

ChildFund International

U.S. COMMITTEE FOR REFUGEES AND IMMIGRANTS

Children's Programs in Refugee and Host Communities in Garissa, Turkana and Nairobi Counties.

Needs Assessment Report | 2025

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List Of Acronyms

AEP	Accelerated Education Programme
CBOs	Community Based Organizations
CBTs	Cash-Based Transfers
CSOs	Civil Society Organizations
CHPs	Community Health Promoters
CPIMS	Child Protection Information Management System
CSB	Corn Soy Blend
DAFI	Albert Einstein German Academic Refugee Initiative
DCS	Department of Children Services
DRS	Department of Refugee Services
DRC	Dannish Refugee Council
FCA	Finn Church Aid
FCS	Food Consumption Score
FGDs	Focus Group Discussions
HESED	Health and Social Economic Development
HI	Humanity and Inclusion
VAWG	Violence against Women and Girls
GoK	Government of Kenya
IRC	International Rescue Committee
JRS	Jesuit Refugee Service
KCS	Kituo Cha Sheria
KDHS	Kenya Demographic and Health Survey
KIIs	Key Informant Interviews
KRC	Kenya Red Cross
KRCS	Kenya Red Cross Society
LWF	Lutheran World Federation
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MoE	Ministry of Education
MoU	Memorandum of Understanding
MSF	Medicins Sans Frontieres
NNAP	National Nutrition Action Plan
NCCS	National Council for Children's Services
NCCK	National Council of Churches of Kenya
NGOs	Non –Governmental Organizations
NRC	Norwegian Refugee Council
OOSC	Out of School Children
RCK	Refugee Consortium of Kenya
RIS	Refugees In Schools
RLOs	Refugee Led Organizations
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
RH	Reproductive Health
TdH	Terre des Hommes
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
URPP	Urban Refugee Protection Program
USCRI	U.S. Committee for Refugees and Immigrants
WIK	Windle International Kenya
WFP	World Food Program

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Executive Summary

This report presents the findings of a comprehensive needs assessment commissioned by ChildFund Kenya, in collaboration with the U.S. Committee for Refugees and Immigrants (USCRI), and implemented by Move on Afrika Ltd.

The needs assessment aimed to understand the needs, vulnerabilities, and service gaps affecting unaccompanied and separated children aged 10–14 years living in both refugee and host communities in Turkana (Kakuma and Kalobeyei), Garissa (Dadaab), and Nairobi counties. The study was intended to inform the design and delivery of responsive, inclusive, and sustainable child protection and development interventions.

Methodology

The assessment employed a mixed-methods approach, integrating both quantitative and qualitative data collection techniques.

A total of 361 caregivers participated in the quantitative survey, while several categories of individuals, including caregivers, children, teachers, child protection officers, healthcare providers, and community leaders, contributed to the qualitative component through focus group discussions (FGDs), key informant interviews (KIIs), and case studies.

The methodology emphasized ethical considerations, gender inclusion, and sensitivity to the lived realities of refugee and host populations.

Key Findings

Child Protection Risks

The assessment confirmed the widespread presence of unaccompanied and separated children across all three target counties, with 94.7% of survey respondents reporting knowledge of unaccompanied and separated children in their communities. These children face multiple, overlapping risks, including child labour (71.6%), physical abuse (70.9%), neglect (56.2%), child marriage (54.9%), sexual abuse (52.0%), and mental and emotional abuse (49.7%).

The absence of parental care leaves unaccompanied and separated children vulnerable to exploitation, psychosocial distress, and social isolation. The risks are further exacerbated by poverty, inadequate adult supervision, weak child protection systems, and harmful cultural practices.

94.7%
respondents reporting knowledge of unaccompanied and separated children in their communities.

Health, Nutrition, and Reproductive Health

The study identified a range of common health conditions affecting children, including malaria, diarrheal diseases, malnutrition, respiratory infections, skin conditions, anaemia, and mental health challenges. Access to healthcare services remains limited, with only 31.3% of respondents reporting that unaccompanied and separated children have access to quality healthcare. Key barriers include poor service provision, high cost, long distances to facilities, lack of documentation, and fear of stigma, especially around HIV/AIDS and mental health.

Malnutrition emerged as a major concern, with 80.1% of respondents acknowledging its presence among unaccompanied and separated children. Contributing factors include food insecurity, poverty, lack of dietary diversity, and inadequate health and nutrition education. Children experiencing malnutrition also suffer from stunted growth, impaired learning, and increased susceptibility to illness.

In the domain of reproductive health, 75.7% of respondents reported that unaccompanied and separated children face RH-related challenges. These include adolescent pregnancies, poor menstrual hygiene, sexual abuse, violence against women and girls, and limited access to contraception and RH education. Financial hardship, poor family structures, limited service access, and cultural barriers were cited as key drivers.

80.1%
respondents acknowledged malnutrition among unaccompanied and separated children

75.7%
respondents reported reproductive health challenges among unaccompanied and separated children

Psychosocial and Mental Health

Unaccompanied and separated children experience significant stress due to separation from families, lack of emotional support, exposure to abuse, and the pressure to contribute economically to their households. Girls face additional burdens such as the risk of early marriage, sexual violence, and menstrual challenges, while boys are more affected by forced labour, peer pressure, and substance abuse.

The mental health needs of caregivers were also highlighted, with many reporting emotional distress linked to poverty, caregiving burdens, lack of support, and insecurity.



Unaccompanied and separated children experience significant stress

Education

Access to quality education is limited. Only 35.6% of respondents believed that unaccompanied and separated children have access to quality education, with access lowest in Turkana. Barriers include school fees, lack of learning materials, overcrowded classrooms, long distances to schools, lack of documentation, trauma, language barriers, and child labour.

Only 33.7% of caregivers reported that children had access to learning materials. Support for education primarily comes from NGOs and international agencies, but gaps in caregiver involvement and government support remain pronounced.



Only **35.6%** respondents believed that unaccompanied and separated children have access to quality education



33.7% of caregivers reported that children had access to learning materials

Food Security and Livelihoods

The majority of households caring for unaccompanied and separated children struggle to meet their basic needs. Only 12.7% of respondents reported being able to afford all household essentials. Food (86.3%), clothing (69.8%), healthcare (69.1%), shelter (68.3%), and education (62.2%) were among the most unaffordable needs.

Households employ a range of coping strategies such as reducing meal frequency, borrowing food or money, skipping meals, and relying on food aid. Food consumption scores indicate widespread food insecurity, with 52% of households having poor food consumption and only 9% achieving acceptable dietary diversity.

Barriers to food security include restricted movement, limited access to employment, insufficient food aid, poor infrastructure, and inflated market prices relative to the value of cash or food transfers received.



Only **12.7%** of respondents reported being able to afford all household essentials



52% households have poor food consumption habits

Conclusion

This assessment paints a concerning picture of the lives of unaccompanied and separated children in refugee and host communities in Kenya. The intersection of poverty, limited access to services, weak social safety nets, and systemic gaps in child protection places these children at high risk of harm. However, it also highlights the resilience of caregivers and the potential for coordinated interventions by state and non-state actors.

Recommendations



By addressing the critical gaps identified in this report, stakeholders can help create a more protective, equitable, and nurturing environment for UASC and other vulnerable children across the targeted counties.

1.0 Introduction

1.1 About the Implementing Partners

1.1.1 ChildFund International
ChildFund International is a child-focused, nonprofit global development and humanitarian organization founded in 1938. Operating in 28 countries, the organization is dedicated to improving the lives of children and their families by connecting them with the people, resources, and institutions they need to grow up healthy, educated, skilled, and safe. ChildFund has maintained a strong presence in Kenya since the 1960s, developing deep expertise in addressing complex humanitarian and development challenges. Today, it operates across 28 counties through a network of 13 local implementing partner organizations, reaching over 3.1 million children, their families, and communities annually.

1.1.2 US Committee for Refugees and Immigrants
The U.S. Committee for Refugees and Immigrants (USCRI), established in 1911, is a non-governmental organization dedicated to protecting the rights and well-being of refugees, immigrants, and displaced persons worldwide. In Kenya, USCRI Kenya has a strong operational presence, working closely with government agencies, UNHCR, and other humanitarian partners to improve the conditions of refugee children. The organization focuses on child protection, education, and psychosocial support, particularly for unaccompanied and separated children. USCRI Kenya also advocates for refugee rights, supports capacity building initiatives, and facilitates access to essential services in both urban areas and refugee camps.

1.2 Objectives of the Assessment

The primary objective of the needs assessment was to identify and analyze the current needs, challenges, and opportunities related to supporting vulnerable refugee children in Kenya. Special focus was given to unaccompanied and separated children, as well as children aged 10–14 years, who faced heightened risks and barriers to accessing essential services.

The needs assessment fulfilled the following specific objectives:

i. Mapped and prioritized the needs of children on the move, unaccompanied and separated children, and other refugee children within urban and refugee camp settings.

ii. Mapped the existing sector specific partners and development actors working with the refugee children in Kenya.

iii. Identified gaps and needs in existing delivery services in child protection, health, including reproductive health and nutrition, psychosocial and mental health, food security and education.

iv. Collected views and feedback from children, caregivers, and stakeholders, including government and CSOs working with children on the move on programs that are contextually relevant, effective, impactful and sustainable.

To address the urgent needs of vulnerable refugee children—especially those aged 10–14, including unaccompanied and separated minors—ChildFund Kenya and USCRI Kenya established a Memorandum of Understanding (MoU). Through this collaboration, both organizations aimed to conduct a comprehensive needs assessment that would inform targeted interventions in key areas such as child protection, health, education, and food security. The goal was to improve outcomes for refugee children and their communities by designing effective, evidence-based programs tailored to their unique needs.

1.3 Scope of the Assessment

The needs assessment targeted Kakuma and Kalobeyei regions in Turkana County, Dadaab in Garissa County and Eastleigh, Kasarani, Kawangware and Kayole regions in Nairobi County. The key targeted population included children on the move, unaccompanied and separated children as well as refugee children aged 10-14 years.

The needs assessment targeted Kakuma and Kalobeyei regions in Turkana County, Dadaab in Garissa County and Eastleigh, Kasarani, Kawangware and Kayole regions in Nairobi County. The key targeted population included children on the move, unaccompanied and separated children as well as refugee children aged 10-14 years.

2.0 Study Methodology

2.1 Evaluation Approach

The evaluation employed a mixed method approach, combining both qualitative and quantitative data collection methodologies. Qualitative methods used included focus group discussions (FGDs), key informant interviews (KIIs), case studies and desk/literature review. Quantitative data collection technique employed survey questionnaires.

2.2 Inception and Planning

2.2.1 Inception and Planning

An inception meeting was held with ChildFund Kenya and USCRI staff to outline the scope of the assessment and agree on the evaluation parameters including tools, assessment design, methodology, respondents that were interviewed, locations covered and timelines to be used during the study.

The meeting also provided a platform to outline the resources and documents needed to deliver the task and to clarify the expectations. Alongside the review of the relevant existing literature and project documents, an inception report and data collection tool were developed and approved by the project staff (ChildFund Kenya and USCRI team) before the data collection exercise.

2.2.2 Sampling Design and Approach

To identify the study respondents the assessment used the following sampling techniques:

Probability Sampling Technique: This targeted caregivers of the vulnerable children targeted by the project. To determine the sample size, the survey employed a simple random sampling method using Cochran's sampling formula for infinite populations, with necessary adjustments to account for variability across the three counties and the areas targeted. The total sample size of the study was calculated using Cochran's formula and distributed pro-rata basis to the targeted project locations, subject to a percentage adjustment rate to derive a representative sample, as shown below;

$n = z\sigma\ 2\ /\Sigma$

$= [1.96*9.95]\ 2\ /1$ (for a 95 % confidence interval)

$N = [1.64*9.95]\ 2\ /1$ (for a 90 % confidence interval)

$n=384$

Where;

n = Sample size

Z = Z value found in the z table at a given confidence value.

Σ = Population variance estimate,

= Level of precision

Based on this formula, a representative sample size of 384 caregivers was determined.

County	Area	Proportion	Sample Size	Total
Nairobi	Eastleigh	0.085	32	128
	Kawangware	0.085	32	
	Kasarani	0.085	32	
	Kayole	0.085	32	
Turkana (Kakuma)	Kakuma	0.17	64	128
	Kalobeyei	0.17	64	
Garissa (Dadaab)	Dagaaley	0.11	42	128
	Ifo	0.11	43	
	Hagadera	0.11	43	
Total				384

Table 1: Proposed number of respondents targeted with survey questionnaires.

Non-Probability Sampling Technique: This was used to target respondents for qualitative data. A purposive sampling procedure was used to identify study respondents for key informant interviews, case studies and focus group discussions.

The respondents were drawn from teachers and school administrators, government stakeholders, unaccompanied, separated and refugee children between the age 10-14 years, local administrators, health service providers, non-governmental institutions, refugee-led organizations and the project staff. The sampled individuals and the number reached were indicated in each of the data collection techniques.

2.3 Data Collection Approaches.

2.3.1 Secondary Data Collection
The assessment conducted a review of policies, reports and other existing documents on programs supporting unaccompanied, separated and refugee children between 10-14 years and their families with a focus in Nairobi, Turkana and Garissa counties.

The review provided a better understanding of the current development contexts. Information collected through secondary data; helped assess the situation of the unaccompanied, separated and refugee children between 10-14 years and their families, hence identifying gaps and opportunities in service provision around four thematic areas such as child protection, health, education and food security.

The review of the secondary also played a major role in identifying key interventions supported by different institutions who could not be reached by interviews.

2.3.2 Primary Data Collection
Survey Questionnaires: A total of 361 survey questionnaires were successfully conducted with caregivers/ heads of households out of the target of 384, achieving an overall response rate of 94.01%. The disaggregation of the surveyed respondents reached is as shown in the table below.

Region	Surveys Targeted	Surveys Conducted	Response Rate
Nairobi	128	133	103.91%
Dadaab	128	118	92.19%
Kakuma	128	110	85.94%
Total	384	361	94.01%

Table 2: Number of Respondents Surveyed.

Key Informant Interviews (KIIs): The study targeted a total of 15 KIIs from the local-based institutions, 5 from each of the 3 counties (Nairobi, Garissa and Turkana). The study reached a total of 23 KIIs from the grassroots level reaching different respondents. This is as shown below.

County	Category	Description	Number of interviews
Nairobi	Community leaders	Nyumba Kumi	02
	Health Representatives	Community health promoter	01
		Health Officer	01
	Refugee led organization (RLOs) representatives	Good Deeds CBO	01
		Tushirikiane Africa Trust CBO	01
		CODE Society of Kenya	01
		Lafricana	01
	Education Representatives	School Teachers	02
		Education Officer	01
Kakuma	Community leaders	Block leader	01
	Household Heads	Caregivers	02
	Education Representatives	Senior Teacher	01
	RLOs Representatives	She Can Initiative	01
		United Safe Environment Cre	01
		Voice for Disabled People Association (VDPA)	01
Dadaab	Community leaders	Child protection community worker	01
		Community mobilizer	01
	Education Representatives	Deputy headteacher	01
	RLOs Representatives	Dadaab Chapter Refugee Voices CBO	01
Total			23

Table 3: Respondents reached with Key Informant Interviews

Focus Group Discussion: The study conducted a total of 34 FGDs, reaching 120 children and 164 caregivers/ heads of households. This included 16 FGDs with children and 18 FGDs with caregivers/ heads of households in the three counties. This was as distributed in the table below.

