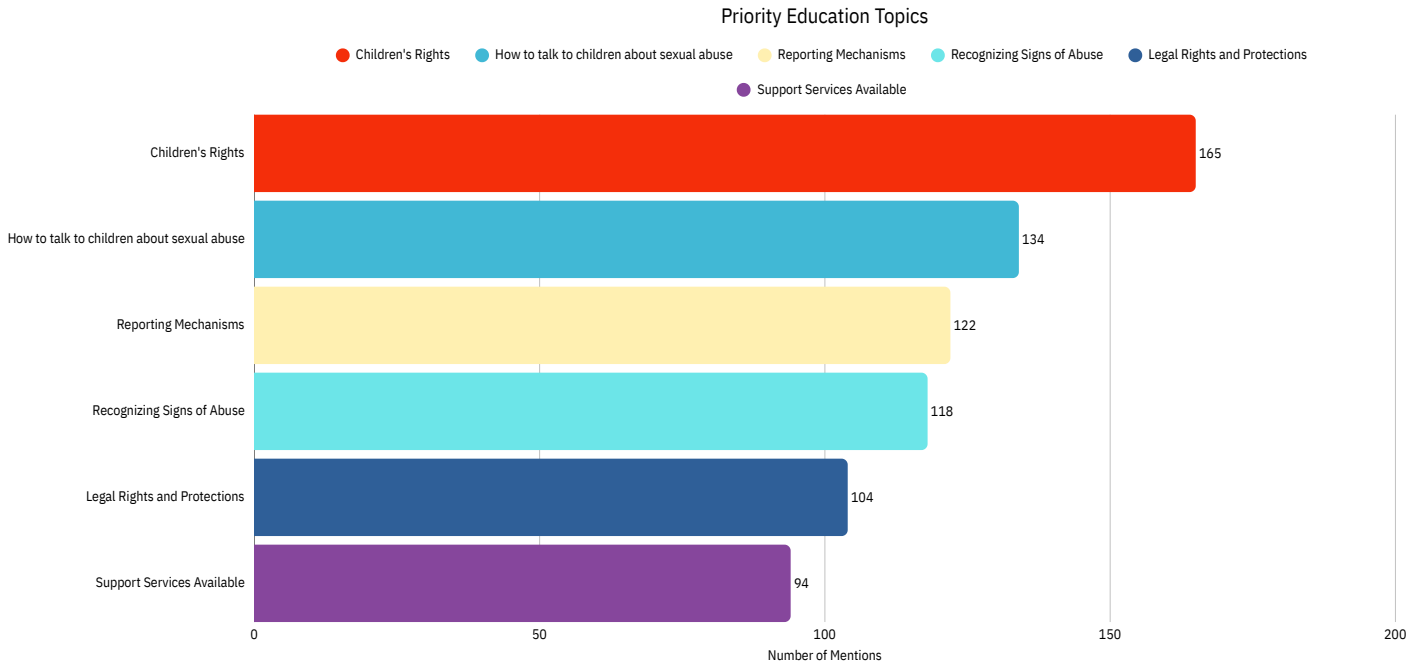



*Figure 18: Priority Education Topics as per the Respondents*

## 6.23 Knowledge Gaps

**Survey data further highlighted deficits in legal and policy awareness. Only 141 respondents described themselves as very aware of children's legal rights, while 111 were somewhat aware, and 38 admitted to only general or partial awareness. Notably, 22 respondents said they were not very aware, and 16 reported no awareness at all (Community Survey – Awareness and Knowledge). Another 210 respondents explicitly reported knowledge gaps or said they "don't know" about child rights and legal protections (Community Survey – Perceptions and Attitudes). These gaps demonstrate the disconnect between recognition of CSA as a problem and the community's ability to act on knowledge of rights and resources.**

## 6.24 Preferred Outreach Methods

**Survey participants expressed clear preferences for how awareness and education should be delivered. The most popular methods included Community meetings (172 mentions), Social media (73), SMS/text messages (69), Printed materials such as flyers/posters (50), Workshops (43), Radio broadcasts (36) (Community Survey – Engagement and Participation).**

**These results emphasize the need for multi-channel strategies that combine traditional, face-to-face approaches with digital tools. Community meetings were by far the most preferred, underlining Mathare's strong culture of collective dialogue and the importance of interpersonal trust in sensitive discussions. At the same time, reliance on social media and SMS highlights opportunities to reach younger populations and urban households with limited access to formal programs.**

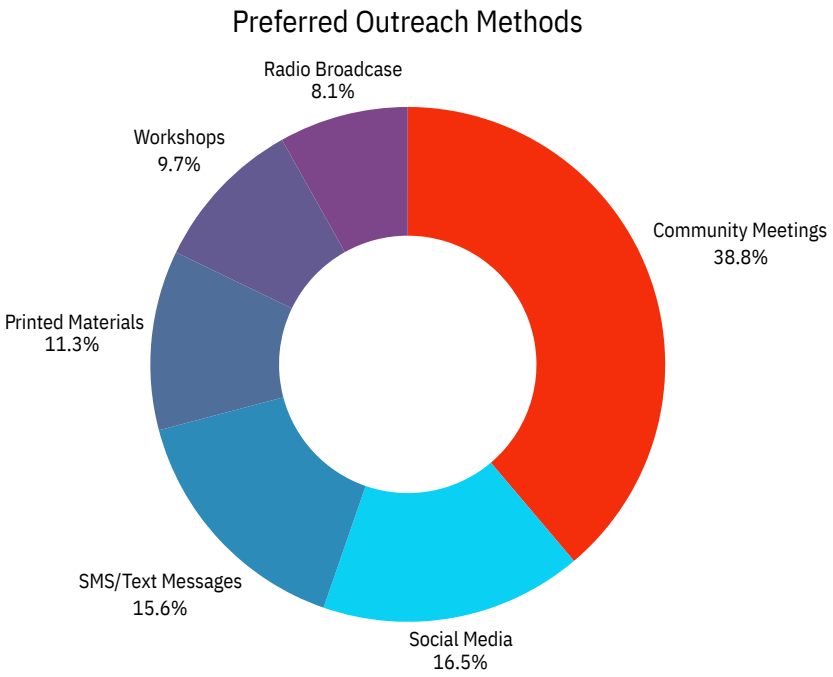



*Figure 19: Preferred Outreach Methods by the Respondents*

***Educational and awareness needs in Mathare are extensive, spanning children's rights, communication with children, reporting pathways, and signs of abuse. Survey results show overwhelming willingness to participate in prevention programs, while interviews with teachers, religious leaders, and health providers highlight critical gaps in both community and institutional knowledge. Preferred outreach strategies emphasize a balance between community meetings and digital tools, ensuring both inclusivity and adaptability. Addressing these needs will require not only content-rich sensitization campaigns but also sustained investment in equipping schools, religious institutions, and health providers with the knowledge and confidence to serve as trusted educators.***

## 6.3 Trusted Figures and Influencers

**Trusted community figures play a decisive role in shaping perceptions of child sexual assault (CSA), influencing whether cases are reported, survivors are supported, and prevention programs gain traction. In Mathare, survey data and stakeholder interviews reveal a landscape where elders, health workers, and local leaders hold significant authority, but where gaps in training, consistency, and trust limit their effectiveness in protecting children.**

### 6.31 Influential Community Figures

**The community survey identified elders (153 mentions) as the most influential figures on child protection matters, followed by community health providers (126), local government officials (87), religious leaders (62), police (60), teachers (52), and youth leaders (47) (Community Survey – Influence of Community Leaders). This hierarchy reflects both cultural traditions and the practical realities of service provision in Mathare. Elders remain the first point of authority in many disputes, while CHPs are viewed as accessible frontline responders for health and protection.**

**Focus group discussions reinforced these patterns, noting that while elders and chiefs carry weight in resolving disputes, their approaches are often informal and may prioritize family harmony over child safety. Religious leaders were described as highly visible but inconsistent in their engagement on CSA, with some congregations addressing it directly and others avoiding the topic altogether.**

## 6.32 Leadership and Advocacy

**Survey data suggests that leaders are increasingly engaging with CSA issues: 202 respondents said their leaders openly discuss CSA, while 41 said they do not, 29 said sometimes, and 12 were unsure (Community Survey – Influence of Community Leaders). Community members also expressed readiness to support leaders in child protection advocacy, with 252 respondents affirming their support, 22 saying maybe, and only 5 saying no. This reflects both a demand for leadership and a willingness to collaborate when trusted figures take a stand.**

**Interviews, however, reveal gaps in capacity and consistency. Local leaders admitted that many chiefs and community representatives lack training in handling CSA cases, with some delegating responsibilities to NGOs or health workers. Religious leaders expressed mixed readiness: some reported being "willing to include CSA in sermons," while others resisted, citing limited knowledge or fear of resistance from congregants. NGOs described frequent competition and lack of coordination among leaders, undermining collective advocacy.**

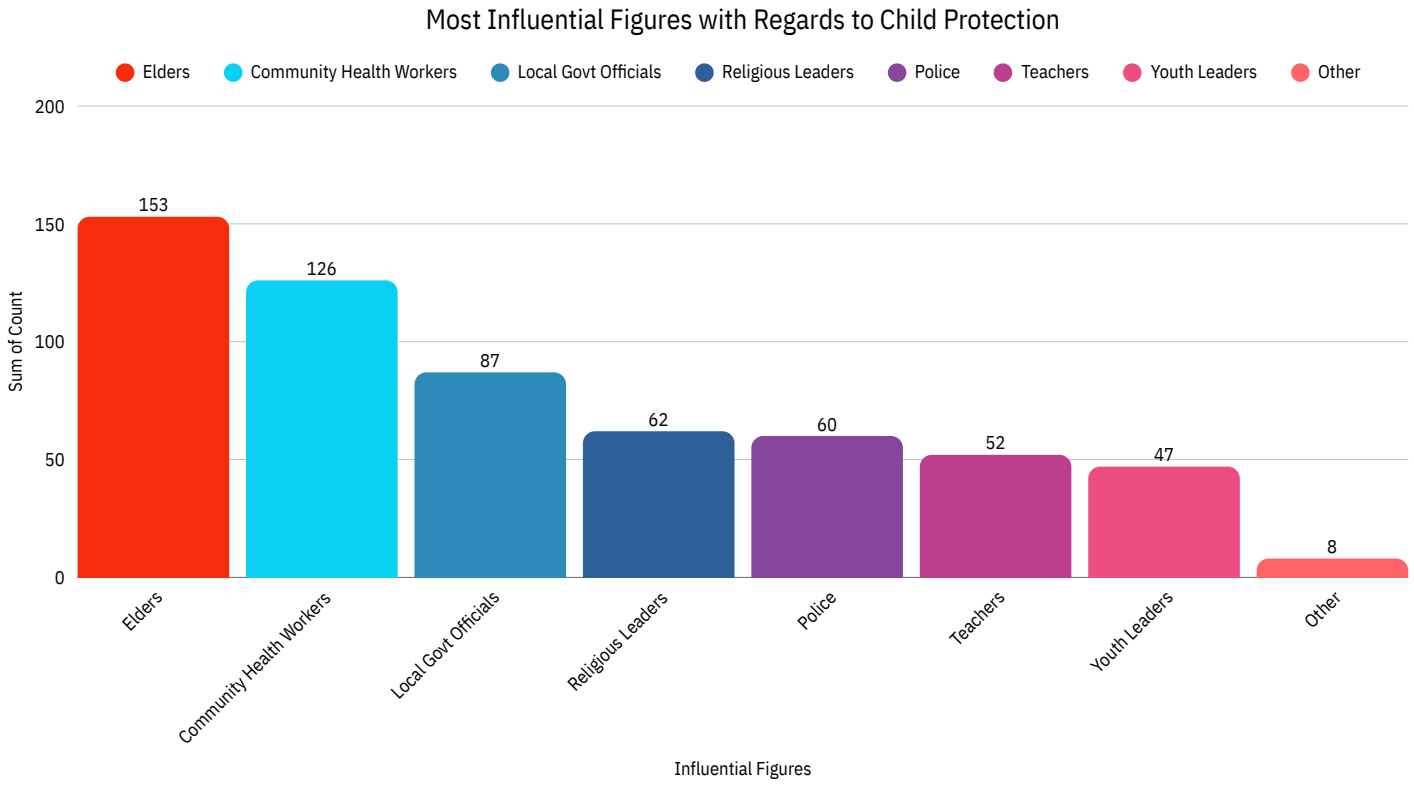



*Figure 20: Most Influential Figures with regards to Child Protection*

## 6.33 Trust and Limitations

**Trust in leaders is not uniform. Focus groups and NGO respondents noted that police and some local officials are mistrusted due to histories of corruption, bribery, and inaction on CSA cases. Survivors and families often hesitate to approach them, preferring to rely on elders, CHPs, or NGOs. Similarly, while religious leaders are influential, their credibility is undermined when they frame CSA as a private or spiritual matter rather than a violation requiring legal and protective responses.**

**Community health providers were consistently highlighted as trusted figures because of their accessibility and role as first responders, though they too noted limited capacity to follow up cases beyond immediate care. Teachers were recognized as potential influencers, but many admitted discomfort in addressing CSA openly, citing lack of training.**

*Trusted figures in Mathare include* ***elders, community health providers, local officials, religious leaders, police, and teachers,*** *with varying degrees of influence and credibility. While the community overwhelmingly supports leaders who take visible action on CSA, persistent challenges include* ***lack of training, inconsistent engagement, and mistrust of certain institutions.*** *Building effective advocacy will require strengthening the capacity of these figures, ensuring coordinated action, and addressing the credibility gaps that undermine trust. Without equipping and aligning these influencers, community-level prevention and reporting efforts will remain fragmented and inconsistent.*

## 6.4 Partnerships and Collaboration

**Effective responses to child sexual assault (CSA) in Mathare require strong collaboration between community members, local institutions, NGOs, and government agencies. Survey results and interviews highlight both the willingness of the community to work with organizations and the significant barriers to coordination among actors. The picture that emerges is one of high trust and readiness for collaboration on the part of residents, but limited effectiveness due to competition, mistrust, and resource constraints among organizations.**

### 6.41 Community Trust in Organizations

**Survey data indicates generally positive perceptions of organizations working on child protection. 155 respondents described such organizations as very trustworthy, while 72 saw them as somewhat trustworthy. A smaller portion were unfamiliar with such groups (41) or said they were not trustworthy (11) (Community Survey – Perception of Outside Organizations). This trust was accompanied by openness to collaboration: 230 respondents said they would work with organizations to improve child safety, while only 20 rejected the idea and 32 were undecided.**

**When asked what advice they would give to outside organizations, responses included clear operational suggestions (22 mentions), education and sensitization emphasis (19), program expansion (8), and character or conduct advice (4). However, a majority (100 respondents) gave no concrete suggestions, reflecting either limited experience with such groups or hesitation to critique them (Community Survey – Perception of Outside Organizations).**

### 6.42 Partnership Experiences and Challenges

**Interviews revealed more complex dynamics. NGO representatives admitted that while collaboration is essential, it is often hindered by competition for resources, lack of coordination, and mistrust among organizations.**

**Community health providers emphasized the importance of linkages between health, police, and local groups, but reported that referral systems were fragmented and often ineffective. Child Protection Officers described networks with Community Protection Volunteers (CPVs) that provided critical support, but warned that fake NGOs exploiting donor resources had undermined trust and made communities more cautious about collaboration.**

**Religious leaders expressed willingness to partner with NGOs and community groups, particularly in hosting awareness campaigns or integrating CSA education into sermons. However, they also acknowledged resistance from some clergy and highlighted the absence of structured CSA programs within religious institutions.**

**"We are all working on the same issue, but everyone wants to show they are the lead. This divides effort instead of uniting it."**
**~NGO Respondent**

## 6.43 Opportunities for Strengthening Collaboration

**Despite these challenges, both surveys and interviews suggest strong potential for building sustainable partnerships. The willingness of over 90% of survey respondents to collaborate with organizations, combined with the influence of elders, CHPs, and religious leaders, provides a strong foundation for community-driven coalitions. Schools and teachers also represent untapped potential for partnership, especially in integrating CSA prevention into curricula and child protection clubs.**

**NGOs identified areas where collaboration could be strengthened, including joint referral systems, shared case management protocols, and coordinated awareness campaigns. Community respondents emphasized the importance of regular community meetings with multiple stakeholders present, ensuring transparency and reducing duplication.**

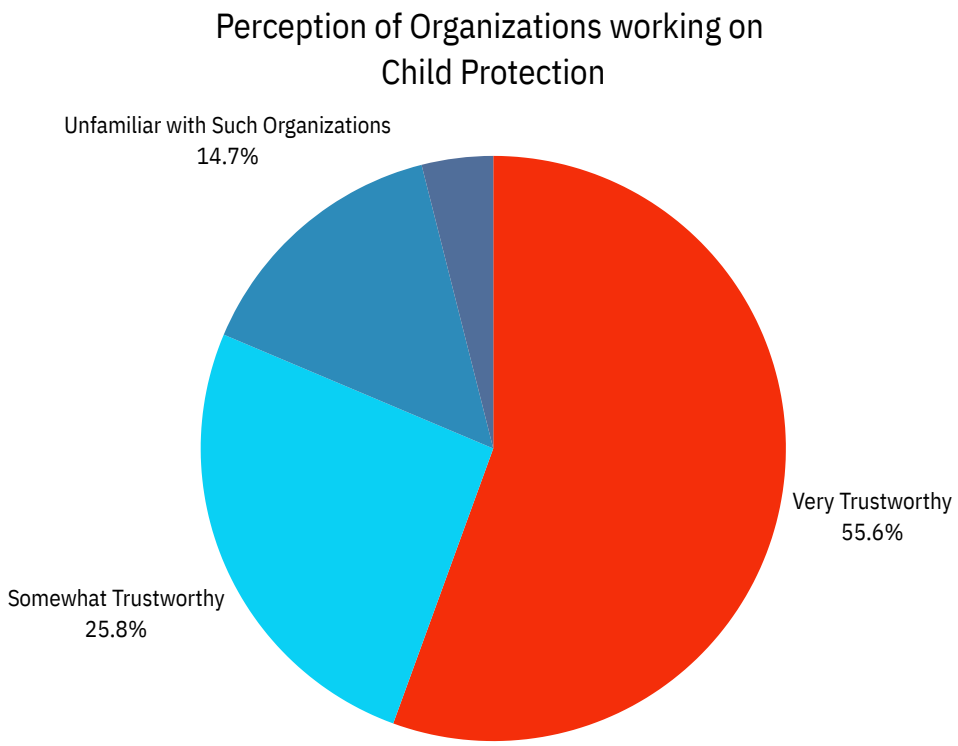



*Figure 21: Perception of Organizations Working on Child Protection*

***Partnerships and collaboration around CSA in Mathare are marked by high community trust and willingness, but weak organizational coordination. Residents view NGOs and community organizations as credible allies and are ready to support their initiatives, but inter-organizational competition, mistrust, and inconsistent referral systems undermine effectiveness. Strengthening collaboration will require formalized networks, joint training, and transparent referral systems that bring together NGOs, CHPs, local leaders, religious institutions, and schools. Harnessing this collective potential will be critical for building a coherent and sustainable response to CSA in Mathare.***

# 7. Needs & Gap Analysis

*Note: Unless stated, figures report % of valid responses; totals may exceed 100%. See Chapter 2 for sampling and instruments; This chapter synthesizes community findings into prioritized needs while simultaneously identifying the key gaps between existing conditions and the desired state of child safety.*

## 7.1 Prioritized Community & Environmental Needs

**Mathare's built environment and socio-economic stressors are not background conditions; they actively drive children's vulnerability to CSA. Overcrowding, dark alleys, unsafe shared facilities, flooding, and crime intersect with poverty and thin supervision to create high-risk times and places where abuse is most likely to occur. Community voices repeatedly link poor lighting, cramped housing, and unsafe routes with night-time exposure and inability to supervise children.**

**The 2019 baseline places ~206,564 residents in ~3 km² (≈69,000/km²), with youth-heavy demographics and fragile livelihoods (self-employed ~43%, unemployed ~30%). Environmental risk mentions cluster around crime (150), poor lighting (81), overcrowding (77), lack of secure housing (70), unsafe public spaces (48). Peak vulnerability is at night (n=224) and evening (n=124).**

**"The environment itself works against children — when housing is unsafe, clinics are far, and schools are overcrowded, protection becomes impossible." (CHP). "We all know the dangerous corners — but the children still pass there because they have no choice." (Local leader). These accounts match survey timing patterns (night/evening) and map to known dark corridors and shared compounds.**

**62.3% of households report inadequate street lighting; 42.9% of incidents occur at night. 51.8% experience flooding/unsafe drainage. 73% report lack of privacy in crowded rooms. Economically, 72% survive on <KES 10,000/month; 64% report leaving children unsupervised; 38% report alcohol/drug use as a neighborhood risk.**