County	Category	Number of FGDs	Number of participants reached		Total
			Male	Female	
Nairobi	Caregivers	08	30	40	70
	Children	08	30	29	59
Kakuma	Caregivers	04	13	19	32
	Children	04	11	11	22
Dadaab	Caregivers	06	43	19	62
	Children	04	21	18	39
Total		34	148	136	284

Table 4: Number of respondents engaged in Focus Group Discussions.

Case Studies: A total of 13 case studies were conducted, including 4 case studies with caregivers and 9 with children. The table below shows the distribution of the respondents reached.

Region	Category	Number Reached
Nairobi (Kayole)	Children	02
Turkana Kakuma and Kalobeyei)	Children	04
	Caregivers	02
Garissa (Dadaab)	Children	03
	Caregivers	02
Total		13

Table 5: Number of Respondents Reached with Case Studies.

2.4 Data Management and Quality Assurance

Qualitative Data Analysis: Qualitative data were transcribed and translated based on the FGDs and Key informant interview recordings. Transcriptions from Kiswahili to English was done. Protocols for coding was established to ensure each transcript was topically categorized and content organized into themes that were informed by the evaluation objectives and purpose, interview guide content, and preliminary findings based on secondary data analysis.

Quantitative Data Analysis: Analysis of quantitative data was done using SPSS vs. 27. This involved several steps aimed at extracting meaningful insights from the dataset. Initially, the data were cleaned and organized to ensure accuracy and consistency. Descriptive statistics were then computed to summarize the main characteristics of the variables under investigation as per the two outcome areas. Measures such as mean and frequencies were employed to provide a comprehensive overview of the data distribution. Visual aids such as line graphs, tables and bar graphs were also utilized to visually inspect the distribution and identify any potential outliers or patterns.

Data Quality Assurance: The study observed data quality protocols to ensure that the information and data collected were accurate and reliable. These protocols included: Training of the research team on child safeguarding protocols and data collection as well as pretesting data collection tools to address any quality issues. The study through the field supervisor and the lead consultant conducted some Back Checks and Spot checks to verify the quality of the data which was collected.

2.5 Ethical and Safeguarding Principles

The study paid attention to the ethical issues highlighted in the TOR and discussed at inception.

These principles were crucial to the evaluation to ensure respect, safety and dignity for all participants, particularly children and survivors of sexual exploitation. The following principles were adhered to:

a. **"Do No Harm" Principle:**
The research study prioritized participants' well-being by ensuring their involvement did not cause distress or re-traumatization. The research assistants were trained on how to report to the study team any cases of trauma, should they identify such cases during interview.

b. **Informed Consent and Assent:**
Participants received clear information about the study, with adults providing consent and children giving assent alongside parental or guardian approval. This ensured voluntary and informed participation, especially for vulnerable groups.

c. **Confidentiality and Privacy:**
All personal information was anonymized, securely stored, and accessed only by authorized personnel. Interviews were conducted in private settings to protect participants' identities and maintain data confidentiality.

d. **Safeguarding Measures:**
Data collectors received specialized training to recognize distress, handle disclosures of abuse, and follow safeguarding protocols to ensure participants' safety.

e. **Voluntary Participation and Right to Withdraw:**
Participants were informed that they could withdraw at any time without consequences, and there was no pressure to answer uncomfortable questions.

f. **Clear and Fair Reporting:**
Evaluators were committed to transparent, accurate, and evidence-based reporting, clearly outlining limitations, findings, conclusions, and recommendations with integrity.

g. **Child Protection:**
The team, well-versed in child protection laws and policies, ensured all members, including enumerators, adhered to ChildFund and USCRI's Child Protection Policy. Ongoing assent allowed children to withdraw at any stage.

2.6 Social Inclusion and Gender Considerations

To ensure sensitivity and social inclusion in the study, the following measures were implemented:

a. **Inclusive Leadership:** The lead consultant, with expertise in equity focused- research, ensured that all aspects of the study adhered to key inclusion considerations.

b. **Balanced Team Composition:** The study team strived for equal representation of males and females, aiming for a 50-50 balance at all levels of the study.

c. **Disaggregated Data Collection:** All collected data were categorized by age and gender to ensure comprehensive analysis and inclusivity.

d. **Integration of Organizational Gender Policies:** The consultant reviewed and incorporated existing ChildFund and USCRI's policies and guidelines on gender inclusion into the study process.

e. **Inclusive Analysis:** Both male and female perspectives were actively incorporated into the analysis, ensuring balanced representation of experiences and insights.

f. **Inclusive Sampling Design:** The sampling approach prioritized diversity, striving for equitable representation of all sexes in participant selection.

2.7 Limitations and Mitigation Measures

Difficulty Reaching Local Targeted Respondents: Despite engaging block leaders in Dadaab, Kakuma and Kalobeyei, many respondents were not willing to take part in the study without any financial benefit. This led to a section of the targeted populations voluntarily turning down the request to take part in the study. The study team mitigated this by individually visiting the respondents at their households and clearly explaining the role of the assessment. This made some of the respondents to change their minds and agree to take part in the study.
Furthermore, the study coincided with food distribution (food ration) which was being conducted by Lotus Kenya Action for Development Organization (LOKADO) in partnership with World Food Programme (WFP), causing delays and staggered data collection as respondents received calls during engagements in the study to go for the rationing. This also made respondents to willingly withdraw from the study in the favor of the food rationing. The affected interviews were rescheduled in order to give the respondents an opportunity to take part in the study.

Difficulty Accessing National Institutional Respondents: Due to their busy schedules and fixed programs, the study was not able to reach the respondents at the national level (including government representatives, NGOs and INGOs) with interviews within the short period of time of data collection. This made it difficult to collect their views and opinions. This was however mitigated through desk review of activities they do through their reports and websites.

Difficulty Accessing Children in School: The study team found it difficult to access school children, especially in Nairobi schools. The research team approached friendly schools who allowed engagement of children in the schools. Additionally, the assessment engaged children mobilized by caregivers at the community level to ensure that children were not only targeted from school but also from the community level, ensuring that both school-going children and out-of-school children took part in the study.

3.0 Contextual Background

3.1 Overview of Refugee Dynamics in Kenya

Kenya is one of the top refugee-hosting countries in Africa, currently accommodating about 853,074 registered refugees and asylum seekers, where 432,380 are in Garissa, 306,414 are in Turkana, and 114,280 are in Nairobi. These populations primarily originate from Somalia, South Sudan, the Democratic Republic of Congo, Ethiopia, Burundi, and Sudan, countries that have experienced decades of violent conflict, political repression, socio-economic instability, and climate-induced crises. Refugees are predominantly settled in Kakuma refugee camp in Turkana County, the Dadaab refugee complex in Garissa County, and increasingly in urban areas such as Nairobi.[1]

Refugee children represent approximately 51.9% of the total refugee population, making them a critical demographic in humanitarian and development programming.[2] These children face layered vulnerabilities due to displacement, family separation, poor living conditions, exposure to violence, and systemic exclusion from social services. In many cases, displacement disrupts key developmental stages, particularly for children aged 10–14 years, and places unaccompanied and separated children at elevated risk of exploitation and abuse.

Kenya's response to refugee protection is guided by a relatively progressive framework. The enactment of the Refugees Act No. 10 of 2021 marked a major policy shift towards local integration, inclusion, and the provision of rights such as access to education, healthcare, freedom of movement, and the right to work.[3] The country is also implementing the Shirika Plan, a government-led initiative supported by UNHCR, to transition refugee management from a purely humanitarian approach to a development-oriented, area-based model that also benefits host communities.[4] However, these policy ambitions face practical implementation gaps, particularly in regions where local government structures, education systems, and child protection services are already overstretched.

3.2 Specific Challenges in Nairobi, Turkana (Kakuma), and Garissa (Dadaab)

The challenges facing refugee and host communities in Kenya vary significantly depending on geographic location, infrastructure capacity, security dynamics, and the level of humanitarian assistance available.

Nairobi is home to some urban refugees primarily residing in informal settlements such as Eastleigh, Kayole/Umoja, and Kawangware. These refugees often lack formal documentation and legal recognition, rendering them invisible within policy frameworks and vulnerable to arrest, police harassment, and exploitation.[5] Refugee children in urban areas face significant risks, including school dropout, early child labour, violence, violence against girls and women, and gang involvement. The urban setting is further complicated by weak coordination between humanitarian actors and government service providers, limited funding for urban refugee programming, and policy gaps in extending refugee rights outside of camps.[6]

Turkana County, home to Kakuma Refugee Camp and the Kalobeyei Integrated Settlement, is the second-largest refugee-hosting region in the country.[7]

1 The Operational Data Portal (ODP) for Kenya
2 Department of Refugee Services - Kenya Operation Statistics 2025
3 The Refugees Act, 2021
4 The Shirika Plan for Refugees and Host Communities
5 Urban Refugees in Nairobi - Tackling barriers to access sing housing, services, and infrastructure
6 Refugee Welfare in Kenya: Challenges and Solutions
7 Research Briefing: Business and the Local Economic Development

The county is arid and semi-arid (ASAL) and faces chronic food insecurity, water scarcity, and poor road infrastructure. Both refugees and host communities suffer from limited access to quality health care, under-resourced schools, and competition over scarce resources. Children in this setting often experience malnutrition, limited psychosocial support, and overstretched child protection systems.[8] While the Kalobeyei Integrated Settlement was designed to promote refugee-host integration and service sharing, challenges related to funding, infrastructure, and community tensions persist.[9]

Garissa County hosts the Dadaab refugee complex, which includes Hagadera, Ifo, and Dagahaley camps. Dadaab hosts majority of the refugees and asylum seekers in Kenya, mostly from Somalia.[10] The area faces long-standing humanitarian pressures, including constrained mobility due to security concerns, frequent disease outbreaks, and poor WASH infrastructure. Children, particularly unaccompanied and separated minors, are at risk of abuse, exploitation, and neglect. Education and health services remain overstretched, with high pupil-to-teacher ratios and insufficient RH services, especially for adolescent girls. The partial closure of the camps in 2016 and intermittent repatriation initiatives have further destabilized service delivery and heightened the protection risks for children and adolescents.[11]

3.3 Vulnerabilities of Unaccompanied and Separated Children

Unaccompanied and separated children are among the most vulnerable sub-populations in humanitarian crises, including refugee and displacement settings. According to the Inter-Agency Guiding Principles on Unaccompanied and Separated Children, unaccompanied children are those who have been separated from both parents and other relatives and are not being cared for by an adult legally or customarily responsible for them, while separated children are those separated from parents but may be accompanied by other relatives or caregivers.[12]

In both camp-based and urban refugee settings in Kenya, unaccompanied and separated children are significantly more likely to experience multiple and compounding protection risks, including sexual exploitation and abuse, military recruitment,[13] child labour and trafficking, neglect, isolation, and psychosocial distress, among other vulnerabilities.[14]

The transition phase between childhood and adolescence (ages 10–14) is particularly delicate, as it marks a period of rapid cognitive, emotional, and social change. If left unsupported, this stage can become a gateway to long-term psychological harm or entrenched risk behaviours.

Barriers to service access for unaccompanied and separated children include:

- Fear of authority figures due to past trauma or undocumented status,
- Weak or poorly coordinated child protection referral mechanisms,
- Overburdened or under-resourced case management systems,
- Limited disability-inclusive services, especially for children with sensory or cognitive impairments.

3.4 Institutional and Legal Landscape

Kenya's institutional and legal framework for refugee protection has evolved significantly in the past decade. The Department of Refugee Services (DRS), established under the Refugees Act, 2021 is responsible for refugee management and coordination across sectors. The Act outlines provisions for refugee registration, rights, and access to national systems, and encourages durable solutions through local integration.[15] Kenya has also adopted the National Care Reform Strategy for Children (2022–2032) which promotes family- and community-based care for vulnerable children, including unaccompanied and separated children.[16]

Despite these advances, the capacity of local systems, is insufficient to meet the growing needs of both refugees and host community children. Stakeholder coordination remains fragmented, with overlapping mandates among government departments, UN agencies, and NGOs. Services are often donor-driven and project-based, leading to gaps in coverage and sustainability. Community-level child protection structures exist but are underfunded, poorly trained, or not adequately linked to formal systems.

8 Prolonged drought and governance challenges in Turkana County, Kenya – Access to water and livelihood changes
9 Barriers to Refugee Integration in Kakuma and Kalobeyei, North-West Kenya.
10 The Operational Data Portal (ODP) for Kenya
11 Dadaab's Silent Crisis - An International Call for Climate Justice
12 Inter-agency Guiding Principles on Unaccompanied and Separated Children
13 Vulnerability of unaccompanied and separated child migrants
14 No Safe Place: Violence among Unaccompanied Refugee Children Seeking Asylum in Kenya.
15 The Refugee Act, 2021
16 Kenya National Care Reform Strategy 2022 - 2032

4.0 Study Findings

4.1 Demographic Characteristics of Respondents

Geographical Distribution of Respondents: The survey collected information from caregivers/ heads of households of unaccompanied and separated children, and refugee children in three different counties in Kenya; Nairobi, Turkana and Garissa. The assessment established that out of the 361 surveyed respondents, 133 were from Nairobi (Kayole, Kawangware, Kasarani and Eastleigh), 118 were from Garissa (Dadaab) and 110 were from Turkana (Kakuma and Kalobeyei). By achieving a total of 361 surveys against a target of 384, the assessment reported a response rate of 94.01%.

Region	Frequency	Percentage
Nairobi	133	36.8%
Dadaab	118	32.7%
Kakuma	110	30.5%
Total	361	100.0%

Table 6: Geographical distribution of respondents

Gender Distribution: Among the surveyed respondents, majority were female comprising of 65.1% of the respondents compared to the male, who represented 34.9% of the respondents. In comparison per county, Nairobi recorded the highest number of female respondents at 82.7% compared to Garissa and Turkana who reached 58.5% and 50.9% female respondents respectively. Among the male respondents, Turkana recorded the highest number (49.1%) while Nairobi reached the least number of male respondents (17.3%).

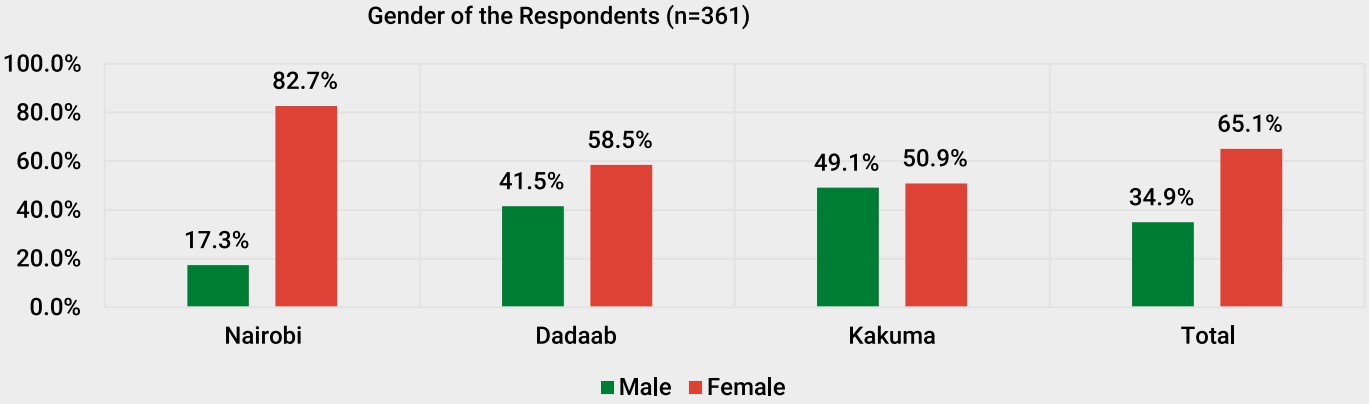


Figure 1: Gender distribution of respondents

Age Distribution: Majority, 36.3% surveyed respondents were aged between 31-40 years. The second largest age group of respondents reached were between 25-30 years, comprising 24.1% respondents. Respondents between 41-50 years followed closely, with 20.2% of the respondents falling into this category. There were only 3.0% of respondents below the age of 18 years. Respondents above 50 years accounted for 9.1% of the respondents.