## 7.11 Ranked needs (Urgency × Feasibility)

### 1. Lighting & safe movement corridors (evening/night risk reduction).

- ***Evidence:*** **Poor lighting among top risks (81 mentions); night-time peaks (n=224). Community accounts tie dark, narrow paths to predation.**
- ***Action:*** **Install/repair streetlights on mapped school-home corridors and alleyways; designate and steward "child-safe" paths (early-evening community stewards).**
- ***Why:*** **Fast, visible risk reduction in the highest-risk windows.**

### 2. Flood & drainage mitigation at known hotspots.

- ***Evidence:*** **51.8% experience flooding/unsafe drainage; residents cite inadequate infrastructure (45) and flooding (34) as child-safety vulnerabilities.**
- ***Action:*** **Clear and maintain drains; reinforce riparian embankments; raise/secure footbridges along school-home routes.**
- ***Why:*** **Seasonal, predictable hazard with cascading displacement and unsafe detours; feasible through County works.**

### 3. Child-safe sanitation & housing upgrades (hotspot compounds).

- ***Evidence:*** **Overcrowding (77), insecure housing (70), unsafe shared spaces (48); shared latrines without locks/lighting expose girls.**
- ***Action:*** **Pilot child-safe latrine blocks (locks/lighting/attendant hours), reinforce doors/windows and compound lighting in blocks prioritized by incident/risk reports.**

## 4. Community safety presence in crime hotspots (youth engagement + deterrence).

- ***Evidence:*** **Crime (150) and poor lighting (81) dominate mentions; risk concentrates at night/evening; unemployment and idleness described as enabling factors.**
- ***Action:*** **Non-vigilante "safe-route" stewards (early evening), youth micro-work patrols, hotspot watch coordinated with local officials.**
- ***Why:*** **Buys immediate safety while infrastructure rolls out; creates employment signal for youth.**

## 5. Socio-economic stabilization to lower exposure (households & youth).

- ***Evidence:*** **Economic fragility pervasive; caregivers absent late; substance use reported by 38% as a neighborhood risk.**
- ***Action:*** **After-school safe hubs (lighting, adult presence, homework help), cash-for-work drain/path clean-ups, link families to livelihoods/skills.**
- ***Why:*** **Essential for durability, but immediate risk falls faster with infrastructure and route safety.**

| Need | Urgency | Significance for Child Safety | Feasibility | Evidence |
|---|---|---|---|---|
| 1. Lighting & Safe Movement Corridors | Night risks peak; direct link to CSA exposure | Reduces attacks on routes home and alleyways | Technically simple (install/repair streetlights) | Ch. 6 Figures 6.1 & 6.2 (Environmental Risks & Time-of-Day) |
| 2. Flood & Drainage Mitigation at Hotspots | Seasonal hazard traps children and displaces families | Prevents unsafe detours & housing collapse | Feasible through County public works | Ch. 6 Env. Risks (Table 6.1); FGDs (local leaders) |
| 3. Child-Safe Sanitation & Housing Upgrades | Latrine risks especially for girls after dark | Direct impact on daily safety and dignity | Moderate engineering challenge; high density sites | Ch. 6 HH Survey (Sanitation); KIIs (NGOs & Youth Leaders) |
| 4. Community Safety Presence in Crime Hotspots | High crime & night-time assault zones | Visible deterrence for evening risks | Feasible via CHPs & youth programs | Ch. 6 FGDs & Leader Quotes on "Known Danger Spots" |
| 5. Socio-Economic Stabilization | Underlying driver of risk but longer-term effect | Reduces transactional sex & unsupervised hours | Feasible through partnerships with NGOs & County | Ch. 6 HH Income Data & KIIs (NGO Staff on Poverty Risks) |

*Table 4 — Prioritized Community & Environmental Needs (Urgency × Feasibility Matrix)*

***Immediate, visible infrastructure* — *lighting on school-home corridors, drainage at flood hotspots, and child-safe latrine blocks in crowded compounds* — *directly targets the highest-risk times and spaces (night/evening; dark alleys; unsafe shared facilities).* *Pairing this with a community safety presence and youth engagement provides near-term deterrence, while household/youth stabilization lowers exposure over time.***

## 7.2 Needs Related to Scope and Awareness

**Mathare residents widely recognize child sexual assault (CSA) as a serious problem and most say they can talk about it. Yet awareness does not reliably become disclosure or formal reporting. Stigma, fear, myths, and low trust in authorities keep cases invisible and survivors unsupported. The core need is to convert awareness into action—safe disclosure, reporting, and timely help-seeking—through targeted norm-shift, literacy on "how to report," and trusted, low-risk entry points.**

### What the data say (scope, awareness, and the action gap)

**Comfort discussing CSA is high, but fragile. 199 respondents reported being *very comfortable* and 37 *somewhat comfortable* discussing CSA; only 33 were *uncomfortable*, 13 *very uncomfortable*, and 9 *neutral.* This indicates broad conversational openness that can be harnessed—but it does not, on its own, drive reporting.**

**Knowledge of reporting pathways is incomplete. A majority knows how to report (78.7%, n=225), but *nearly one in five does not* (n=49) or *is unsure* (n=12), leaving a large gap at the exact moment families must act.**

**Stigma remains the dominant barrier. 210 respondents agreed there is stigma around reporting, compared with 64 who disagreed and 26 unsure. Community reactions to disclosure skew toward *silencing/shame/victim-blaming (n=183)*, with relatively few citing *supportive responses (n=33).***

**Myths and taboos still discourage reporting. 103 respondents acknowledged that cultural myths/taboos block reporting (146 rejected; 21 unsure). As one participant summarized, *"Families fear being judged more than they fear the crime itself."***

**Underreporting is systemic and predictable. When asked directly, the most cited barriers were *fear of retaliation (162 mentions), stigma/shame (129), lack of trust in authorities (69), fear of legal processes (43), not knowing how to report (33), and cultural taboos (25).* Over half (57%) reported that they or someone they knew had faced barriers when attempting to report.**

**Institutional frictions worsen the drop-off. Key informants reported *police refusal to record cases (30.9%), poor follow-up (16.7%),* and *bribery/corruption (11%),* further discouraging formal pathways.**

***Mathare exhibits high conversational awareness but low action conversion. Stigma and safety fears dominate household decisions; weak reception at first contact with authorities amplifies drop-off. The immediate need is a paired strategy: visible norm-shift that protects disclosers + a simple, trusted, well-publicized reporting pathway.***

### 7.21 Prioritized needs (urgency × feasibility)

### 1. Stigma reduction and protection of disclosers

- ***Need:*** **Community-level norm-shift to make disclosure socially safe, paired with explicit assurances against retaliation.**
- **Evidence: 210 agree stigma accompanies reporting; community reactions skew to silencing/shame (183) vs supportive (33).**
- **Action: Short, repeated dialogues in schools/faith venues/CHPs; visible endorsements by respected leaders; survivor-safe messaging; anonymous or shielded disclosure options.**

## 2. Reporting pathway literacy and safe disclosure points

- ***Need:*** **A simple, public "How to report" script with where/when/whom and child-friendly steps; deploy safe disclosure points where families already go (schools, clinics, faith settings).**
- **Evidence*:* 78.7% know how to report but ~1 in 5 do not/unsure; 57% have faced reporting barriers.**
- **Action*:* 1-page flowchart in Kiswahili/Sheng/English; teacher/CHP scripts; "first-mile" desks at clinics/schools with privacy and referral slips.**
- **Ideal Success: Increase in documented first contact intakes with case numbers, decrease in the people who say "unsure on how to report" and increase in proportion receiving a case number after first contact.**

## 3. Risk-timed outreach led by trusted figures

- ***Need:*** **Concentrate awareness bursts in evenings and school holidays when risk and idle time rise; deliver via elders/CHPs/teachers and youth groups.**
- **Evidence*:* Qualitative accounts link exposure windows (evenings/holidays) with increased vulnerability; trusted conduits are local influencers already embedded in daily life.**
- **Action*:* Pre-holiday mini-campaigns; evening courtyard meetings; scripts emphasizing rights, where to go, and safety planning.**
- **Ideal Success: Short, dated campaign logs together with pre/post shifts in "knows where to report" and first-contact intakes in the following month.**

## 4. Trust-building with authorities (minimum reception standards)

- ***Need:*** **Make the *first official contact* predictable, respectful, and documented.**
- **Evidence*:* Police refusal to record (30.9%), poor follow-up (16.7%), corruption (11%); fear/distrust among households.**
- **Action*:* MoUs with police/CPS: OB/case number at first contact, child-friendly room, explained next steps, and a 48-hour feedback rule.**
- **Ideal Success: % of complainants receiving an OB number at first contact; time-to-feedback medians.**

## 5. Myth-busting and legal literacy integrated into everyday spaces

- ***Need:*** **Replace myths/taboos with plain-language rights, grooming signs, and consent education; normalize seeking help as care, not shame.**
- **Evidence*:* 103 acknowledge myths/taboos discourage reporting; legal/rights awareness remains uneven.**
- **Action*:* 10-minute modules for faith/school/community settings; child-safe Q&A; clear referrals**
- **Ideal Success: Decline in "myths/taboos discourage reporting" count; Increase in correct answers to 3-item rights quiz in spot checks.**

***Immediate priority is norm-shift and protection for disclosers, paired with a simple public reporting pathway and trusted safe-disclosure points. Time short bursts to evenings/holidays and co-deliver through elders/CHPs/teachers. Formalize minimum reception standards with police/CPS (case number on first contact; 48-hour feedback). Integrate myth-busting/rights literacy in faith and school settings. This sequence moves Mathare from awareness to action, increasing case detection and survivor access to services.***

## 7.3 Support System and Service Needs

**Survivors and families in Mathare can often name a provider, but cost, distance, stigma, weak referrals, and thin capacity keep many from receiving timely, child-appropriate care—producing visible services but limited effectiveness, with heavy reliance on NGO facilities and inconsistent public provision.**

### What the data says (by service)

**Healthcare. Visibility is relatively high (200 know at least one organization; 91 do not). Perceived access is 159 easy, 73 somewhat, 41 not, 11 unsure. Top barriers: cost (109), discrimination (63), distance (53), lack of information (52), complicated processes (32). Providers note delayed/inconsistent care and near-absence of specialized post-assault services; referrals skew to NGOs (e.g., SHOFCO, MSF), raising sustainability concerns. "We see children come for initial treatment, but there is no system to ensure they return or get further support. It ends at the first visit."**

**Counseling / Psychosocial. Awareness is 138 yes / 100 no / 42 unsure. Perceived quality is 62 high / 73 acceptable / 30 low / 70 unsure—a split picture reflecting uneven capacity. Local leaders report less than 84% absence of psychosocial services in their areas; CHPs and NGOs echo gaps in trained child-trauma counselors, continuity of care, and stigma deterring therapy.**

**Legal Aid / Child Protection Services (CPS). Awareness is low/uncertain: 133 say absent, 97 present, 41 unsure. KII evidence cites police refusal to record cases, poor follow-up, bribery/corruption, and lack of child-friendly procedures, reinforcing community mistrust and pushing families toward informal resolution. An NGO summarized: *"Even when a child reports, the system collapses—evidence is lost, families are intimidated, and perpetrators walk free."***

**Safe spaces / Shelters. Leaders consistently report no dedicated child shelters in Mathare; where "safe spaces" exist, they function as day-only spaces (no overnight protection).**

***Mathare has recognizable service points, but the care pathway breaks at multiple junctures: first-mile affordability and transport, clinic to counseling linkage, and clinic/counseling to CPS/justice. The practical need is to fix affordability, capacity, and referral continuity, while making first official contact predictable and child-friendly.***

### 7.31 Prioritized needs (urgency × feasibility)

#### 1. Remove cost/transport barriers to first care and follow-up

- **Evidence: Cost leads all barriers (109), with discrimination, distance, information, and bureaucracy close behind; many families still miss care despite "easy" access counts.**
- **Action: Fee waivers/vouchers at point of first contact; transport stipends; a dated follow-up token (clinic name/provider) issued with the first visit.**
- **Ideal Success: Increase in proportion of survivors receiving timely clinical care (PEP/forensics) and returning for a scheduled follow-up.**

## 2. Stand up child-focused trauma counseling capacity (with continuity)

- **Evidence:** Awareness exists but supply is thin (>84% of leaders report absence); quality perceptions are mixed (62/73/30/70). Care typically "ends at the first visit."
- **Action:** Fund 2–3 full-time child-trauma counselors with supervision; ≥3-session standard per child; embed care navigators to book/confirm sessions.
- **Ideal Success:** Increase in share of enrolled children completing to greater or equal than 3 sessions; Decrease "unsure" quality responses.

## 3. Clinic to Counseling to CPS referral loop with unique case ID + 48-hour feedback

- **Evidence:** Inconsistent referrals and lost follow-up reported by providers; CPS visibility weak (133 absent / 97 present / 41 unsure); KIIs detail police refusal/poor follow-up.
- **Action:** One-page referral form with unique case ID; 48-hour feedback rule (did the survivor reach the next service?); monthly multi-agency case conference (de-identified) to close loops.
- **Ideal Success:** Increase in % referrals with documented receipt at next service; median time-to-feedback ≤ 48 hours.

## 4. Child-friendly justice desks and minimum reception standards (MoUs)

- **Evidence:** Police refusal to record, poor follow-up, corruption, and lack of child-friendly procedures deter formal reporting and retraumatize children.
- **Action:** MoUs with police/CPS: (i) OB/case number on first contact, (ii) child-friendly room, (iii) escort letter to clinic, (iv) timeline card for families.
- **Ideal Success:** Increase in % of complainants receiving OB number at first contact; Decrease in reported refusals.

## 5. Upgrade day safe spaces; be explicit about shelter gap (and plan)

- **Evidence:** No dedicated child shelters; day spaces only. Families need safe entry points now, while formal shelter options are scoped.
- **Action:** Upgrade day spaces with private interview room, lockable evidence cabinets, on-site counselor hours, posted referral maps; include a clear statement in the report that overnight shelter capacity is absent and describe external shelter referrals.
- **Ideal Success:** Increase in number of intakes initiated at day spaces; documented shelter referrals where applicable.

***Actions 1–3 are low-capital, high-conversion investments that move families from "knowing providers exist" to finishing the care pathway. Actions 4–6 establish system reliability (justice desks) and first-mile clarity (directories, scripts)***

***Remove cost/transport barriers immediately, stand up child-focused counseling capacity with greater than 3 session continuity, and enforce a clinic↔counseling↔CPS referral loop with unique IDs and 48-hour feedback. Pair with child-friendly justice desks under MoUs, upgraded day safe-spaces (not shelters), and clear service navigation (directories + scripts). These steps move Mathare from visible services to completed care pathways.***

## 7.4 Educational, Legal, and Partnership Needs

**Community willingness to engage is high, but uneven rights/legal literacy, variable capacity among trusted messengers, and fragmented partnerships keep prevention and reporting from scaling. Getting education, law, and collaboration right is how we convert broad concern about CSA into consistent, child-safe action.**

### What the data says (education & legal literacy; channels)

**Priority education topics (counts).** Residents want practical, rights-anchored content: children's rights (165); how to talk to children (134); reporting mechanisms (122); recognizing signs (118); legal protections (104); available services (94). These choices show a gap between recognizing CSA and knowing what to do next.

**Legal/policy awareness is mixed.** 141 very aware, 111 somewhat, 38 general/partial, 22 not very, 16 not at all; an additional 210 explicitly report gaps/"don't know." Programs must therefore teach both rights and how to act on them.

**Preferred outreach methods (counts).** Community meetings (172) dominate, followed by social media (73), SMS (69), flyers (50), workshops (43), radio (36)—a clear blueprint for multi-channel delivery with an in-person core.

> ***Teachers report gaps in definitions, prevention, early detection, and referral; religious leaders rarely integrate CSA into sermons and request evidence-based content; health providers note low awareness and persistent myths—all calling for structured, continuous sensitization rather than one-off talks.***

### What the data says (trusted figures & partnership readiness)

**Influencers (counts).** Elders (153) and CHPs (126) lead, followed by local officials (87), religious leaders (62), police (60), teachers (52), youth leaders (47). Programs should start where influence already sits.

**Leaders are talking—but capacity is uneven.** 202 say leaders discuss CSA (41 no, 29 sometimes, 12 unsure), and the community is ready to back visible leadership (252 would support). Capacity/trust vary by actor and must be upgraded and bounded (codes of conduct, scripts).

**Trust & collaboration appetite (counts).** Organizations working on child protection are seen as very trustworthy (155) / somewhat (72); 230 would collaborate. Interviews, however, flag competition, weak coordination, and fragmented referrals—so partnership needs simple rules and a light backbone.

> ***Mathare is primed for rights-anchored education delivered by credible local figures, but it requires practical scripts, minimum standards for leaders, and coordination compacts so that messages and referrals are consistent across schools, clinics, faith venues, and local leadership.***

## 7.41 Prioritized needs (urgency × feasibility)

### 1. School-anchored reporting pathway and teacher child-protection CPD

- **Evidence:** Topics prioritized should include reporting mechanisms (122) and children's rights (165); teachers cite training needs; meetings are the top channel. Schools are natural hubs for children and caregivers.
- **Action:** One-page school reporting flow (who/where/when), mandatory CPD (3 modules: rights & grooming; safe disclosure & do-no-harm; referral scripts), and child clubs/parent forums each term.
- **Ideal Success:** Increase in % disclosures routed via school with documented referral; Increase in teacher CPD completion; Increase in parent knowledge of "where to report."

### 2. Rights & legal-literacy drives via elders, CHPs, and faith leaders

- **Evidence:** Legal awareness mixed (141/111/38/22/16) and 210 report explicit gaps; elders (153) and CHPs (126) are top influencers; faith venues have reach but variable readiness.
- **Action:** Monthly rights forums and sermon inserts with plain-language steps: your rights → how to report → where to get help; distribute elder/CHP toolkits (poster, SMS script, hotline card).
- **Ideal Success:** Decrease in "don't know" on rights items; Increase in correct answers to a 3-item rights quiz in spot checks; Increase in first-contact intakes following forums.

### 3. Partnership compacts + coordination backbone (light secretariat)

- **Evidence:** High trust (155 very / 72 somewhat) and 230 open to collaborate; interviews flag competition and weak coordination undermining impact.
- **Action:** Quarterly CSA coalition, shared referral form with unique case ID, shared campaign calendar, and data-sharing MoUs clarifying roles, confidentiality, and minimum reception standards.
- **Ideal Success:** Percentage increase in referrals with documented receipt across agencies; monthly coalition minutes; joint campaigns delivered per calendar.

### 4. Multi-channel outreach timed to evenings/holidays (meetings + social + SMS)

- **Evidence:** Community meetings (172) lead channels; digital tools (social 73, SMS 69) extend reach to youth/households. Choir of messengers needed for recall and repetition.
- **Action:** Quarterly burst cycles (pre-holiday and term openings) with a single visual identity and a 3-message script.
- **Ideal Success:** Campaign logs + pre/post changes in "knows how to report" and first-contact intakes in the 30 days after each burst.

### 5. Leader capacity & credibility upgrade (codes of conduct + scripts)

- **Evidence:** 202 say leaders discuss CSA; credibility uneven, with police/local officials facing mistrust; religious engagement inconsistent.
- **Action:** Short certification (elders/faith/police/teachers): do-no-harm interviewing, safe referral, confidentiality; public pledge + helpline display to signal accountability.
- **Ideal Success:** # leaders certified; adherence checks (mystery client or community feedback); Increase in supportive reactions to disclosure.