	Nairobi	Dadaab	Kakuma	Total
Below 18 years	0.0%	0.0%	10.0%	3.0%
Between 18-24 years	9.0%	6.8%	5.5%	7.2%
Between 25-30 years	21.1%	29.7%	21.8%	24.1%
Between 31-40 years	41.4%	28.8%	38.2%	36.3%
Between 41-50 years	20.3%	22.0%	18.2%	20.2%
Above 50 years	8.3%	12.7%	6.4%	9.1%
Total	100.0%	100.0%	100.0%	100.0%

Table 7: Age distribution of respondents

Education Status: The levels of education of respondents varied with the majority, 33.5% having attained primary school education. Only 7.2% and 4.4% of the respondents attained tertiary/college education and university education respectively. Findings revealed that 3.6% and 11.9% of respondents attained Madrassa education {the traditional Islamic system of education focused on religious studies, primarily the Quran, Hadith (sayings of the Prophet Muhammad), and Fiqh (Islamic jurisprudence)} in Turkana and Garissa Counties, respectively accounting for 5.0% of the respondents. Only 2.1% of respondents attained secondary education. The study, however, noted that the second largest group, 27.4% of respondents, had no formal education. In this category, the majority, 47.5%, were from Garissa followed by Nairobi (21.1%) while only 13.6% came from Turkana.

Level of Education of Responsdents (n=361)

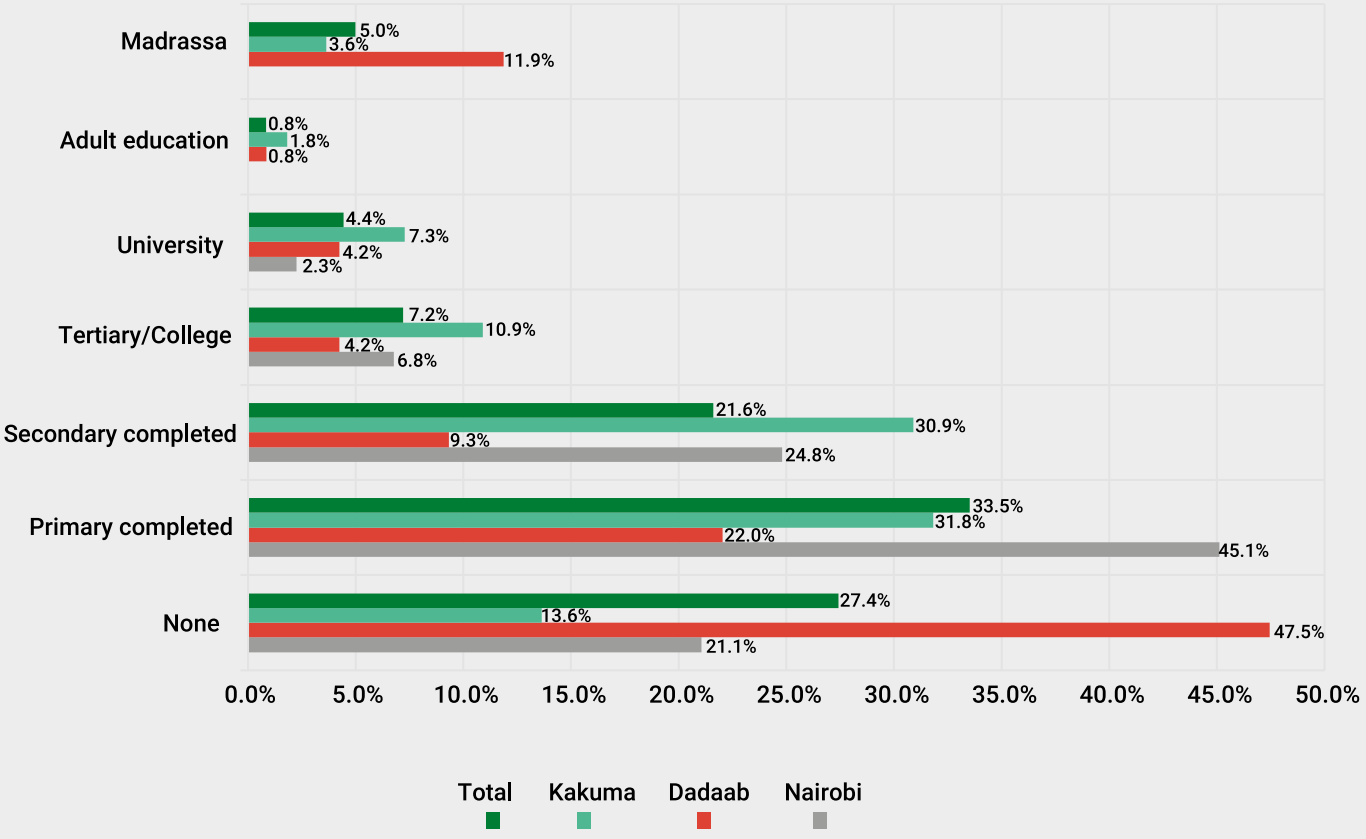


Figure 2: Level of education of respondents

Legal Status of Respondents: Among the respondents reached, majority of the respondents identified themselves as registered refugees, accounting for 93.1% of the surveyed population. This was followed distantly by respondents who identified themselves as asylum seekers at 4.4%.

Only 1.7% of respondents indicated that they came from host communities. The study noted that 0.8% were unregistered migrants, with 1.5% and 0.9% respondents reporting to be from this category from Nairobi and Turkana respectively.

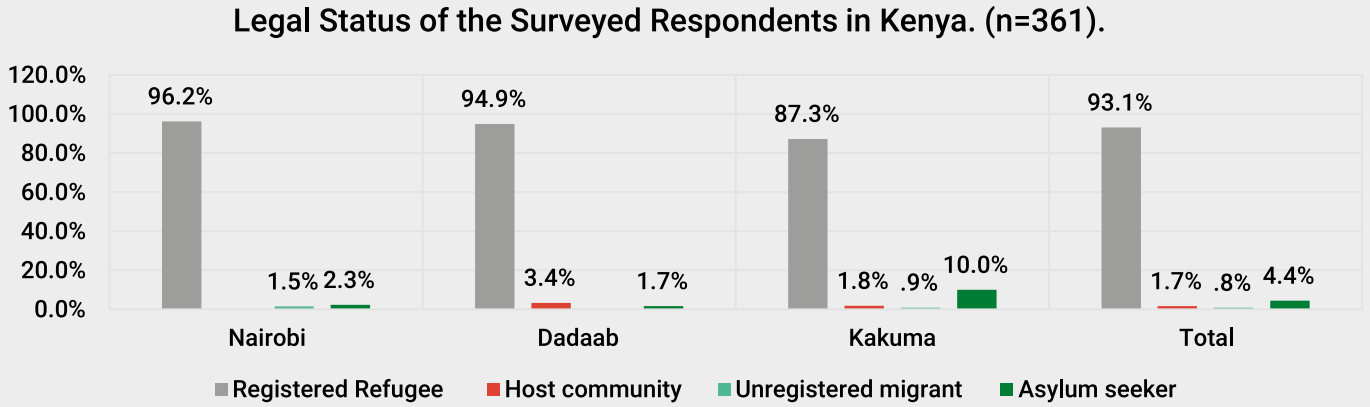


Figure 3: Legal status of the respondents

Parental Status: Among the surveyed respondents, the majority, 89.5% were the caregivers of separated, unaccompanied and separated children between the ages 10-14 years. This was reported by 96.4% respondents from Turkana, 89.0% from Garissa and 84.2% from Nairobi.

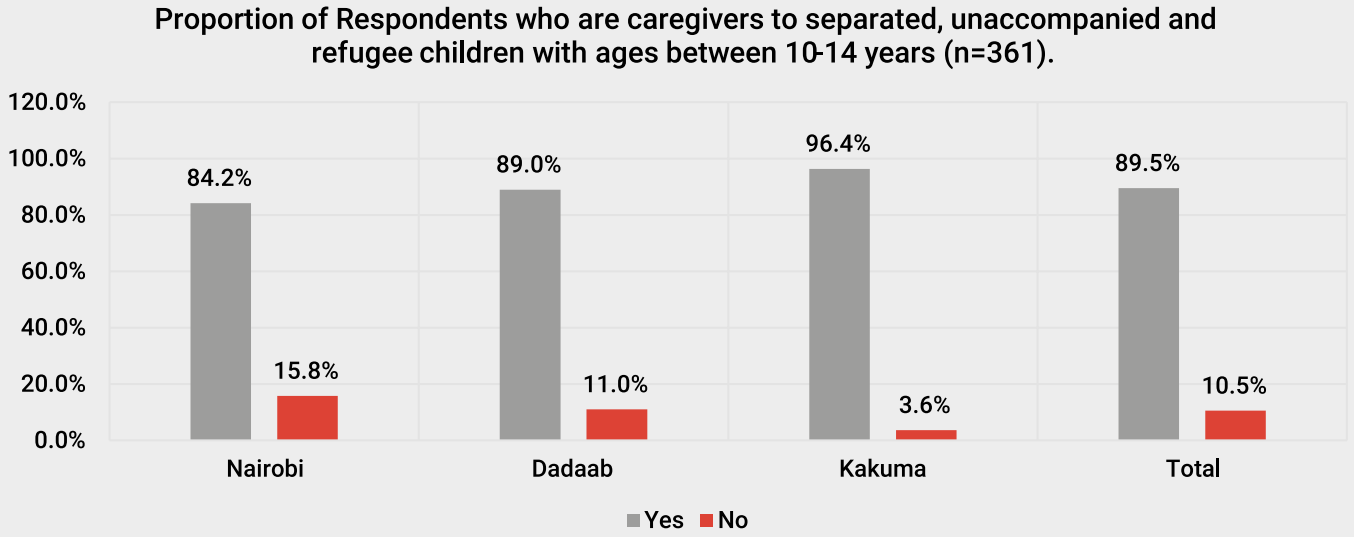


Figure 4: Proportion of respondents who are caregivers to separated, unaccompanied and refugee children with ages between 10-14 years.

Disability Status of Respondents: There were 10.0% (36) respondents who identified themselves as living with disability, compared to 89.2% who reported no form of any disability. Among the respondents with disabilities, 54.8% had physical forms of disabilities, 19.4% had visual impairments, 12.9% had hearing impairments, while only 6.5% had psychosocial challenges. The study noted that only 17.1% of the respondents with any forms of disabilities were registered with the National Council for Persons with Disabilities (NCPWDs). Form of Disability Nairobi (n=15)

Form of Disability	Nairobi (n=15)	Dadaab (n=8)	Kakuma (n=13)	Total (n=36
Physical	40.0%	33.3%	90.0%	54.8%
Speech	13.3%	0.0%	0.0%	6.5%
Hearing	20.0%	16.7%	0.0%	12.9%
Visual	13.3%	50.0%	10.0%	19.4%
Psychosocial	13.3%	0.0%	0.0%	6.5%
Other	13.3%	0.0%	0.0%	6.5%

Table 8: Disability status of respondents

Visual Impairment: Among the respondents with visual impairments, 62.9% had no difficulty seeing if wearing glasses, 34.3% had some difficulty while 2.9% had a lot of difficulty seeing even if wearing glasses, with the majority coming from Garissa (12.5%).

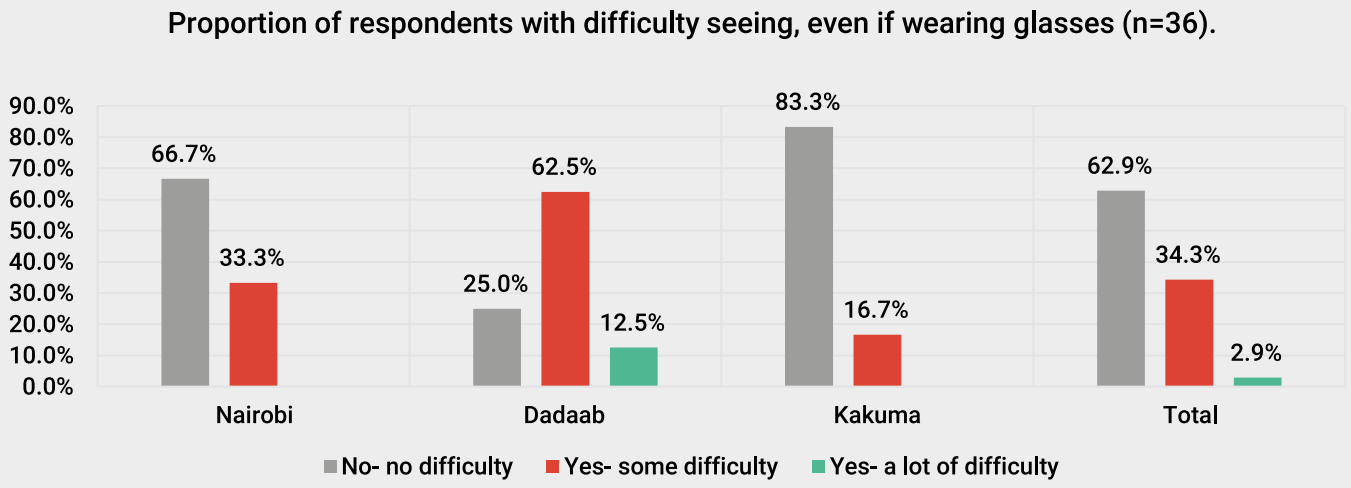


Figure 5: Proportion of respondents with difficulty seeing, even if wearing glasses.

Hearing Impairment: The findings established that 11.4% respondents had a lot of difficulty hearing even if using hearing aids, 11.4% had some difficulty while 77.1% had no difficulty.

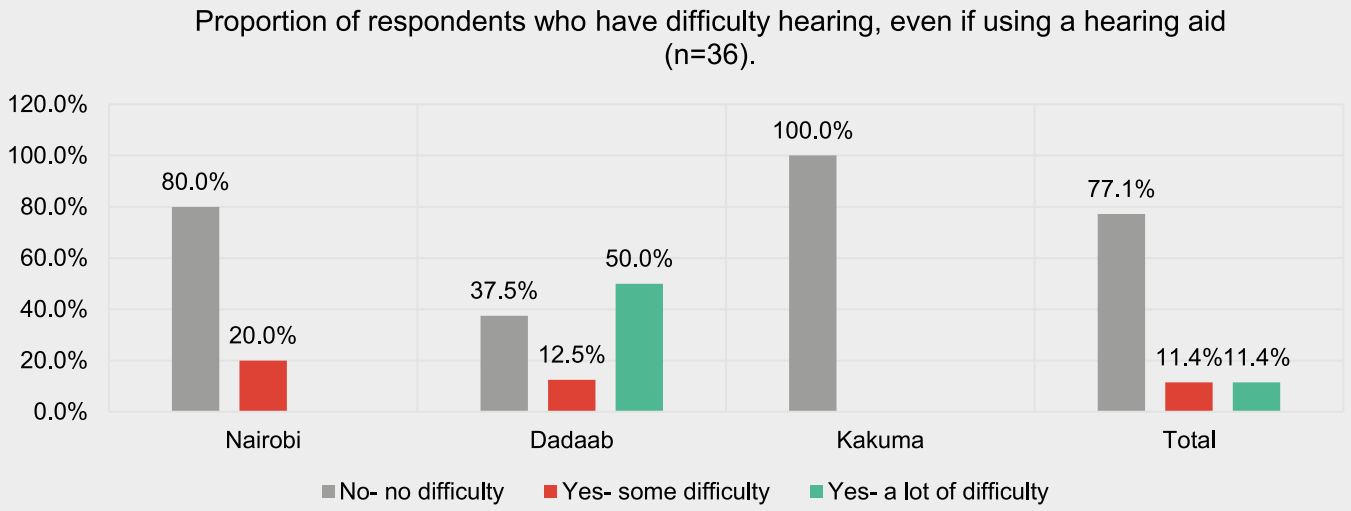


Figure 6: Proportion of respondents who have difficulty hearing, even if using a hearing aid.