# 8. Recommendations

***Note:*** *The recommendations outlined below are intended as actionable guidance for all stakeholders engaged in child protection in Mathare. BSF will integrate selected insights into its forthcoming Strategic Plan (2026–2029), focusing its immediate priorities on education, awareness, and data-driven research to strengthen foundational understanding and community trust. In subsequent phases, BSF will expand into prevention and response interventions—supported by stronger baselines, partnerships, and community ownership. This phased approach ensures sustainable, evidence-aligned impact while maintaining strategic focus. Any stakeholder categories mentioned are indicative. They identify relevant sectors or duty-bearers rather than assigning responsibility to any named institution.*

## 8.1 Immediate / Short-Term Recommendations (0–6 Months)

**This section presents urgent, high-impact actions that can be undertaken within six months to reduce immediate risks, strengthen reporting, and improve survivor support systems in Mathare. Recommendations are drawn from the evidence in Chapters 3–6, reflecting environmental vulnerabilities, barriers to disclosure, and service gaps. Each recommendation outlines its rationale, indicative timeline, and expected outcomes.**

### 1. Targeted Lighting and Environmental Improvements

#### Recommendation:

**Prioritize installation and repair of lighting in unsafe corridors, school-home routes, and informal markets identified as evening-risk hotspots.**

#### Rationale:

**Chapter 3 confirmed that poor lighting and sanitation correlate with increased vulnerability to assault. Environmental improvements are among the fastest, most visible protection measures.**

#### Indicative Action:

**Map and upgrade priority corridors (e.g., Gitathuru, Mabatini) within three months through coordinated public-safety initiatives.**

#### Expected Outcome:

**Improved visibility, reduced evening-hour risks, and increased community perception of safety in rapid surveys.**

### 2. Community Reporting and First-Mile Support

#### Recommendation:

**Introduce multilingual awareness materials and basic triage desks in schools, clinics, and faith institutions outlining how to report and where to seek help.**

#### Rationale:

**As shown in Chapter 4, fear, stigma, and lack of information deter reporting. Clear guidance at trusted points can normalize disclosure.**

#### Indicative Action:

**Develop posters and guides within two months; orient community focal persons to triage and refer survivors. Where feasible, pilot barrier-removal options—such as transport or fee support—to ensure timely access to clinical and counseling services.**

#### Expected Outcome:

**Higher awareness of reporting pathways and measurable growth in formally logged cases**

### 3. Minimum Child-Friendly Reception Standards

#### Recommendation:

**Adopt a baseline set of survivor-centred standards for all first-contact facilities to guarantee safety, privacy, and timely follow-up.**

#### Rationale:

**Chapter 5 highlighted inconsistent handling of cases and poor feedback loops. Standardising intake will immediately improve trust and continuity.**

#### Indicative Action:

**Implement the following within 1–3 months:**

- **Private interview area at each intake point;**
- **Immediate case/OB number issuance;**
- **One-page referral slip with unique case ID;**
- **48-hour feedback rule confirming receipt at the next service point.**

#### Expected Outcome:

**Shorter response times, fewer lost cases, and enhanced survivor confidence.**

### 4. Short-Term Counseling Surge Capacity

#### Recommendation:

**Deploy mobile or part-time psychosocial counselors for immediate trauma support and case follow-up.**

#### Rationale:

**Only one-quarter of those needing counseling accessed it (Chapter 5). Rapid surge capacity can close this early gap.**

#### Indicative Action:

**Activate two or three trauma-focused counselors for a three-month pilot in high-prevalence zones.**

#### Expected Outcome:

**Higher counseling uptake, better adherence to follow-up sessions, and reduced distress indicators among survivors.**

### 5. Rapid Stigma-Reduction Dialogues

#### Recommendation:

**Launch structured 12-week dialogues in schools, barazas, and faith settings addressing myths, blame, and silence surrounding child sexual assault.**

#### Rationale:

**Chapter 6 underscored stigma as a dominant barrier to disclosure. Community conversation is an achievable early win.**

#### Indicative Action:

**Train community leaders and facilitators; implement rotating dialogues supported by standardized discussion guides.**

#### Expected Outcome:

**Observable improvement in community attitudes and increased willingness to report.**



## 6. Public Service Directory and Coordination Dashboard

### Recommendation:

**Publish a simple directory of health, psychosocial, and legal support services, complemented by a live dashboard for coordination and follow-up.**

### Rationale:

**Many residents (Chapter 5, 7) lacked clarity on where to seek help. A unified reference tool can dramatically improve referrals.**

### Indicative Action:

**Map services, validate contacts, and release the first directory (print + digital) within three months; update quarterly.**

### Expected Outcome:

**Stronger inter-agency coordination and faster service navigation.**

## 7. Privacy Upgrades in Day Spaces and Shelter Referral Clarity

### Recommendation:

**Enhance privacy and child-safeguarding conditions in existing community day spaces, and publish referral pathways for emergency accommodation.**

### Rationale:

**The study found no dedicated child shelters in Mathare and limited safe disclosure venues. Improving day-space privacy while clarifying external shelter links provides an ethical interim solution.**

### Indicative Action:

**Minor refurbishments (partitioning, lighting, signage) within three months; document available external shelter contacts in the service directory.**

### Expected Outcome:

**Safer disclosure settings and more effective referral continuity.**

| Priority | Action (What) | Timeline | Expected Short term Impact |
|---|---|---|---|
| HIGH | Targeted lighting and environmental upgrades | 0–3 months | Safer evening routes, reduced hotspot risks |
| HIGH | Community reporting desks + first-mile barrier support | 0–2 months | Higher formal reporting rates |
| HIGH | Minimum child-friendly reception standards (**OB #, referral slip, 48-hr feedback**) | 1–3 months | Faster access; reduced case loss |
| HIGH | Short-term counseling surge capacity | 1–3 months | Increased trauma-care uptake |
| MEDIUM - HIGH | 12-week stigma-reduction dialogues | 0–3 months | Greater community support, lower stigma |
| MEDIUM - HIGH | Service directory + coordination dashboard | 0–2 months | Improved referral efficiency |
| MEDIUM | Barrier-removal pilots (transport / fee support) | 0–3 months | More timely clinical & legal follow-up |
| MEDIUM | Day-space privacy upgrades + shelter referral clarity | 1–3 months | Safer disclosure & referral continuity |

*Table 5— Summary of Immediate (0–6 Month) Recommendations*

## 8.2 Medium-Term Recommendations (6–18 Months)

**This section outlines strategic, medium-term interventions that consolidate the short-term gains achieved through immediate actions. Over a period of six to eighteen months, these measures aim to strengthen education, legal awareness, and support systems, moving from reactive responses to sustained prevention and institutional capacity. Recommendations draw from the educational and legal gaps in Chapters 5 to 7, focusing on practical, scalable reforms that embed child protection within community, school, and service structures.**

### 1. Institutionalize School-Based Child Protection Education

#### Recommendation:

**Integrate structured child-protection modules into school programs to build consistent awareness among teachers, learners, and parents.**

#### Rationale:

**Findings in Chapter 6 revealed that although awareness of abuse exists, understanding of prevention, reporting, and legal implications remains limited. Schools provide the most sustainable platform for behavioral change.**

#### Indicative Action:

**Within 12 months, train at least 80 percent of teachers across sampled schools on recognition, response, and reporting protocols, and develop age-appropriate lesson inserts on personal safety.**

#### Expected Outcome:

**Increased student awareness of risks and rights (baseline ≈ 40 percent → target ≥ 70 percent), enhanced early detection, and reduced tolerance for abuse.**

### 2. Expand Community-Level Legal Literacy and Case Navigation

#### Recommendation:

**Establish regular legal awareness workshops for community members, parents, and local leaders, emphasizing child-rights provisions, the Children Act (2022), and reporting obligations.**

#### Rationale:

**As demonstrated in Chapters 4 and 6, many residents perceive legal systems as inaccessible or intimidating. Legal literacy helps bridge that confidence gap and encourages lawful intervention.**

#### Indicative Action:

**Implement quarterly legal-literacy forums co-facilitated by pro bono advocates or paralegal officers. Produce and distribute simplified booklets in Kiswahili and Sheng.**

#### Expected Outcome:

**Improved understanding of due-process rights, a measurable rise in case follow-through rates, and fewer reports of mishandled or withdrawn complaints.**

### 3. Strengthen Counseling Continuity and Case Management Systems

#### Recommendation:

**Scale up the short-term psychosocial initiatives introduced earlier into structured counseling networks with digital case-tracking.**

#### Rationale:

**Chapter 5 indicated that fewer than 25 percent of survivors completed more than one counseling session, largely due to discontinuity and weak follow-up. A systematized network ensures consistent care.**

### Indicative Action:

**Over 6–12 months, formalize referral protocols among counseling providers, develop a secure digital register for case follow-up, and expand trauma-focused training for at least 15 community counselors.**

### Expected Outcome:

**Improved survivor retention in counseling (≥ 60 percent completing ≥ 3 sessions) and stronger data for monitoring mental-health outcomes.**

## 4. Develop Multi-Sectoral Child-Protection Coordination Forums

### Recommendation:

**Create structured collaboration platforms bringing together schools, health facilities, police, legal officers, and community-based organizations for regular coordination.**

### Rationale:

**The Needs Analysis (Chapter 7) identified fragmentation and duplication among service providers. A formal coordination forum enhances communication, referrals, and joint accountability.**

### Indicative Action:

**Within 12 months, establish a Child-Protection Forum in each Mathare sub-area, meeting bi-monthly with standardized minutes and shared progress indicators.**

### Expected Outcome:

**Better case referral efficiency, reduced information loss, and measurable improvements in inter-agency collaboration.**

## 5. Pilot Data and Research Strengthening Initiatives

### Recommendation:

**Invest in data-collection and management tools to continuously track CSA trends, service utilization, and emerging risks.**

### Rationale:

**Chapters 4 and 5 emphasized the scarcity of disaggregated and longitudinal data on CSA in informal settlements. Strengthening data systems ensures evidence-based policy and programming.**

### Indicative Action:

**Deploy digital data-collection applications for frontline workers and develop quarterly analytics reports feeding into community dashboards.**

### Expected Outcome:

**Regular availability of reliable CSA trend data and a documented evidence base supporting prevention planning and advocacy.**

## 6. Build Structured Partnerships for Specialized Support Services

### Recommendation:

**Form medium-term partnerships with technical organizations (e.g., mental-health networks, child-rights coalitions, and universities) to enhance service quality and innovation.**

### Rationale:

**As observed in Chapter 8, specialized care—such as forensic examination, trauma therapy, and survivor reintegration—is under-developed locally. Partnering allows shared expertise without duplicating capacity.**

### Indicative Action:

**By month 18, finalize at least three collaboration agreements or memoranda of understanding to pilot integrated service pathways.**

| Priority | Action (What) | Timeline | Expected Impact |
|---|---|---|---|
| HIGH | Institutionalize school-based child-protection training | 6–12 months | Sustainable awareness among students & teachers |
| HIGH | Community legal-literacy & case-navigation workshops | 6–12 months | Increased legal confidence & case follow-through |
| HIGH | Structured counseling & digital case-management | 6–18 months | Improved continuity & retention |
| MEDIUM - HIGH | Multi-sectoral child-protection coordination forums | 6–12 months | Stronger inter-agency communication |
| MEDIUM | CSA data & research strengthening | 6–18 months | Regular evidence generation |
| MEDIUM | Partnerships for specialized care & reintegration | 12–18 months | Access to expert services & innovation |