Physical Disability: Among the respondents with the forms of physical disabilities, 22.9% had a lot of difficulty walking while 2.9% could not walk at all. 25.7% reported that they had some difficulty walking while the majority, 48.6%, indicated that they had no difficulty walking.

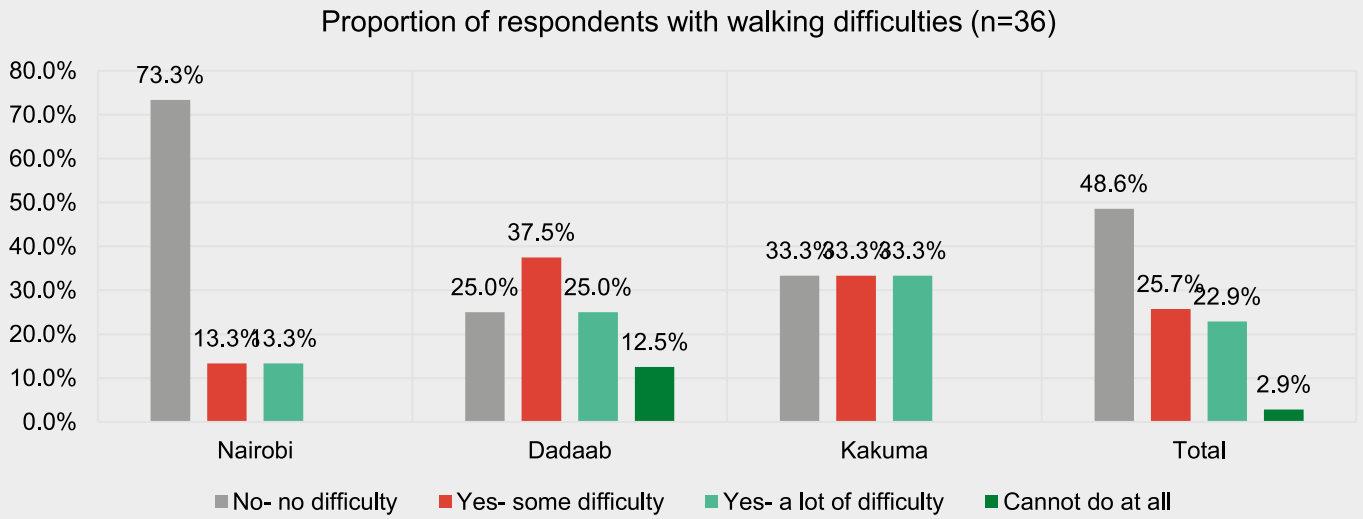


Figure 7: Proportion of respondents with walking difficulties

Concentration Difficulties: Findings revealed that a larger proportion of respondents, 68.6% had no difficulty concentrating. On the other hand, 20.0% had some difficulty, 8.6% had a lot of difficulty while only 2.9% could not concentrate at all.

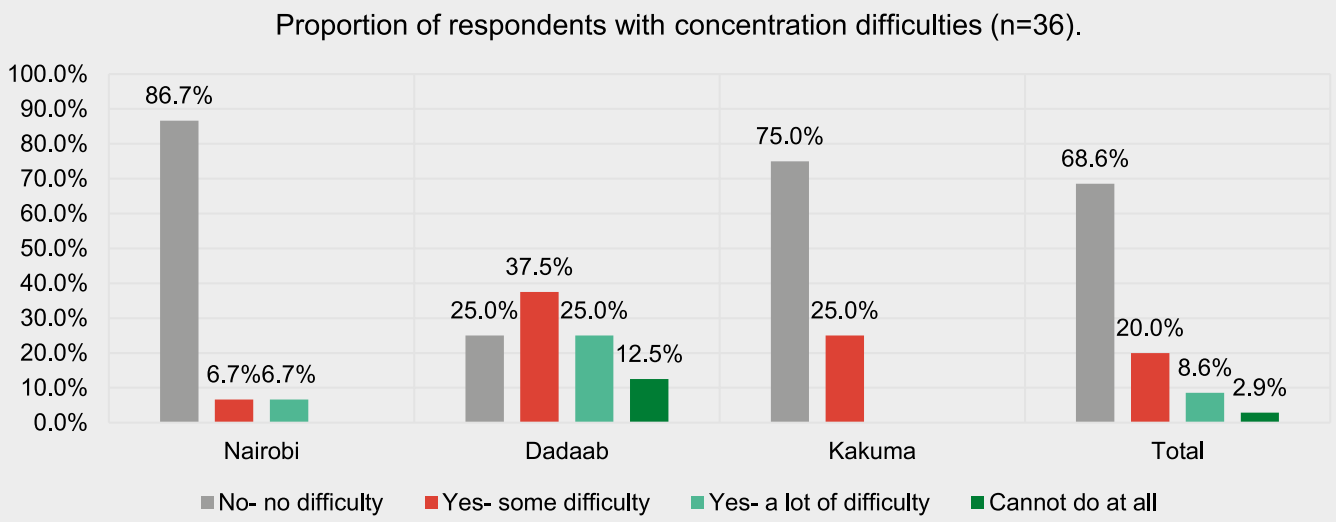


Figure 8: Proportion of respondents with concentration difficulties

Respondents with difficulties providing self-care: When asked whether they have difficulties with self-care such as washing all over or dressing, many respondents, 74.3% reported that they had no difficulty, 14.3% had some difficulty while only 11.4% had a lot of difficulty. Majority of respondents with a lot of difficulty in providing self-care were reported from Garissa (37.5%) followed by Turkana (8.3%).

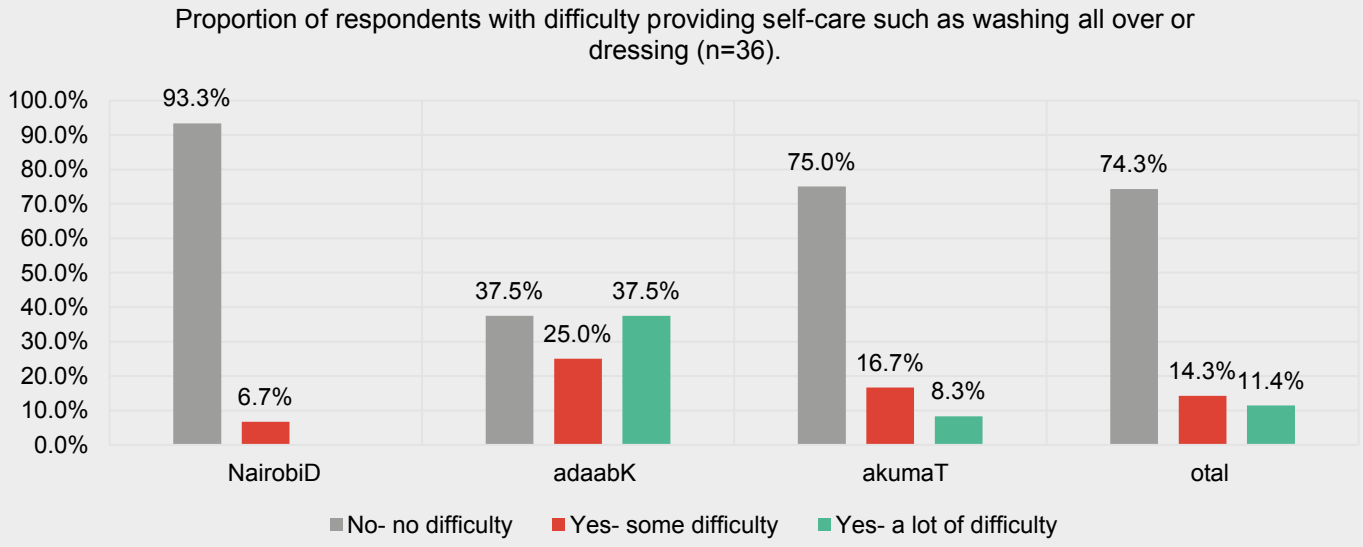


Figure 9: Proportion of respondents with difficulty providing self-care such as washing all over or dressing.

Speech Impairment: 88.6% respondents from the three counties reported that they had no difficulty communicating compared to 8.6% who reported that they had some difficulty communicating.

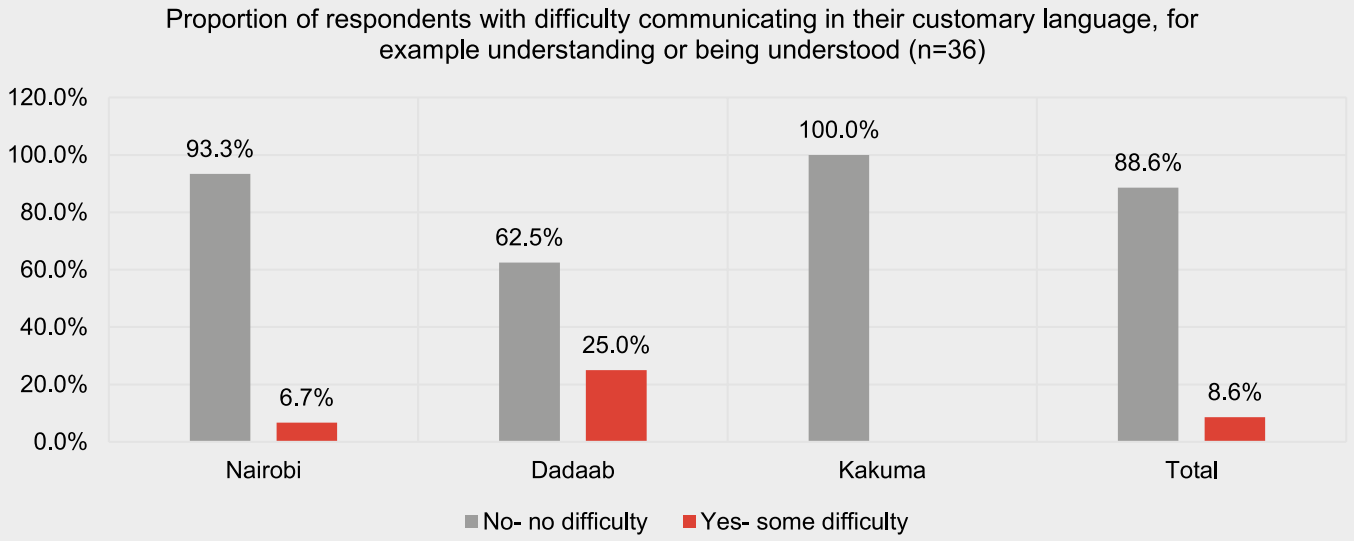


Figure 10: Proportion of respondents with difficulty communicating in their customary language.

4.2 Findings by Thematic Area

4.2.1 Child Protection

The needs assessment explored key child protection concerns affecting unaccompanied and separated children across Nairobi, Garissa, and Turkana counties. It focused on understanding the presence of unaccompanied and separated children in communities, the risks they may face, their priority needs, contributing factors to abuse, and available reporting mechanisms. This section presents the findings related to child protection within the assessed locations.

#Presence of Unaccompanied and Separated Children. The needs assessment revealed a widespread presence of unaccompanied and separated children aged 10–14 across the targeted communities. Overall, 94.7% of survey respondents reported that unaccompanied and separated children are present within their communities. This perception was highest in Turkana County (98.1%), followed by Nairobi (94.6%) and Garissa (91.4%). Conversely, only 5.3% of respondents indicated that they were not aware of any unaccompanied and separated children in their areas, 8.6% in Garissa, 5.4% in Nairobi, and 1.9% in Turkana. These findings suggest that the presence of unaccompanied and separated children is widely recognized by community members across all three counties. The distribution of these perceptions is illustrated in Figure 11.

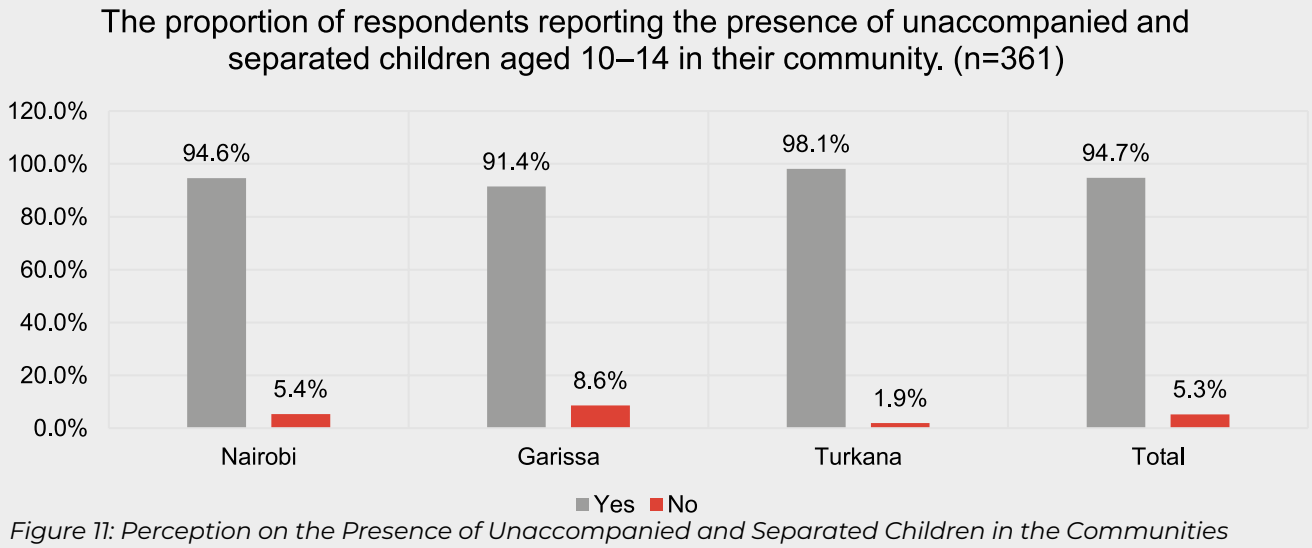


Figure 11: Perception on the Presence of Unaccompanied and Separated Children in the Communities

Challenges Faced by Unaccompanied and Separated Children

The needs assessment revealed that unaccompanied and separated children are exposed to multiple and overlapping risks that compromise their physical safety, emotional stability, and long-term development. Quantitative data highlights several critical protection concerns: child labour (71.6%), physical abuse (70.9%), neglect (56.2%), child marriage (54.9%), sexual abuse (52.0%), mental and emotional abuse (49.7%), and alcohol and drug abuse (35.6%). These risks were consistently reported across all assessment locations in Nairobi, Garissa, and Turkana, reflecting a widespread protection crisis for unaccompanied and separated children in refugee communities. The challenges faced by unaccompanied and separated children are illustrated in Figure 12.

Challenges Faced by Unaccompanied & Separated Children

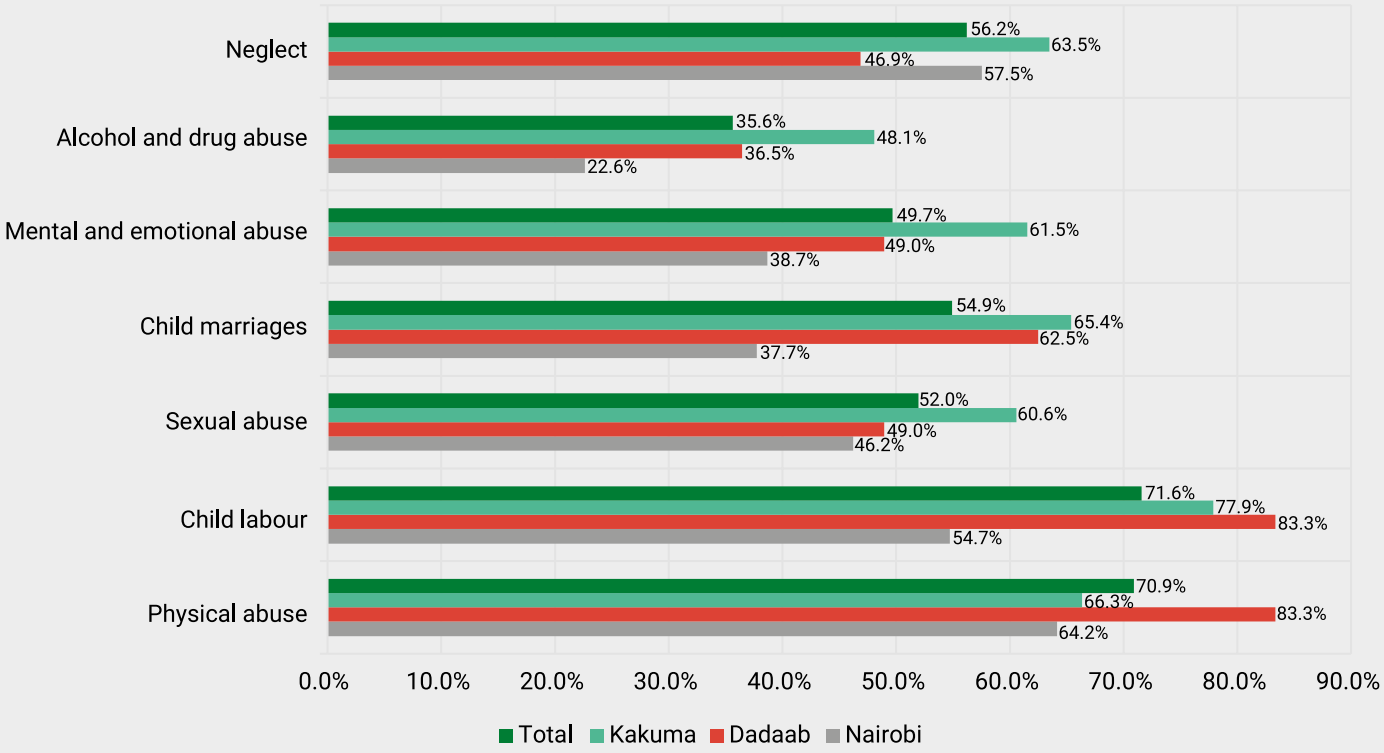


Figure 12: Challenges Faced by Unaccompanied Children

Upon further probing, the respondents revealed their perception of the categories of the most affected children. The respondents perceive that unaccompanied children (75.2%) are the most affected group, followed by unaccompanied and separated children (68.0%), children with disabilities (63.4%), girls (68.0%), and boys (31.4%).

These figures were strongly supported by qualitative insights gathered through focus group discussions, key informant interviews, and case studies, which painted a detailed picture of the day-to-day challenges faced by unaccompanied and separated children.

Child Labor

Children without adult care or supervision are often burdened with economic responsibilities. Girls reported being engaged in domestic chores such as cooking, cleaning, fetching water, and vending to support their households.

While some of these activities are considered culturally acceptable, they at times cross into exploitative territory, particularly when they interfere with school attendance or place children in unsafe environments.

Boys shared experiences of engaging in physically demanding and unsafe work, including scavenging for scrap metal (mabati), performing informal construction work, and doing errands for meagre compensation. In some cases, boys reported being paid in food. These forms of labour increase children's exposure to harm, disrupt their education, and contribute to long-term physical and psychological strain.

> Girls within the communities are exposed to child labor, working in different households to earn a living for their families. For example, some of the girls do the work on behalf of their parents, doing washing and cleaning and fetching water for other families when their parents are unwell or engaged in other activities.
>
> *– FGD with Unaccompanied and Separated Girls in Garissa*

> Children are often forced or coerced into work that is harmful to their health, development, and education, frequently under hazardous conditions.
>
> *– FGD with Unaccompanied and Separated Boys in Garissa*

> Girls within the communities are abused physically either by their parents, guardians, caregivers, or an elder. For instance, they are forced to do an activity that, when they resist, they are beaten and hurt, causing physical injuries to their bodies.
>
> *– FGD with Unaccompanied and Separated Girls in Garissa*

> In my community, the most common risks and forms of abuse that children face are child labour and physical abuse. Personally, I am at risk of being physically beaten.
>
> *– FGD with Unaccompanied and Separated Boys in Turkana*

Physical Abuse

Physical violence is a common form of discipline in homes, reported across all assessment locations. Children described being beaten for perceived disobedience or failure to meet expectations. Boys shared that such violence often occurred without provocation, creating a pervasive sense of fear.

The normalization of physical punishment, both within households and the broader community, discourages children from reporting abuse and reinforces cycles of violence and silence.

Neglect

Neglect emerged as a challenge, manifesting as the failure to meet children's basic needs and the absence of emotional care. The respondents informed the assessment about how children, at times, go without food, clean clothing, shelter, or hygiene supplies.

Some mentioned being left to fend for themselves, engage in begging, or rely on peers for survival. Emotional neglect was also highlighted, with children expressing feelings of abandonment, invisibility, and rejection by adults in their communities.

> Most of the learners often lack food, and some come to class too hungry to concentrate or learn effectively. Another major challenge is the lack of learning materials, which makes it difficult for them to follow lessons and participate fully.
>
> *– KII with a Teacher in Nairobi*

> As a separated child, I face emotional trauma, risk of exploitation, and limited access to health and education services. My daily routine involves household chores, school, and participating in activities run by humanitarian agencies. Despite the structure, I often feel lonely and miss my parents. Like many unaccompanied children, I struggle with psychological stress, discrimination, and limited autonomy due to dependence on foster caregivers.
>
> *– Case Study with a Child in Garissa*

> The Somali community has one of the highest prevalence rates of Female Genital Mutilation (FGM) in the world, with almost all girls undergoing the procedure. In addition to FGM, child marriage is also widespread, with many girls being married off between the ages of 12 and 15.
>
> *– FGD with Unaccompanied and Separated Girls in Garissa*

Child Marriage

Early and forced marriages were reported as ongoing risks, particularly among girls in Somali and pastoralist communities. Marriages of girls as young as 12–15 years were linked to economic hardship, traditional norms, and perceived protection mechanisms. These unions interrupt education, expose girls to early pregnancies, and increase vulnerability to domestic violence. The practice is often rooted in gender norms that devalue girls' education and prioritize their domestic or reproductive roles.

Sexual Abuse

Sexual abuse remains a serious and underreported issue, especially for adolescent girls. Incidents frequently involve perpetrators known to the victims, relatives, neighbours, or other community members. Girls described being subjected to harassment, coercion, and assault, often without access to safe reporting or support services. Fear of retaliation, community stigma, and lack of awareness about rights and services contribute to a culture of silence and impunity.

> Girls in this community face all sorts of abuse like sexual, physical, and emotional abuse, which normally goes unreported due to stigma or lack of legal protection.
>
> *– FGD with Unaccompanied and Separated Girls in Garissa*

Mental and Emotional Abuse

Children also experience emotional harm in the form of verbal aggression, humiliation, constant criticism, and rejection. These experiences erode self-esteem and lead to emotional withdrawal, trauma, and symptoms of anxiety and depression. Teachers and child protection staff noted that children exposed to such abuse often struggle academically and socially, with limited access to psychosocial support services that could aid their recovery and development.

Alcohol and Drug Exposure

Substance abuse was reported as a growing concern among unaccompanied and separated children, particularly in economically vulnerable environments. Some children are exposed to alcohol and drugs through work settings or peer groups, while others are offered alcohol as a form of payment for labour.

This exposure contributes to risky behaviors, school dropout, and involvement in informal criminal networks. The presence of substances in children's immediate environments deepens their vulnerability and social exclusion.

> We face numerous challenges in our daily lives. Some of us are introduced to drugs and alcohol, while others struggle with a lack of school fees and food. These hardships often force us to drop out of school and start hustling at a young age just to survive. Unlike other children, we lack basic necessities such as proper clothing, school uniforms, and enough food.
>
> *– FGD with Girls in Nairobi*

> Some get paid alcohol instead of money when they have worked.
>
> *– FGD with Boys in Garissa*

Needs of Unaccompanied and Separated Children

Unaccompanied and separated children experience a wide range of needs influenced by their lack of parental care and the circumstances surrounding their separation. Their vulnerability often increases when these needs intersect or remain unmet, particularly in environments where child protection systems are weak or overstretched. The absence of consistent adult support and limited access to essential services contributes to compounding risks that affect their overall wellbeing and development.

The assessment identified several core needs that reflect the physical, emotional, social, legal, and developmental dimensions of children's lives.

These include:

- **Food and Nutrition** – Regular access to adequate and nutritious meals to support health and development.
- **Shelter and Safe Housing** – Stable, secure living environments that offer protection and dignity.
- **Education (Access and Quality)** – Opportunities for school enrolment, access to learning materials, and supportive learning environments.
- **Clothing and Hygiene Items** – Basic clothing, footwear, and personal hygiene supplies, including sanitary products.
- **Healthcare and Medical Support** – Access to health services, medication, and preventive care.
- **Psychosocial and Emotional Support** – Counselling, safe spaces, and structured interventions that support mental and emotional wellbeing.
- **Parental Love and Caregiving** – Presence of responsible, nurturing adults to provide consistent guidance and emotional stability.
- **Protection and Safety** – Safeguards to prevent and respond to abuse, exploitation, neglect, and violence.
- **Legal Support and Documentation** – Legal identity through birth registration and access to documentation to facilitate access to services.
- **Financial Assistance** – Resources to support basic needs such as food, education, clothing, and healthcare.
- **Guidance, Mentorship, and Life Skills** – Opportunities to develop decision-making, interpersonal, and resilience-building skills.
- **Reintegration or Family Tracing** – Support for reconnecting with family members or placement in family-based care settings.
- **Spiritual and Moral Support** – Opportunities for value-based guidance and emotional grounding.
- **Social Inclusion and Acceptance** – Environments that promote acceptance and reduce stigma or discrimination.
- **Recreational and Child-Friendly Spaces** – Safe and inclusive areas for play, creativity, and peer interaction.

Factors Contributing to Child Abuse

The assessment explored the various factors that contribute to child abuse among unaccompanied and separated children in Nairobi, Garissa, and Turkana counties. The findings suggest that child abuse is shaped by a combination of individual vulnerabilities, weakened community protection systems, and household-level socio-economic conditions.

One of the most commonly identified contributors to child abuse is the status of being unaccompanied. Across the three counties, 74.8% of respondents linked unaccompanied status to increased exposure to harm. Children who are orphaned were also seen as particularly vulnerable, with 67.3% of respondents identifying orphanhood as a contributing factor.

Neglect by caregivers or the community was mentioned by 57.8% of respondents, indicating that the absence of consistent adult supervision or care may leave children unprotected in high-risk environments. Inadequate access to education was cited by 55.9% of respondents as a risk factor, suggesting that children who are out of school or lack access to quality learning opportunities may be more exposed to harmful practices.

Similarly, 54.6% of respondents identified the absence of support structures, such as child protection services, community safety nets, and referral systems, as contributing to children's vulnerability. Government support was seen as insufficient by 32.0% of respondents, while 30.7% highlighted the risks associated with placement in alternative care arrangements, especially when such placements lack adequate monitoring or oversight. This is captured by figure 13 below.

Factors Contributing to Increased Risk of Abuse

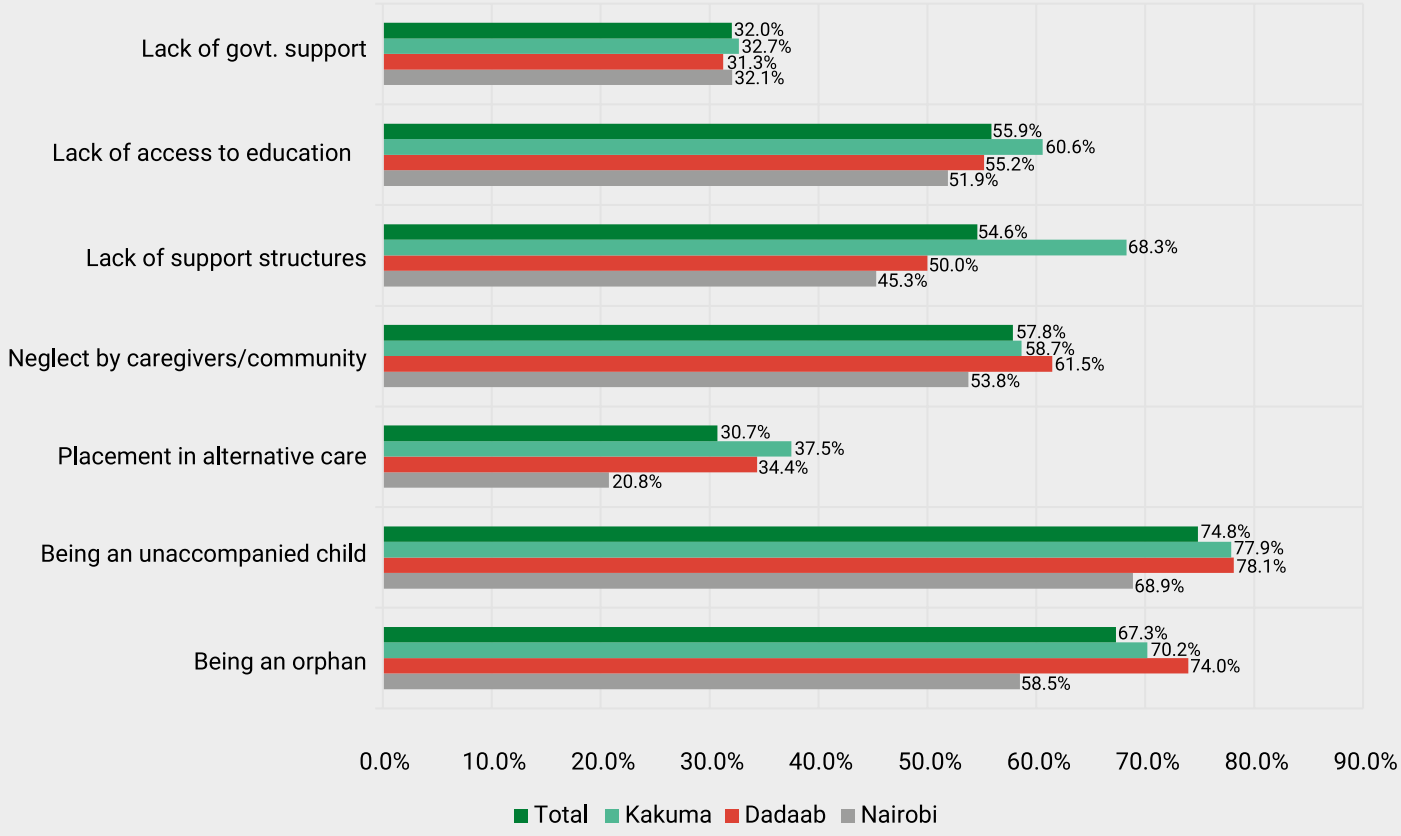


Figure 13: Factors Contributing to Risk of Abuse.