*Table 6 — Summary of Medium-Term (6–18 Month) Recommendations*

## 8.3 Long-Term Recommendations (18 Months – 3 Years)

**This section presents systems-level measures to institutionalise prevention, response, and accountability beyond early pilots. Over 18–36 months, the focus shifts from quick wins to durable capacity in schools, health and justice services, coordinated partnerships, and sustainable financing. Recommendations reflect the findings (Ch. 3–6) and priorities from the integrated Needs & Gaps Analysis (Ch. 7), and are framed for multi-stakeholder adoption.**

### 1. Safe Corridors Programme (scale & maintain)

#### Recommendation:

**Convert the short-term lighting/drainage fixes into a ward-level programme covering school-home routes and market approaches, with preventive maintenance.**

#### Rationale:

**Environmental exposure (dark corridors, flooded detours) was repeatedly linked to risk. Long-term impact requires coverage targets, maintenance SLAs, and annual audits**

#### Indicative Action:

**Map full corridor network; phase installations; sign service-level agreements (SLAs) for repairs. Combine lighting, footbridges, and drain upgrades with community safety presence standards.**

#### Expected Outcome:

**Stable reductions in evening-hour exposure; safer access year-round.**

### 2. Safe Schools Accreditation (policy, practice, and audits)

#### Recommendation:

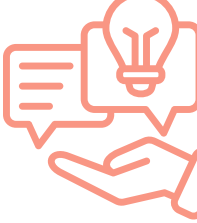
**Establish a "Safe School" standard covering child-protection focal points, reporting flows, private interview spaces, and annual safeguarding audits.**

#### Rationale:

**Establish a "Safe School" standard covering child-protection focal points, reporting flows, private interview spaces, and annual safeguarding audits.**

#### Indicative Action:

**Train and certify child-protection focal persons; institute termly drills for reporting/referral; Integrate child-protection content in curricula and parents' forums; conduct annual audits with corrective action logs.**



### Expected Outcome:

**Higher disclosure quality, faster referrals, and normalised preventive education.**

## 3. Integrated Survivor Pathway Network (ISPN)

### Recommendation:

**Formalise a referral and case-management network linking clinics, counseling services, child protection services, and legal actors with standard forms, IDs, and feedback rules.**

### Rationale:

**Case loss occurs at hand-offs. A codified network with data-sharing protocols (privacy-preserving) sustains continuity.**

### Indicative Action:

**Adopt a single referral slip with unique case ID;Enforce 48-hour confirmation & 7-day appointment targets; Monthly de-identified case reviews; annual inter-agency MoU refresh.**

### Expected Outcome:

**Fewer missed appointments; improved survivor experience and evidence quality.**

## 4. Workforce Development (CHPs, counselors, social workers, forensic nurses)

### Recommendation:

**Build a tiered workforce with competency frameworks, supervision, and retention incentives.**

### Rationale:

**Long-term quality depends on trained personnel across community and facility levels, not ad-hoc volunteers.**

### Indicative Action:

**Certify CHPs in safe disclosure and referral; Train trauma-focused counselors (child modalities); Develop forensic nursing capacity and chain-of-custody SOPs; Establish quarterly supervision and peer-learning.**

### Expected Outcome:

**Higher technical quality, better retention in care, improved legal outcomes.**

## 6. Justice & Protection System Strengthening (child-friendly, timely, accountable)

### Recommendation:

**Institutionalise minimum reception standards in police/CPS and magistrate interfaces, with oversight and complaint mechanisms.**

### Rationale:

**Refusal to record, poor follow-up, and procedural opacity deter families; institutional norms must lock in improvements.**

### Indicative Action:

**Child-friendly rooms and OB number at first contact embedded in SOPs; Time-bound steps (OB → P3/forms → medical → statement); Quarterly OB-issuance audits; formal complaint channels.**

### Expected Outcome:

**Increased trust and case throughput; reduced attrition.**

## 7. Sustainable Financing & Partnership Compacts

### Recommendation:

**Create multi-year partnership compacts (public, NGO, private) with pooled or braided funding aligned to corridor safety, school standards, and survivor pathways.**

### Rationale:

**Long-term reliability (maintenance, counselors, audits) needs predictable financing.**

### Indicative Action:

**2–3 three-year compacts with shared outcomes; Budget lines for maintenance, training, and audits; Annual public progress statements.**

### Expected Outcome:

**Stability of core functions and reduced programme drift.**

## 8. Emergency/Transitional Child-Safe Accommodation (partnership-based)

### Recommendation:

**Where feasible, formalise access to emergency or transitional accommodation for children through partnerships with accredited providers; maintain clear referral criteria and safeguarding SOPs.**

### Rationale:

**The assessment identified gaps in safe overnight options; long-term risk management requires ethical, governed pathways (not informal arrangements).**

### Indicative Action:

**Define eligibility and length-of-stay parameters; Train staff on trauma-informed care and PSEA; Link to ISPN and justice services.**

### Expected Outcome:

**Higher technical quality, better retention in care, improved legal outcomes.**

| Priority | Action (What) | Timeline | Expected Impact |
|---|---|---|---|
| HIGH | Safe Corridors Programme (lighting, bridges, drainage + SLAs) | 18–36 months | Durable reduction in environmental exposure |
| HIGH | Safe Schools Accreditation (focal persons, audits, curricula) | 18–30 months | Normalised prevention + faster, safer disclosure |
| HIGH | Integrated Survivor Pathway Network (ISPN) | 18–24 months | Fewer lost cases; faster service transitions |
| MEDIUM - HIGH | Workforce Development (CHPs, counselors, forensic nurses) | 18–36 months | Technical quality and continuity improve |
| MEDIUM - HIGH | Justice & Protection SOPs (child-friendly, time-bound, audits) | 18–30 months | Higher trust; reduced attrition |
| MEDIUM | Data, Research & Learning System (joint M&E) | 18–36 months | Evidence-led adaptation; transparency |
| MEDIUM | Financing & Partnership Compacts (3-yr) | 18–36 months | Budget stability for core functions |
| CONTEXTUAL | Emergency/Transitional Accommodation (partnership-based) | 24–36 months | Ethical crisis options; fewer ad-hoc placements |

*Table 7— Summary of Long-Term (18–36 Month) Recommendations*

# 9. Conclusion

***Note:****This chapter brings together key findings from across the assessment to provide a neutral synthesis of evidence. It is structured to summarize critical findings and priority needs, highlight their implications for child protection in Mathare, outline the urgency and potential for impact, and set out a call to action for stakeholder collaboration. The conclusion is intended to guide strategic planning and coordination, rather than prescribe specific interventions or funding requests.*

## 9.1 Summary of Critical Findings and Needs

**This assessment synthesizes evidence from household and school surveys, focus group discussions, key informant interviews, and community mapping to identify the primary drivers of child sexual assault (CSA) and the most urgent gaps in Mathare's child protection ecosystem. The settlement's baseline (2019 census estimate of approximately 206,564 residents; 2025 projection of roughly 260,000) and higher NGO spot estimates highlight both the scale and youth-heavy profile of the population, which amplify vulnerability to CSA. Household data and community mapping reveal widespread environmental risks—particularly inadequate lighting and unsafe public spaces—concentrated in known dark corridors. Approximately 62.3% of households reported inadequate street lighting, and over half of respondents noted seasonal flooding in priority hotspots.**

### Scope and Nature:

**Community surveys indicate high awareness of CSA as a local problem, with 86% of respondents reporting that they have heard of CSA and 78% indicating knowledge of incidents. Qualitative interviews and service data point to girls, particularly those aged 10–14, as a disproportionately affected group. Underreporting remains pervasive, with more than two-thirds of survey respondents identifying stigma as a key barrier to disclosure.**

### Support Systems:

**Formal response mechanisms are fragmented. Counseling and child-trauma services are limited and unevenly distributed, with local leaders reporting near-absence of psychosocial capacity in several sub-areas. Cost is a leading barrier to access, and legal and child protection processes are widely perceived as inaccessible or not child-friendly. Shelters and safe-space options for survivors remain scarce, further constraining support pathways.**

### Community Attitudes and Partnerships:

**While many residents express openness to discussing CSA, prevailing victim-blaming attitudes and low legal literacy continue to limit reporting and help-seeking. Most teachers and schools lack formal training on child protection and response mechanisms. Several NGOs operate in the area, providing partial services; however, both their capacity and geographic reach are insufficient to meet current needs.**

### Needs and Gaps:

**Analysis from Chapter 7 identifies four priority areas for intervention:**

1. **Improving lighting and safe movement corridors along mapped school-to-home routes.**
2. **Expanding sustainable, child-focused psychosocial and clinical care with reliable continuity.**
3. **Strengthening child-sensitive reporting and referral mechanisms.**
4. **Enhancing community awareness, stigma reduction, and school-based prevention and teacher training.**

## 9.2 Implications for Child Protection in Mathare

**The findings and identified gaps have immediate and compounding implications for child safety and community trust in Mathare. Environmental risks—most notably widespread inadequate street lighting and seasonal flooding—concentrate children's exposure in predictable crime hotspots and along common school-to-home routes. Survey and mapping data show that these physical vulnerabilities, coupled with overcrowded living conditions, materially increase opportunities for abuse and reduce informal community surveillance capacity.**

**Social and systemic barriers further erode protection. Although awareness of child sexual assault is high, disclosure and help-seeking are suppressed by pervasive stigma: more than two-thirds of respondents identified stigma as a barrier to reporting. This stigma, together with limited legal literacy and perceptions of non-child-friendly legal processes, contributes to low confidence in formal response mechanisms; a substantial share of respondents reported limited trust in authorities and allied institutions. Where survivors attempt to access care, services are uneven and often unavailable locally—only a small proportion of survivors access counselling or child-focused clinical care—so disclosure rarely results in sustained support or effective case follow-up.**

**These dynamics produce a cycle of harm: environmental and social risk factors drive incidents; stigma and distrust prevent disclosure; and weak service and referral systems fail to deliver care or accountability. The result is ongoing vulnerability for children, erosion of community trust in protection systems, and missed opportunities for prevention and early intervention.**

***Alongside these challenges, the assessment identifies clear entry points for change. Community assets—including respected local leaders and several NGOs willing to partner—offer credible avenues to rebuild trust and scale interventions. Targeted, evidence-aligned actions (for example, improving lighting on mapped high-risk routes, expanding child-focused psychosocial services, strengthening referral pathways, and implementing school-based prevention and teacher training) can interrupt the cycle of risk. If coordinated with community stakeholders and formal child protection actors, such measures can translate the report's findings into practical protective gains without undermining community trust.***

## 9.3 Urgency and Potential for Impact

**The evidence collected in this assessment demonstrates that child protection in Mathare is at a point of acute need where timely, targeted interventions can produce measurable gains. High levels of stigma (approximately 70%) and limited legal awareness (about 45%) undermine disclosure and help-seeking; combined with limited service access (roughly 20% of survivors access counselling) and concentrated environmental risks, these factors create a context in which children remain persistently vulnerable. The pattern of risk observed across mapping, surveys and stakeholder interviews indicates that delays in response will allow existing crime hotspots and cultural barriers to persist, perpetuating both harm and community mistrust.**

**At the same time, the assessment identifies feasible, evidence-aligned entry points for rapid impact. Short-term "quick wins" could include community awareness workshops and stigma-reduction campaigns that reach large numbers of residents, targeted school-based prevention and teacher training, and pilot counselling services in priority zones. Examples of possible near-term outputs are: community workshops reaching 1,000 residents and a pilot counselling programme able to provide initial support to 500 survivors, with monitoring to capture immediate changes in reporting and help-seeking behaviours.**

Scenario modelling based on baseline metrics suggests that coordinated interventions can deliver measurable medium-term outcomes. For planning purposes, an indicative resource scenario shows that with a targeted, multi-component programme (planning, community engagement, counselling, school prevention, and initial infrastructure improvements), an organisation could provide ongoing psychosocial support to an estimated 200 survivors annually and achieve demonstrable reductions in stigma (for example, a 20% relative decrease) over a multi-year period. Over five years, strengthening referral systems and prevention efforts could plausibly increase reporting rates and system responsiveness by substantial margins.

These projections are indicative and intended for strategic planning; they should be refined through a rapid costing and implementation design exercise. Nonetheless, the balance of high need and identifiable, community-anchored assets indicates that prompt, coordinated action is both necessary and likely to yield meaningful protection gains for children across Mathare.

## 9.4 Call to Action for Stakeholder Collaboration

This assessment highlights that a coordinated, multisectoral response is needed to translate findings into effective protection for children in Mathare. The following stakeholder actions are proposed as evidence-aligned, indicative steps to address the priority needs identified in Chapters 3-7. These are intended to guide joint planning and should be refined through a rapid costing and implementation design process.

### Donors/Funders:

1. Consider targeted support for community awareness and stigma-reduction campaigns and for pilot psychosocial counselling services in priority zones.
2. Prioritise flexible funding that supports coordination, monitoring, and small infrastructure improvements (lighting, safe-route upgrades) identified by the mapping.

### Government (county & sub-county):

1. Strengthen law enforcement and child protection unit capacity to ensure child-friendly procedures and timely case handling.
2. Allocate resources or co-fund safe-space options and shelter facilities, and integrate report/referral pathways into county health and social services.

### Community leaders & informal structures:

1. Mobilise community networks to lead stigma-reduction efforts, promote safe reporting, and support survivor confidentiality.
2. Work with schools and parents to champion prevention activities and to ensure safe school-to-home routes.

### Non-governmental organisations (NGOs) and service providers:

1. Formalise partnerships for referrals, clinical and psychosocial care, and joint community outreach.
2. Share geographic coverage plans and capacity maps to reduce duplication and expand reach into underserved micro-zones.

*Taken together, these collaborative actions—implemented with clear roles, shared monitoring, and community leadership—can translate the report's findings into tangible protection gains. These indicative allocations and responsibilities are a starting point for coordinated planning. Together, stakeholders can protect Mathare's children and work toward the goal that no survivor is left behind.*

# Acknowledgements

The successful completion of this Needs Assessment Report, *Breaking the Silence: A Needs Assessment on Child Sexual Assault in Mathare, Kenya,* required profound trust, courage, and dedication from the Mathare community and the commitment of the entire Bringing Smiles Foundation (BSF) team. We extend our sincerest gratitude to all who contributed their time, resources, and insights to make this evidence-based document possible.

Our deepest appreciation goes to Gathoni Mburu, our Executive Director for providing the strategic vision and institutional mandate necessary to initiate this critical needs assessment.

We also appreciate Elmer Nyabuto, Chief Operating Officer (COO) of BSF, who conceptualized the Needs Assessment Strategic Plan. As the project lead, Elmer Nyabuto ensured the meticulous execution of the assessment on the ground in Mathare, overseeing the team, providing essential training to data collectors, and maintaining the integrity and careful handling of data from collection through to analysis.

We reserve special recognition for Ivan Wawire, BSF's Data Coordinator. His dedication was exceptional, working tirelessly day and night to ensure the integrity of the findings. Ivan Wawire was solely responsible for the complex analysis of both the qualitative and quantitative data, providing the rigorous, evidence-based foundation for this report's core recommendations.

This project relied entirely on the trust and operational support of local governance and community structures. We gratefully acknowledge:

- The Office of the Sub-County Commissioner of Mathare for their valuable contribution and support throughout the assessment period.
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We salute the dedication, resilience, and sensitivity of our Data Collectors, who executed the fieldwork under challenging conditions and ensured the ethical collection of sensitive data. They include:

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In remembrance.



# APPENDICES

## Appendix A: Full Methodology & Sampling Frame

**This appendix provides the technical documentation and statistical parameters used to establish the evidence base for this Needs Assessment, ensuring transparency, rigor, and representativeness for partners and research bodies.**

### A.1 Population Baseline and Sampling Frame

**The sampling frame was constructed to ensure proportional representation across Mathare's varied sub-areas.**

| Parameter | Value | Source/Justification |
|---|---|---|
| Total Population Estimate (2025) | ≈260,000 residents | 2019 KNBS Census baseline (206,564) projected to 2025 (applied urban growth rate of 3.8%). |
| Target Population | Households with children aged 0-18 years | Focus of the Child Sexual Assault (CSA) assessment. |
| Estimated Households (2025) | ≈22,000 households | 2019 Census data adjusted for growth rate and informal settlement dynamics. |
| Strata/Clusters (4 Sub-Areas) | Mlango Kubwa, Hospital Ward, Mabatini, Mathare 4A | Stratification by distinct geographic and administrative zones to ensure comprehensive coverage. |

### A.2 Sample Size Determination and Statistical Parameters

**The sample size for the Household Survey was calculated based on international standards for prevalence studies, ensuring a high degree of confidence and acceptable margin of error for community-level intervention planning.**

| Parameter | Value | Rationale |
|---|---|---|
| Confidence Level (CL) | 95% | Standard for rigorous community-level research. |
| Margin of Error (MOE) | ±5.0 percentage points | Acceptable precision for planning a needs assessment. |
| Expected Prevalence (p) | 22.75% | Midpoint derived from local Nairobi informal settlement studies (ranging 20-27%). |
| Base Sample Size | n=270 households | Calculated using standard statistical formula (unadjusted). |
| Design Effect (Deff) | 1.3 | Adjustment for stratified/cluster sampling typical of informal urban settings. |
| Non-Response Adjustment | 10% | Based on pilot testing and field constraints. |
| Planned Target Sample (Households) | 390 households | Base sample × Deff × Adjustment (270×1.3×1.1). |
| Achieved Sample Size (Households) | 350 households | Actual number of completed, validated household surveys. |

## A.3 Sampling Methodology and Procedures

**The sampling was a two-stage process combining stratification and systematic random selection.**

| Stage | Procedure Detail | Rationale |
|---|---|---|
| Stage 1: Stratification | The planned target sample (390 HHs) was proportionally allocated across the four sub-areas (Mlango Kubwa, Hospital Ward, Mabatini, Mathare 4A) based on their estimated population size. | Ensures that the sample is geographically representative and not skewed toward any single area. |
| Stage 2: Household Selection | Within each sub-area, Systematic Random Sampling (SRS) was applied. Enumerators selected a random starting point and then visited every nth household (where n was the sampling interval calculated for that sub-area). | Provides an unbiased, representative selection of units within each stratum. |
| Substitution Rules | Non-responding or ineligible households were revisited up to three times at different times/days before being replaced by the next eligible household along the systematic route. | Mitigates non-response bias while preserving the random nature of the selection. |
| Respondent Selection | The most eligible adult caregiver/guardian in the household, knowledgeable about the children, was interviewed. For the Student Survey (n=160), adolescents aged 13-17 were randomly chosen within sampled schools. | Ensures the most appropriate respondent provided data, following ethical child assent procedures. |

## A.4 Fieldwork Schedule, Supervision, and Quality Assurance

| Activity | Detail | Timeline / Metric |
|---|---|---|
| Fieldwork Period | Data collection phase. | November 2024 – February 2025 (4 months) |
| Data Collection Team | 8 enumerators and 2 field coordinators. | All fluent in Swahili and Sheng; same-gender matching for sensitive KIIs/surveys. |
| Training | Trauma-informed interviewing, safeguarding protocols, referral scripts, and mandatory reporting procedures. | 4 days of intensive, role-play based training. |
| Supervision & QA | Field coordinators conducted daily debriefs, spot-checks, and back-checks on a minimum of 10% of completed surveys. | Minimizes non-sampling error and ensures data consistency. |
| Response Rate (HH) | 350/390 planned | 89.7% (A high response rate for informal settlement studies). |
| Weighting Approach | Data was analyzed using survey-weighted descriptive statistics to correct for minor disproportionality resulting from the achieved response rates in each sub-area. | Ensures that final estimates accurately reflect the population distribution across the four strata. |

# Appendix B: Data Collection Instruments and Tools

**This appendix details the primary instruments used to collect the mixed-methods data for the Needs Assessment, ensuring full transparency for technical review. The instruments were adapted from international best practices, including the WHO Violence Against Children Survey (VACS) and the INSPIRE framework, and were administered in English, Kiswahili, and Sheng.**

## B.1 Quantitative Instruments: Household and Student Surveys

**The household (n=350) and student (n=160) surveys contained structured, confidential questions to quantify prevalence, risk factors, and access gaps.**