The assessment also examined household-level factors contributing to violations of children's rights. Financial instability emerged as the most widely recognized issue, reported by 76.1% of respondents.

Households struggling with income insecurity are often unable to provide consistent care or meet the basic needs of children. Poor parenting practices were mentioned by 66.3% of respondents, while neglect by caregivers was cited by 56.9%, highlighting gaps in the ability or willingness of adults to offer adequate protection and guidance.

Access to essential resources was another area of concern. Inadequate access to food, water, healthcare, education, and shelter was identified by 43.5% of respondents as a factor that can increase children's risk of abuse and neglect. In addition, strained relationships within communities, specifically between host and refugee populations, were also noted. Poor relationships with host communities were cited by 31.4% of respondents, while 26.1% pointed to poor relationships with refugees as contributing to tension and, in some cases, increased vulnerability for children.

Household Factors that Contribute to Children's Rights Violations

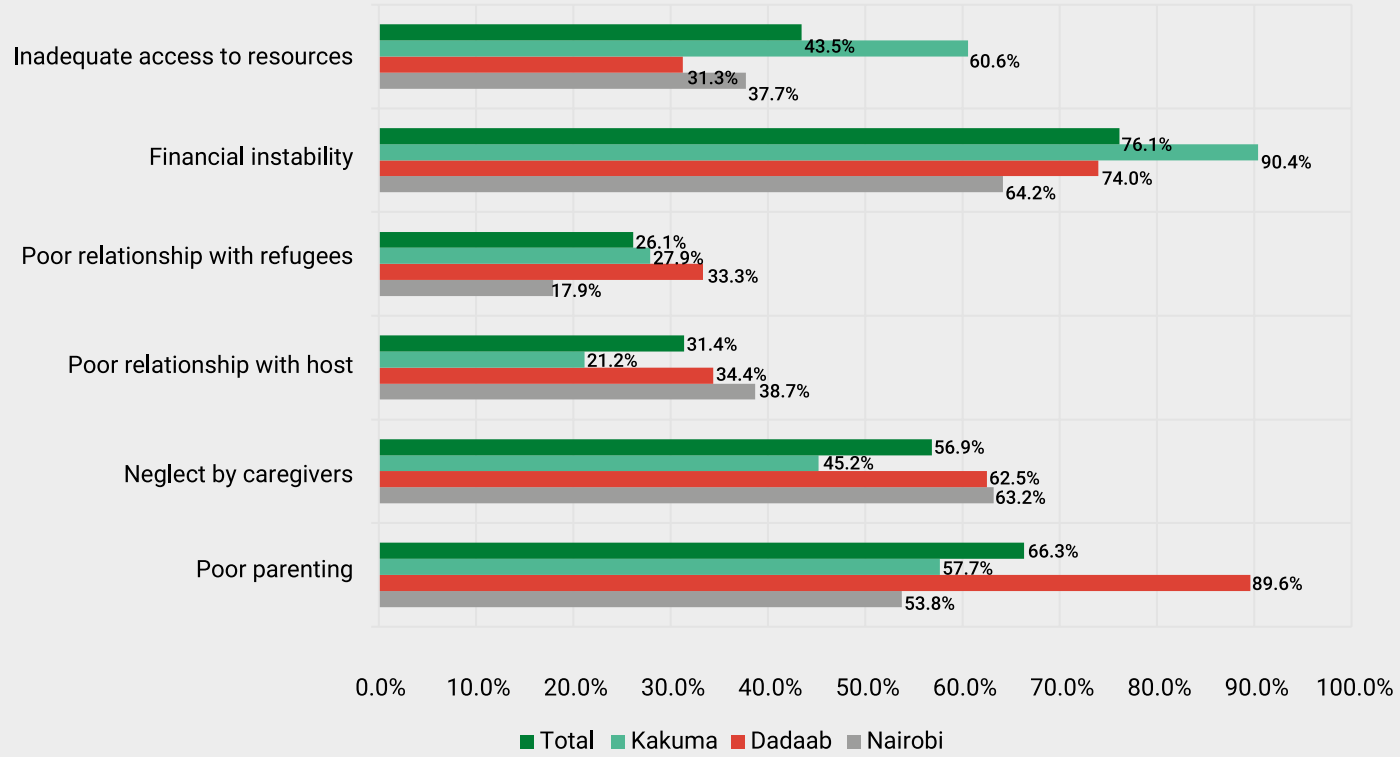


Figure 14: Household Factors that Contribute to Unaccompanied and Separated Children's Rights Violations.

Reporting Mechanisms and Services Offered

The assessment identified several channels used by community members in Turkana, Garissa, and Nairobi to report cases of child abuse, neglect, or exploitation. Respondents cited a variety of reporting mechanisms, reflecting both formal and informal structures within their communities.

The most frequently mentioned reporting avenue was the police, identified by 67.0% of respondents. This was followed by child protection officers, mentioned by 55.6%, and caregivers or family members, cited by 49.0%. Humanitarian workers were reported as points of contact by 37.9% of respondents, while local chiefs were mentioned by 34.3%.

Reporting Mechanisms for Cases of Child Abuse

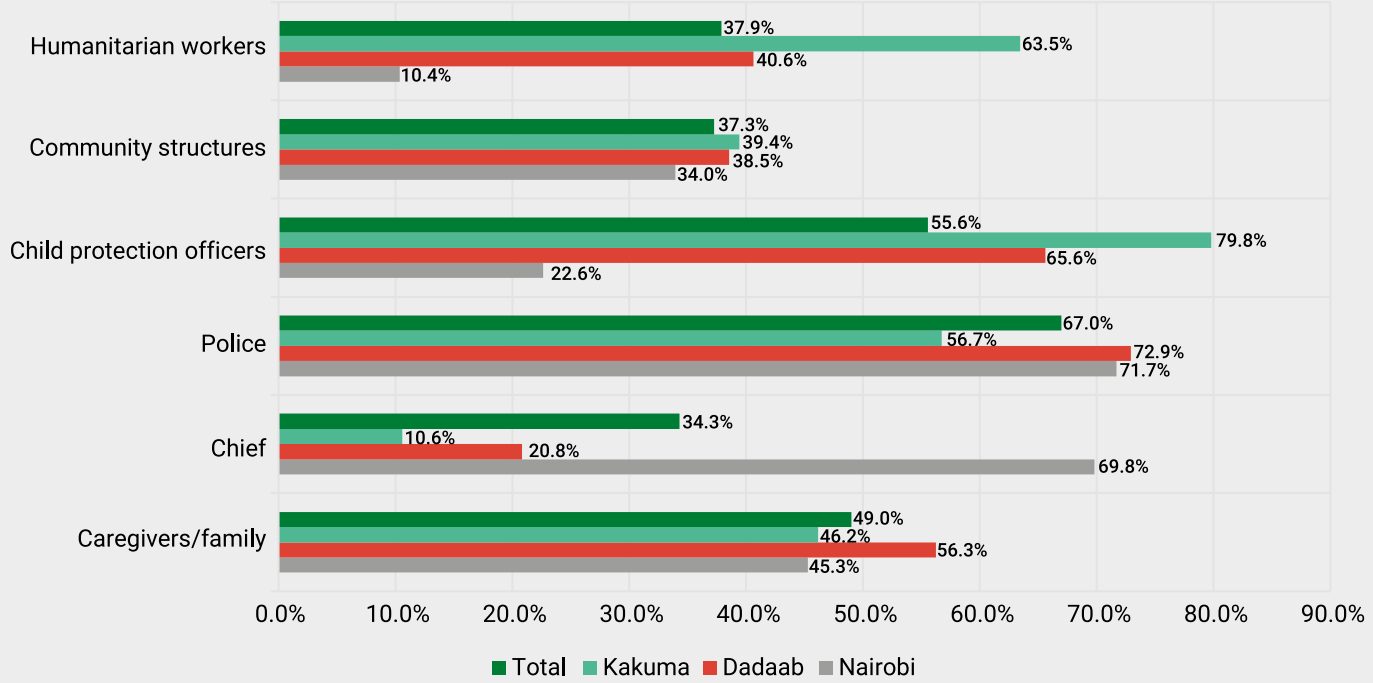


Figure 15: Reporting Mechanisms for Cases of Child Abuse

> We respond to child abuse by reporting it to trusted adults, such as parents, teachers, or community members, and seeking help from authorities like the police or child protection officers. Support can also be found through NGOs, shelters, or helplines. We confide in friends or relatives for emotional support, document the abuse, and seek medical care when needed.
>
> *– FGD with Unaccompanied and Separated Girls in Garissa*

4.2.2 Health, Nutrition, and RH

This section explores key aspects of the health and well-being of unaccompanied and separated children aged 10–14 years across the target locations, with a focus on physical health, nutrition, and reproductive health (RH).

The assessment examined the availability and accessibility of essential health services, perceptions of nutritional wellbeing, and the existence of RH-related concerns among children. It also sought to understand how children and caregivers experience and respond to challenges in these areas.

Common Health Issues/ Diseases

The needs assessment identified several health conditions commonly affecting unaccompanied and separated children across the target locations. These include malaria, malnutrition, pneumonia and other respiratory infections, diarrheal diseases, skin infections and conditions, anemia, mental health issues, cholera and other waterborne diseases, HIV/AIDS, tuberculosis (TB), measles, and urinary tract infections (UTIs).

Insights from focus group discussions further revealed that these health challenges have a broad impact on children's daily lives and overall wellbeing. Respondents noted that illness can limit children's participation in education, either by forcing them to miss school or by affecting their concentration and performance. Some children reportedly experience embarrassment or stigma related to visible or chronic conditions. In more severe cases, health issues were said to place children at risk of long-term developmental setbacks or life-threatening complications, particularly in contexts with limited access to timely medical care and treatment.

> In our community, unaccompanied and separated girls face numerous health challenges, both physical and mental. One of the most pressing issues is poor menstrual hygiene, mainly due to limited access to sanitary products and clean water. This often leads to infections and feelings of shame, causing some girls to miss school." "Teenage pregnancies are also common, disrupting girls' education and exposing them to serious health risks. Additionally, poverty contributes to poor nutrition, some girls attend school without having eaten, which affects their concentration, well-being, and overall health.
>
> *– FGD with Unaccompanied and Separated Girls in Nairobi*

> In our community, children face a high prevalence of infectious diseases, largely due to poor sanitation and hygiene. Diarrheal illnesses such as cholera, typhoid, and dysentery are common, often resulting from contaminated water and inadequate waste management. Malaria is another significant concern, especially as cases are brought in from endemic areas, putting children at particular risk." "Respiratory infections are widespread, largely due to overcrowded living conditions and exposure to indoor air pollution. Skin conditions like ringworm are also common, stemming from poor hygiene and close physical contact among children. Many children suffer from intestinal worms, which are closely linked to unclean environments and the lack of safe drinking water." "Malnutrition is a persistent issue, with many children unable to access adequate and nutritious food. The impact of HIV/AIDS is also notable, particularly for children who are orphaned or living in households affected by the virus. In some cases, tuberculosis (TB) is reported, often occurring alongside HIV.
>
> *– FGD with Unaccompanied and Separated Boys in Garissa*

Access to Healthcare

The assessment explored the extent to which unaccompanied and separated children are able to access quality healthcare services across the target counties. Overall, 31.3% of survey respondents indicated that unaccompanied and separated children have access to quality healthcare.

Disaggregated by location, 50.5% of respondents in Garissa, 25.9% in Nairobi, and 17.9% in Turkana reported access to quality healthcare services. In contrast, 68.7% of respondents stated that unaccompanied and separated children do not have access to healthcare services, with the highest proportion reported in Turkana (82.1%), followed by Nairobi (74.1%) and Garissa (49.5%).

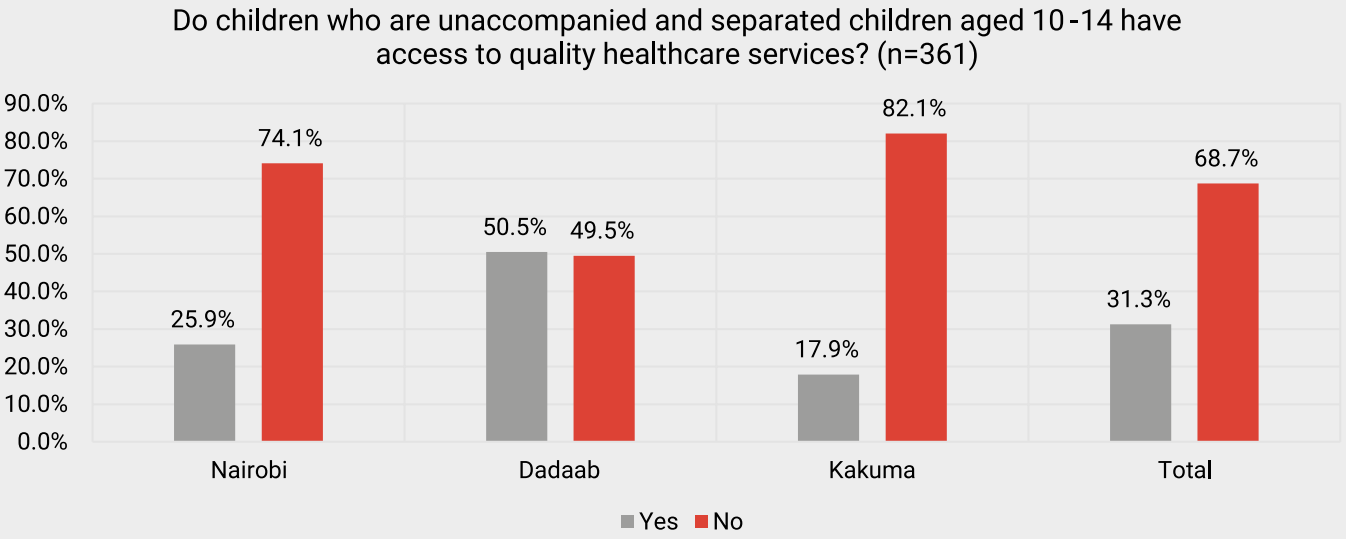


Figure 16: Perception on Unaccompanied and Separated Children's Access to Quality Healthcare Services.

Among those respondents who affirmed access to healthcare, respondents identified a range of services available to unaccompanied and separated children. These include general treatment (73.3%), nutritional support (46.5%), psychosocial and mental health services (39.6%), preventive care or wellness visits (32.7%), and reproductive health services (30.7%).

However, focus group discussions revealed gaps between availability and actual accessibility. In some cases, children reported being unable to access needed healthcare services due to various barriers such as distance, cost, or lack of documentation. When formal services were unavailable, children reported relying on home remedies, prayer, or herbal medicine as alternative forms of care.

> There was a time I became very sick and wasn't taken to the hospital. It was during the rainy season, and I had a high fever, body aches, and was vomiting a lot. I believe it was malaria. My mother tried to treat me with home remedies like hot water and herbs, but they didn't help."
>
> My father insisted we wait and pray, saying we shouldn't go to the clinic unless the situation was very serious. I was bedridden for nearly a week. I missed school, and I was really scared, I thought I might die.
>
> *– FGD with Girls in Garissa*

> I use herbal medicine instead, but it takes a long time to feel better.
>
> *– FGD with Girls in Turkana*

Challenges Preventing Access to Healthcare

The needs assessment identified several barriers that limit unaccompanied and separated children from accessing healthcare services.