### 1. Student Survey: Core CSA Awareness Module

**This module, administered via confidential pen-and-paper, captures awareness of different forms of abuse.**

| Section | Purpose | Question (Excerpt) |
|---|---|---|
| **Awareness** | Assesses basic knowledge of the subject. | **Do you know what child sexual abuse is?** (Yes / No / Not Sure) |
| **Forms of Abuse** | The core 5-item module assessing recognition of various forms of abuse (aligned with VACS adaptations). | **Which of these do you think counts as child sexual abuse?** (Check all that apply): (a) Being touched in a way that makes you uncomfortable; (b) Being asked to keep a "secret" about touching or behavior; (c) Being shown inappropriate pictures or videos; (d) Being asked to take inappropriate pictures or videos; (e) Being forced to do something you don't want to. |
| **Safety Perception** | Assesses perceived environmental risk. | **Do you feel safe in your neighborhood?** (Always / Sometimes / Rarely / Never) |
| **Disclosure Barriers** | Captures personal barriers to seeking help. | **If someone made you uncomfortable, did you tell anyone?** If no, why not? (e.g., I was scared, I didn't think anyone would believe me, I was told not to tell, I was ashamed/embarrassed) |
| **Trusted Figure** | Identifies key initial reporting channels. | **If you needed help, who would you tell first?** (Check one: Parent/Guardian, Teacher, School Counselor, Friend, Police, Religious Leader, Other) |

### 2. Community Members Survey (Household)

**This survey focused on caregivers' perceptions, environment, and reporting systems.**

| Section | Purpose | Question |
|---|---|---|
| **Environmental Risk** | Quantifies factors contributing to vulnerability (Chapter 3). | **What environmental factors contribute to child vulnerability in Mathare?** (Select all that apply: Poor lighting, Lack of secure spaces, Overcrowding, High crime rates, Flooding). |
| **CSA Beliefs** | Assesses cultural barriers (Chapter 4 & 6). | **Are there cultural beliefs or myths that discourage reporting of child sexual assault?** (Yes / No / Unsure) |

| | | |
|---|---|---|
| **Underreporting** | Identifies systemic/social barriers to justice. | **What are common reasons for underreporting child sexual assault?** (Select all that apply: Fear of retaliation, Stigma and shame, Lack of trust in authorities, Cultural taboos, Fear of legal processes). |
| **Service Gaps** | Captures barriers to accessing critical post-disclosure services (Chapter 5). | **What barriers exist in accessing support services?** (Select all that apply: Cost of services, Distance to facilities, Lack of information, Fear of discrimination, Complicated processes). |
| **Priority Topics** | Informs educational and awareness needs (Chapter 6). | **What topics would you like to learn more about?** (Select all that apply: Recognizing signs of abuse, Reporting mechanisms, Children's rights, Support services available, Legal rights and protections). |

## B.2 Qualitative Instruments: Key Informant Interviews (KIIs)

**This survey focused on caregivers' perceptions, environment, and reporting systems.**

| Target Group (n) | Section | Sample Questions (Excerpts) |
|---|---|---|
| **Local Leaders** (12) | Reporting & Support | **What role do you and other local leaders play in addressing cases of child abuse in this community?** What challenges do you face as a leader when handling cases of child sexual assault? |
| | Gaps & Improvement | **If you could make three key changes to improve child protection in this community, what would they be?** What services are currently available in this community to support children who have been abused? |
| **Healthcare Providers** (13) | Services & Process | **Can you walk me through the process when a child survivor first comes to your facility?** What psychological or counseling services do you offer to survivors and their families? |
| | Systemic Barriers | **What challenges do you face in the referral process** (e.g., to psychological counseling, legal aid, safe houses)? |
| **Police Officers (2)** | Reporting & Handling | **What challenges do you face when receiving reports of child sexual abuse?** (e.g., Delayed reporting, Lack of physical evidence, Family interference/withdrawal). **How child-friendly are the reporting and investigation procedures at your station?** |
| | Accountability & Trust | **What changes would you recommend to strengthen the police response to child sexual abuse cases? How do community attitudes affect the willingness to report CSA cases to the police?** |
| **Teachers (36)** | Risk & Response | **What factors do you think put children at greater risk of sexual abuse in this community? Do you know the proper procedure for reporting suspected or disclosed child sexual abuse in your school?** |
| | Capacity | **What additional training or resources would help you handle child protection issues better?** |

| | | |
|---|---|---|
| **NGO Personnel (7)** | Coordination & Gaps | **What are the biggest gaps in services for survivors of child sexual abuse?** Is there collaboration between different NGOs and service providers? If not, what are the barriers? |
| **Religious Leaders** (6) | Cultural Influence | **Are there common cultural or religious beliefs that prevent people from reporting cases of child sexual abuse? How can religious institutions help change harmful stigmas and encourage open discussions about child protection?** |

## B.3 Qualitative Instruments: Focus Group Discussion (FGD) Guide

**FGDs were used to explore sensitive social norms and communal experiences among parents, adolescents, and service providers (6 FGDs total, separated by age/gender).**

| Discussion Topic | Objective | Sample Guiding Questions (Excerpt) |
|---|---|---|
| **Topic 3: Cultural Beliefs and Attitudes** | Explore societal stigma and victim-blaming. | **What is the community's typical reaction when a case of child sexual assault is disclosed?** Why might victims or their families hesitate to report abuse? |
| **Topic 4: Perpetrators and Relationships** | Determine the nature of the threat. | In your opinion, **who are usually the perpetrators of child sexual assault in our community?** Are they typically strangers, acquaintances, or even family members? |
| **Topic 6: Access to Support Services** | Identify functional and non-functional support channels. | What services are you aware of that support child survivors of sexual assault? **Are there safe spaces available for children at risk?** |
| **Topic 8: Influence of Community Leaders** | Assess local governance capacity. | Who are the most influential figures in our community regarding child protection? Do they actively address issues like child sexual assault? |

## B.4 Environmental Observation and Mapping Checklist

**A structured checklist combined with GPS-enabled transect walks identified and geo-located physical risks, which were then correlated with survey data on high-risk times/locations.**

| Data Point | Metric Collected | Rationale |
|---|---|---|
| **Lighting** | Presence and functionality of streetlights on high-traffic routes (school-home corridors). | Linked to night-time risk (Chapter 3). |
| **Sanitation & Safety** | State of shared latrines/water points (locks, lighting, supervision, visibility). | Linked to high-risk public/shared spaces (Chapter 3). |
| **Infrastructure Risk** | Evidence of flooding, open drainage, or abandoned structures/compounds (GPS coordinates taken). | Linked to environmental risks and unsafe detours. |
| **Social Hotspots** | Location of known drug/alcohol use areas and idle youth gathering points. | Linked to perpetrator risk factors. |

# Appendix C: Data Processing, Coding, and Analysis Notes

**This appendix documents the end-to-end process of transforming raw data collected in the field into the findings presented in this report, ensuring full transparency regarding data quality, cleaning, and analysis methods.**

## C.1 Data Entry, Cleaning, and Anonymization

| Stage | Procedure | Rationale & Details |
|---|---|---|
| **Data Capture** | Paper forms were used in the field for the Community and Student Surveys (n=510) to maintain confidentiality and manage security risks associated with electronic devices. | Ensured ethical compliance and participant safety in sensitive informal settlement contexts. |
| **Data Entry** | Completed paper forms were **double-entered** by trained BSF staff into a secure **Google Forms** database. | Double-entry method minimizes data entry errors, achieving greater than 95% accuracy compared to single-entry. |
| **Anonymization** | All identifying information (names, specific house numbers, detailed GPS coordinates for individual homes) were stripped at the point of data entry. | Guaranteed **anonymity**, adhering to the initial consent and BSF's Child Protection Policy. |
| **Data Cleaning** | Checked for inconsistencies, logical errors (e.g., impossible age/grade combinations), and outliers ( ±2 standard deviations). | Outliers were investigated for contextual plausibility before retention or removal, maintaining data integrity. |

## C.2 Treatment of Missing Data

| Category | Procedure | Metric & Justification |
|---|---|---|
| **Non-Response Rate** | Handled via systematic household substitution (up to 3 revisits) to maintain the target sample size. | Achieved 89.7 % response rate (350/390 target HHs), mitigating initial non-response bias. |
| **Missingness** | Variables with >5% missing data were reviewed for systematic bias. | The overall percentage of item-level missing data was managed to remain below 5% the threshold for most variables. |
| **Imputation Method** | Where necessary (for demographic variables in multivariate analysis), **multiple imputation (MI)** was used. | MI generates unbiased parameter estimates by modeling missing values based on observed data, superior to mean substitution. |
| **Handling of Sensitive Data** | Questions in Section M (Sensitive Questions) of the Community Survey were **optional**. Responses were analyzed separately and only used for qualitative context if no identifiers were present. | Preserved participant agency and ensured ethical treatment of high-risk data points. |



## C.3 Coding Scheme and Software

### Quantitative Coding

- **Software:** Quantitative analysis was performed using **Microsoft Excel** (for initial cleaning/descriptive statistics) and **R Statistical Software** (for advanced analysis, cross-tabulations, and regression models).
- **Variable Names:** All quantitative variables were coded numerically. Categorical variables (e.g., Age Group, Education Level, Gender) were analyzed using dummy coding where appropriate.
- **Weighting:** Data was analyzed using **survey-weighted descriptive statistics** to account for stratification and ensure the sample estimates accurately reflect the sub-area population proportions.

### Qualitative Coding

- **Coding Approach:** Thematic content analysis was applied to transcribed KII and FGD data. A codebook was developed iteratively, blending **deductive codes** (derived from the assessment objectives, e.g., Stigma, Referral Gaps, Environmental Risks) and **inductive codes** (emerging themes, e.g., "Fear of Retaliation," "Cost as Barrier").
- **Reliability:** Two independent researchers double-coded of all qualitative transcripts, achieving a satisfactory Cohen's Kappa ($\kappa \geq 0.85$), indicating high inter-rater reliability.
- **Software:** While structured processes were used, coding was performed primarily in **Microsoft Excel** for accessibility and team training purposes.

## C.4 Analysis Flow and Triangulation

**The analysis adhered to a structured flow designed to maximize the validity and depth of the findings:**

1. **Descriptive Statistics:** Calculation of frequencies, percentages, means, and standard deviations for all demographic and key outcome variables (e.g., prevalence, awareness levels, risk ranking).
2. **Bivariate Analysis:** Cross-tabulations were used to test associations between key independent variables (e.g., Age, Education, Sub-area) and dependent outcomes (e.g., Awareness, Reporting Barriers) using **Chi-Square tests** ($p<0.05$).
3. **Qualitative Synthesis:** Thematic coding results were synthesized to explain the how and why behind the quantitative trends (e.g., Stigma is the number one barrier because of cultural myths cited in FGDs).
4. **Triangulation:** All core findings were subjected to **cross-validation** (triangulation) by comparing results across three distinct data sources (Survey data KII expert opinion FGD community narratives). Convergence across these sources strengthened the reliability and credibility of the final findings.

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