According to survey responses, the most frequently mentioned challenges include poor service provision by healthcare providers (60.1%), neglect (55.4%), lack of available healthcare services (52.9%), and limited knowledge or awareness of available services (50.8%).

Additionally, cultural practices and traditions were cited by 23.5% of respondents, while religious beliefs were mentioned by 14.2% as contributing factors.

Barriers at the Community Level that Prevent Children from Accessing Healthcare

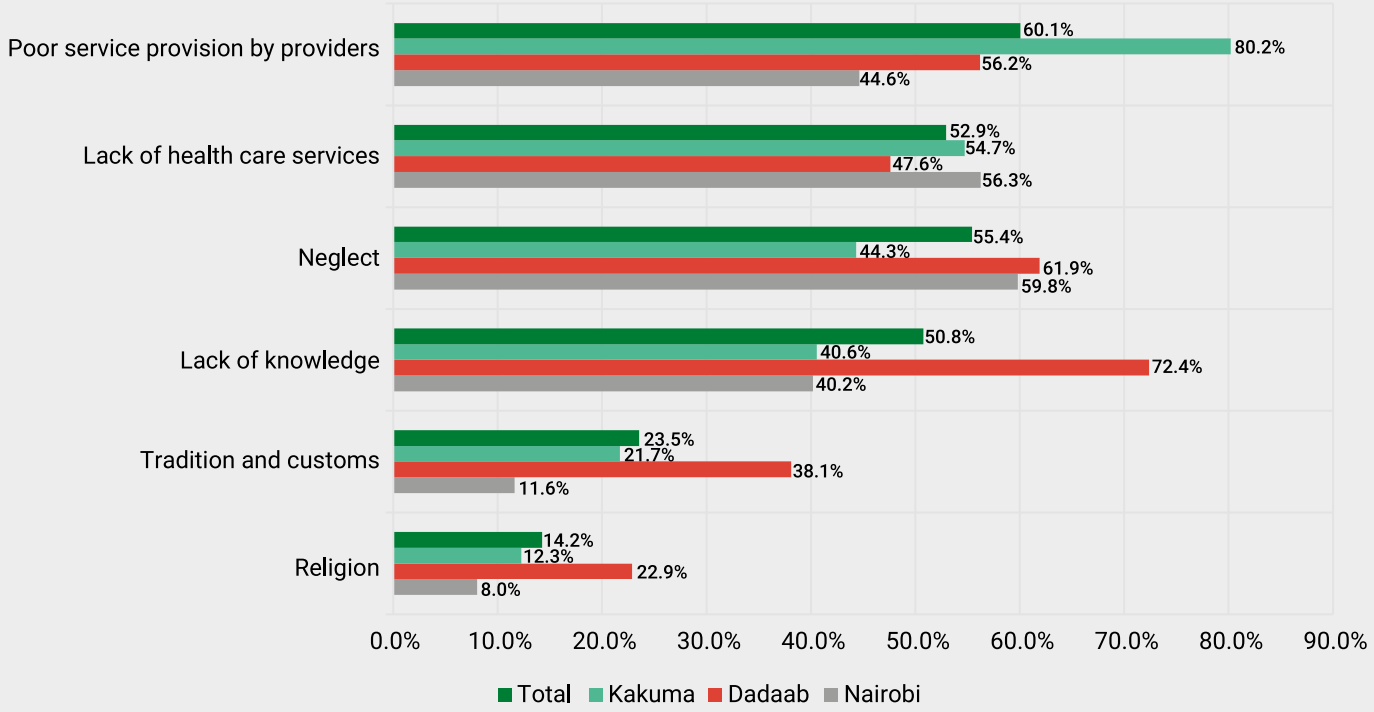


Figure 17: Barriers at the Community Level that Prevent Unaccompanied and Separated Children from Accessing Healthcare

Qualitative insights gathered from focus group discussions and interviews provided a deeper understanding of these barriers. Financial constraints were cited, with caregivers and children reporting that healthcare services were unaffordable due to out-of-pocket costs for treatment and transportation. In many cases, health facilities are located far from where the children reside, making access difficult, especially in emergencies or for those without means of transport.

Other reported challenges included overcrowded health facilities, long waiting times, and limited availability of qualified healthcare personnel, all of which discourage timely care-seeking.

Lack of official identification documents also emerged as a significant barrier, particularly for refugee or displaced children, some of whom reported facing harassment or denial of services due to documentation issues.

Social and psychological barriers were also noted. These include fear of stigma, especially when seeking sensitive services such as HIV/AIDS-related care or mental health support. Children expressed concern about being judged or excluded if seen accessing such services, further limiting their willingness to seek help.

My caregiver was at home but refused to take me to the hospital. I asked her, but she didn't respond, so I stayed quiet.

– FGD with Boys in Turkana

It's common for people here to fall sick and not go to the hospital. The main reasons are financial challenges, many families live hand to mouth and can't afford transport, consultation fees, or medication. Public hospitals are often far away, and getting there is difficult, especially during emergencies or for those who are very ill." "Sometimes people don't think their illness is serious enough to require a hospital visit, or they prefer to try traditional remedies first. Public hospitals are also overcrowded, and the long waiting times discourage many from seeking care. In some cases, fear of stigma, especially with conditions like HIV/AIDS, prevents people from going.

– FGD with Boys in Garissa

In many families here, going to the hospital is only considered when the illness is very serious because of the cost and distance. Some of us don't have identification documents, and when we go to the hospital, the police harass us.

– FGD with Girls in Nairobi

Malnutrition

Presence of Cases of Malnutrition.

The needs assessment sought to determine the prevalence and community perception of malnutrition among unaccompanied and separated children aged 10–14 years across the targeted counties of Turkana, Garissa, and Nairobi. Findings indicate that 80.1% of survey respondents were aware of cases of malnutrition affecting children in this age group within their communities.

Disaggregated data show that this perception was highest in Turkana (83.0%), followed closely by Garissa (78.9%) and Nairobi (78.6%).

Conversely, 19.9% of respondents reported that they were not aware of malnutrition cases in their areas. This included 21.4% of respondents in Nairobi, 21.2% in Garissa, and 17.0% in Turkana. These results, illustrated in Figure 18, suggest that while a majority of community members recognize malnutrition as a concern among unaccompanied and separated children, awareness varies slightly across locations.

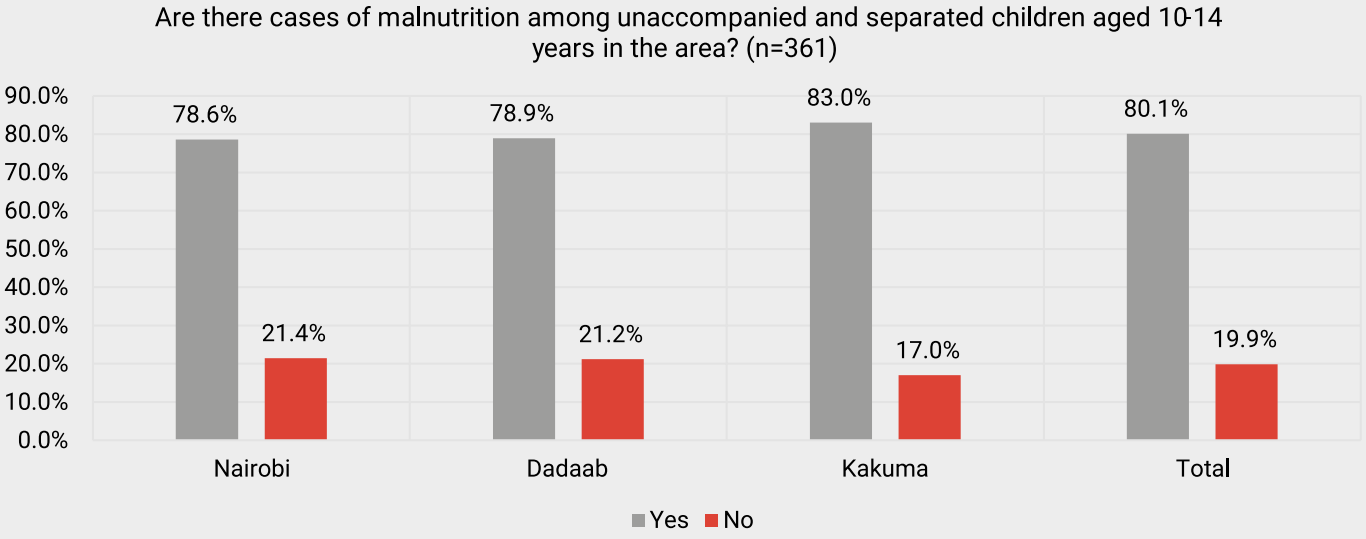


Figure 18: Perception on Presence of Cases of Malnutrition among Unaccompanied and Separated Children Aged 10-14 years within the Community.

Causes of Malnutrition

The assessment identified multiple factors contributing to malnutrition among unaccompanied and separated children. Respondents highlighted that malnutrition is often the result of intersecting social, economic, and environmental challenges.

Key contributing factors include lack of a balanced diet, driven by limited access to diverse and nutritious foods. Poverty and financial constraints were frequently mentioned, with households and caregivers struggling to afford regular meals or adequate food portions. Food insecurity and shortages, particularly in arid and semi-arid regions like Turkana and Garissa, further exacerbate the problem by reducing food availability and reliability.

Additional causes cited by respondents include poor feeding practices and inadequate nutrition programs, which limit children's access to age-appropriate dietary support. Inadequate health services, coupled with frequent disease and infections, were also seen as contributing to undernutrition, as untreated illnesses can reduce appetite and nutrient absorption.

Other reported causes include limited awareness of proper nutrition and poor hygiene and sanitation, both of which increase the risk of infections such as diarrhea and intestinal worms, thereby worsening nutritional outcomes.

> Malnutrition is caused by poverty and lack of a balanced diet.
>
> *– FGD with Unaccompanied and Separated Girls in Garissa.*

Malnutrition has significant short- and long-term effects on children's wellbeing. Physically, it weakens immunity, increases susceptibility to illness, and may lead to stunting, wasting, or developmental delays. Cognitively, malnourished children often experience reduced concentration and poor academic performance.

Emotionally, prolonged undernutrition can lead to low energy, reduced participation in social activities, and in severe cases, psychological distress. For unaccompanied and separated children, who already face multiple vulnerabilities, malnutrition compounds their risks and further undermines their growth, dignity, and future potential.[17]

> Chronically ill or malnourished children struggle to concentrate and attend school regularly.
>
> *– FGD with Unaccompanied and Separated Boys in Garissa*

Reproductive Health

Reproductive Health Issues Affecting Unaccompanied and Separated Children

The needs assessment revealed that reproductive health (RH) issues are a concern for children within the target communities.

Overall, 75.7% of survey respondents acknowledged the presence of SRH issues affecting teenage children, with the highest proportion reported in Nairobi (84.8%), followed by Turkana (83.2%) and Garissa (60.6%). Conversely, 24.3% of respondents indicated that they were not aware of any RH-related concerns affecting children, with this view most prevalent in Garissa (39.4%), followed by Turkana (18.8%) and Nairobi (15.2%).

Among respondents who reported the existence of RH challenges, several key issues were identified. Adolescent pregnancies were the most frequently mentioned, cited by 78.9% of respondents. This was followed by concerns over poor menstrual hygiene management (74.6%), increased risk of sexual abuse (70.6%), violence against girls and women (60.1%), and limited access to contraception (30.7%), as illustrated in Figure 19.

17 WHO - Malnutrition in Children

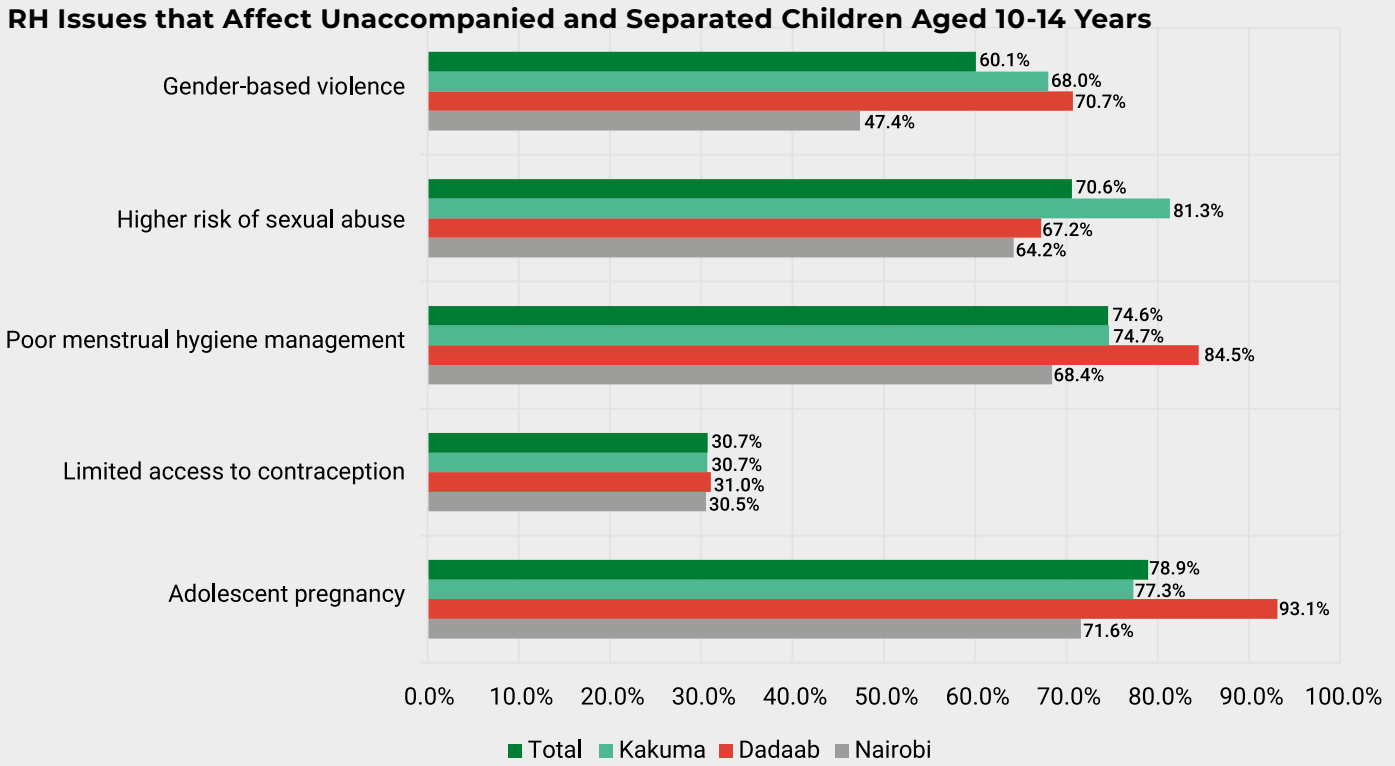


Figure 19: RH Issues that Affect Unaccompanied and Separated Children Aged 10-14 Years.

Causes of Reproductive Health Issues

The assessment explored underlying factors contributing to reproductive health issues affecting children within the target communities. Respondents identified a range of causes shaped by social, economic, and structural conditions.

The most commonly cited cause was financial constraints, mentioned by 85.5% of respondents. Economic hardship often limits access to basic needs, which can increase children's exposure to risky behaviours or exploitative situations. Poor family structure, including absence of parental guidance or unstable caregiving environments, was highlighted by 61.4% of respondents as another significant contributor.

Limited access to RH services, such as adolescent-friendly clinics, counselling, and information, was reported by 60.5% of respondents, underscoring barriers to early intervention and preventive care. Additionally, mental health challenges were mentioned by 37.3%, reflecting how stress, trauma, and emotional instability can influence decision-making and vulnerability among children. Cultural and language barriers were also noted by 30.3% of respondents, pointing to the influence of traditional beliefs, stigma, and communication challenges in shaping awareness and access to SRH information and services. This is as captured by Figure 20.

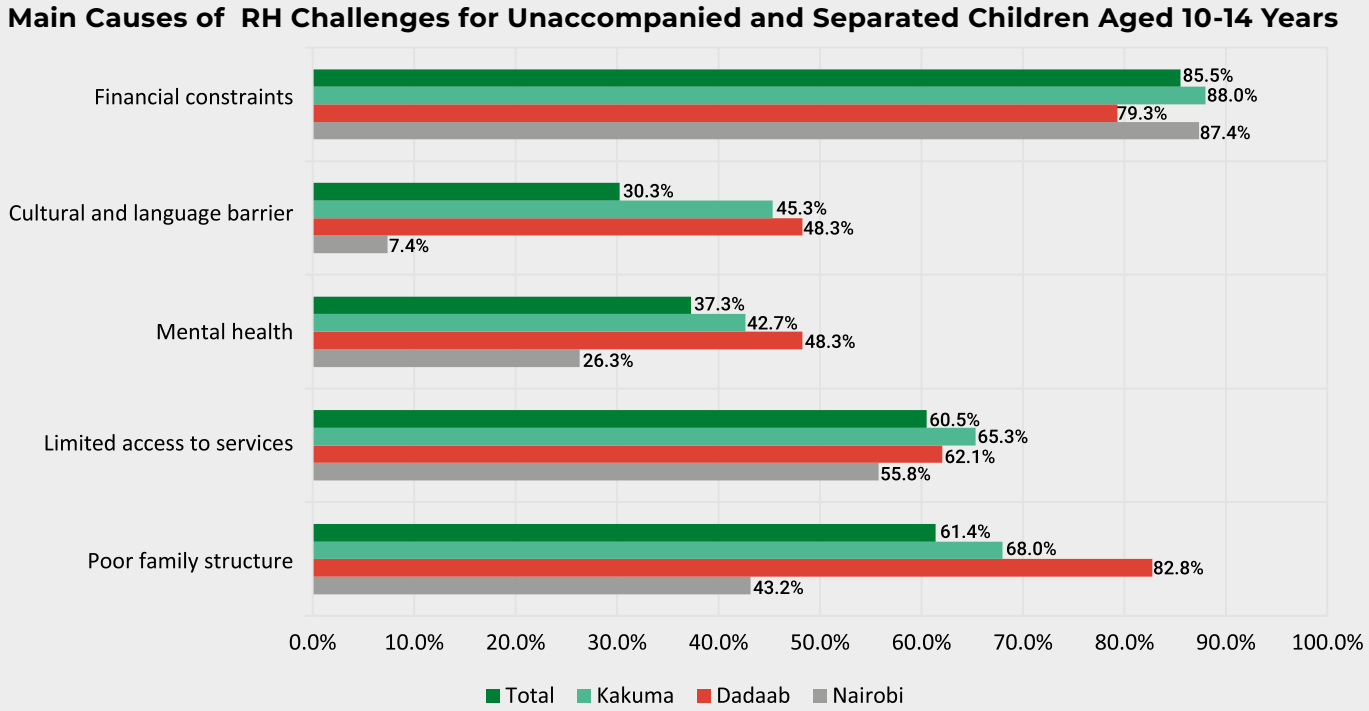


Figure 20: Main Causes of RH Challenges for Unaccompanied and Separated Children Aged 10-14 Years.

Sources of Stress for Unaccompanied & Separated Children

The needs assessment revealed that unaccompanied and separated children aged 10–14 experience a wide range of stressors that affect their mental and emotional well-being. These stressors stem largely from the absence of stable parental care, exposure to hardship, and living in environments with limited protection and support systems.

Among the reported sources of stress were the lack of basic needs such as food, shelter, clothing, and hygiene items. Children also experienced distress related to separation from their parents or family members, and the absence of emotional care and guidance. Financial hardship was noted as a stressor, not only because of material deprivation but also due to the responsibilities it places on children to provide for themselves or contribute to household income.

Other reported stressors included discrimination, social exclusion, and the inability to access or continue with education. Experiences of abuse and neglect, whether physical, emotional, or sexual, also contributed to feelings of fear, shame, and isolation. Children expressed feelings of loneliness and emotional distress, particularly in situations where they lacked trusted adults to confide in. Insecurity in living environments, exposure to violence or displacement, and poor hygiene conditions further intensified these experiences.

The assessment also highlighted that boys and girls are affected differently by stress, based on their roles, expectations, and vulnerabilities within their communities. For girls, stress was often linked to a heightened risk of sexual abuse and exploitation, heavy domestic workloads, and challenges related to menstrual hygiene. Girls also faced the threat of early and forced marriage, stigma following abuse, and limited mobility or autonomy. In many cases, their education was more likely to be disrupted due to household responsibilities or social norms that devalue girls' schooling.

Boys, on the other hand, were more likely to be exposed to forced labour and peer pressure, including involvement in substance use. They often faced emotional neglect, with social expectations discouraging them from expressing vulnerability or seeking support. Some boys reported pressure to contribute financially to their households, leading them to drop out of school. Others were at risk of recruitment into violent groups or criminal activity. Additionally, boys were less likely to report incidents of sexual violence due to stigma and limited recognition of such experiences. These findings suggest that while both boys and girls face significant psychosocial stress, the nature and expression of this stress vary.

> "Emotional or psychological abuse involves patterns of behavior that damage a child's self-worth or emotional well-being, including constant criticism, threats, intimidation, and social isolation".
>
> *– FGD with Boys in Garissa*

> "Emotional trauma resulting from abuse is rarely addressed, largely due to the stigma surrounding mental health issues."
>
> *– FGD with Unaccompanied and Separated Girls in Garissa*

Sources of Stress for Caregivers

The needs assessment also examined the psychosocial wellbeing of caregivers responsible for unaccompanied and separated children, revealing a range of stressors that affect their ability to provide consistent care and emotional support. The findings indicate that the stress experienced by caregivers often directly impacts the wellbeing of the children under their care. When caregivers are overwhelmed or unsupported, their capacity to respond to children's needs, emotionally, physically, and materially, is significantly diminished.

Caregivers identified several key sources of stress. Financial constraints and the inability to meet children's basic needs, such as food, clothing, and shelter, were the most frequently mentioned. Many also cited ongoing food insecurity, unemployment

or underemployment, and the high cost of living as persistent challenges. These economic pressures are often compounded by a lack of external support, including limited assistance from government, community structures, or humanitarian agencies.

Emotional and psychological strain was also noted, especially among caregivers managing large families or caring for multiple dependents without adequate resources. Some reported feeling isolated, unsupported, and overwhelmed by the daily demands of caregiving. A lack of access to essential services, including health, education, and psychosocial support, further intensified their burden.

Additional stressors included experiences of discrimination or social marginalization, difficult child behaviour, and concerns about safety and insecurity in their living environments. Some caregivers also expressed feeling ill-equipped to manage the unique needs of unaccompanied and separated children, citing a lack of parenting knowledge or relevant caregiving skills. Poor housing conditions and broader social and cultural expectations added to the pressures they faced.

During focus group discussions, some caregivers shared their frustrations and feelings of helplessness. In the absence of adequate support, a few acknowledged that they had reached points where they considered, or even resorted to, extreme actions, such as sending children away, when they felt unable to cope with the demands placed on them.

> "Limited resources, including a lack of essentials like firewood, make it difficult for caregivers to meet the basic needs of children. This scarcity is often compounded by insufficient food at home, which can result in neglect or even the expulsion of children from their households. In some cases, when a child requests specific food that the caregiver is unable to provide, the frustration and helplessness may lead the caregiver to chase the child away."
>
> *– FGD with Caregivers of Unaccompanied and Separated Children in Turkana*

Stress Coping Mechanisms for Unaccompanied and Separated Children

The assessment examined how unaccompanied and separated children aged 10–14 cope with stress in the absence of stable parental support. Findings revealed a variety of coping strategies, ranging from constructive behaviours to concerning and maladaptive responses, influenced by individual temperament, environment, and the availability of supportive relationships.

One of the most common coping strategies mentioned was play. Children often engage in physical activities such as football, games, or child-friendly recreational programs as a way to distract themselves and release emotional tension. Crying, tantrums, and emotional outbursts were also noted, particularly among younger children, as non-verbal expressions of stress, sadness, or frustration.

Many children seek comfort from trusted adults, such as caregivers, foster parents, teachers, or community members, in search of reassurance, emotional security, and physical affection. Talking and sharing with peers, siblings, caregivers, or spiritual leaders was another strategy, allowing children to unburden themselves and process emotions.

Some children cope by attending school, where structured routines, peer interaction, and educational engagement offer distraction and stability. Others turn to creative activities, such as drawing, music, storytelling, or dancing, which help them express feelings they may not be able to verbalize.

Sleep was also mentioned as a form of emotional withdrawal, particularly when children feel overwhelmed. Similarly, some turn to spiritual or religious practices, such as prayer or participation in faith-based gatherings, which offer emotional grounding and a sense of hope.

In some cases, children benefit from guidance and counselling, either formally through support programs or informally through mentorship or conversations with trusted adults. Forming friendships and peer support networks emerged as another coping mechanism, offering emotional companionship and a sense of belonging.

However, not all coping mechanisms were positive. Some children responded to stress by isolating

or withdrawing, becoming quiet or physically separating themselves from others. Some resort to negative coping behaviours, including substance use, aggression, involvement in child labour, or dropping out of school. These behaviours often signal deeper psychosocial distress and the absence of adequate support systems.

The assessment also found that children turn to a wide range of individuals for support, both within and beyond their immediate households. These include caregivers (biological, foster, or host parents), extended family members, friends and peers, teachers and school staff, and older siblings. Children also rely on community leaders, religious institutions, NGOs and social workers, child protection services, community-based organizations (CBOs), and refugee-led groups or youth councils. However, the respondents reported that some children have no one to turn to, highlighting a critical gap in support for the most vulnerable.

4.2.3 Education

Education plays a critical role in the protection and development of unaccompanied and separated children. Beyond academic learning, it offers children routine, emotional stability, psychosocial support, and a safe environment. This section presents findings on UASC's access to quality education across the three target counties, Turkana, Nairobi, and Garissa, as well as the key barriers, affordability, learning materials, support systems, and caregiver engagement influencing their educational outcomes.

Access to Quality Education

The assessment found that access to quality education for unaccompanied and separated children is limited across the three target counties. Overall, only 35.6% of respondents reported that these children have access to quality education. When disaggregated by location, the perception of access was highest in Garissa (61.0%), followed by Nairobi (33.9%), and lowest in Turkana (12.3%). In contrast, 64.4% of respondents indicated that unaccompanied and separated children do not have access to quality education, with Turkana reporting the highest proportion (87.7%), followed by Nairobi (66.1%) and Garissa (39.0%) as illustrated by Figure 21.

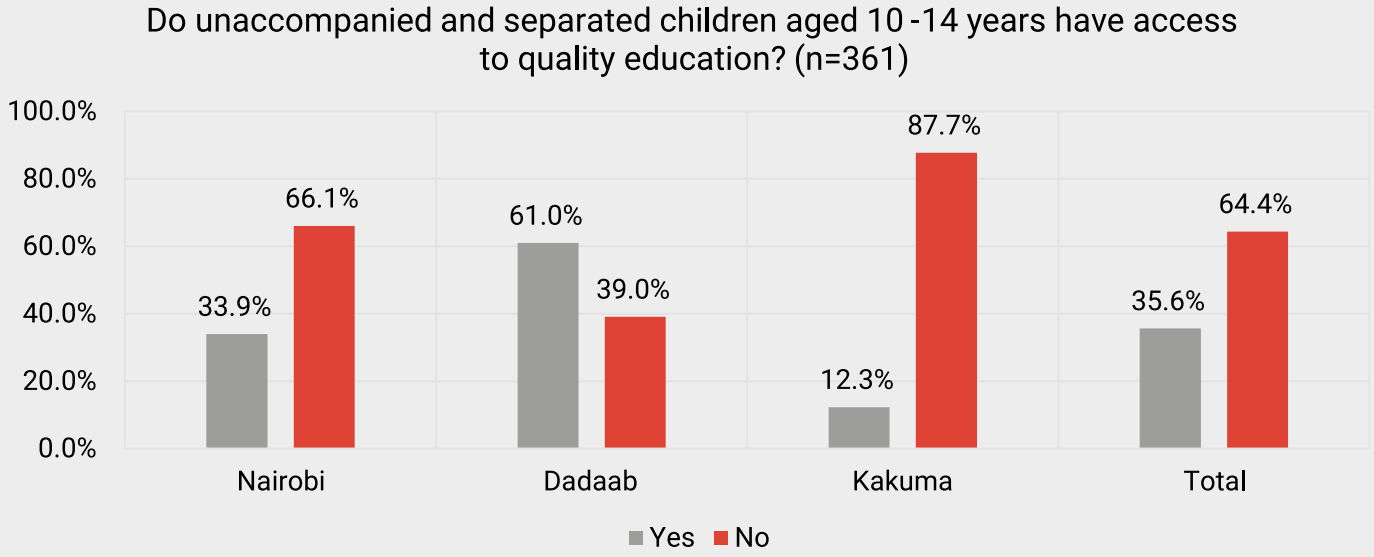


Figure 21: Perception on Unaccompanied and Separated Children's Access to Quality Education.

Respondents who perceived that children had access to quality education described characteristics such as the availability of educational support, adequate classrooms, sufficient play areas, learning materials, well-equipped facilities, and a competent and adequately staffed teaching force.

On the other hand, those who believed that UASC lacked access to quality education cited several indicators to support their view. Notably, the recruitment of unqualified or undertrained teachers was identified as a key concern.

Additionally, some caregivers reported that even where children are enrolled in school, they are unable to demonstrate basic literacy skills such as writing, raising concerns about the effectiveness and quality of education.

"Quality education is not available here. One of the main issues is the recruitment of unqualified teachers. For example, someone can finish secondary school today and be hired as a teacher the next day, without any formal training."

– FGD with Caregivers in Turkana

"We can say that here in the camp, there is no quality education. It is because if you can move in the classes, you will find even a child, the children of classes 1, 2, and 3, even though they don't have benches on the way to sit. They are sitting down."

"Our children do not know how to write their names, and they are in class 4 or 5. We just send them to avoid the burden of our kids at home. Education is a formality here".

– FGD with Caregivers in Turkana

Barriers to Access of Quality Education

Among respondents who reported that unaccompanied and separated children lack access to quality education, several interrelated barriers were identified. Financial constraints were among the most frequently cited challenges. Many households are unable to afford school-related expenses such as fees, uniforms, books, and other learning materials, often due to poverty or the absence of reliable caregiver support.

In addition to cost-related challenges, the learning environment itself poses substantial obstacles. Respondents noted the inadequacy of learning materials, overcrowded classrooms, and a shortage of qualified teachers, all of which undermine the quality of instruction and learner engagement.

For children living in remote or rural areas, long distances to school and lack of transportation were reported as major barriers, particularly for children with disabilities.

The absence of school feeding programs was another significant issue. Hunger and food insecurity directly affect school attendance, concentration, and academic performance. Further, the lack of legal documentation, such as birth certificates or school records, prevents some children from enrolling in or progressing through school.

Psychosocial and emotional stressors also play a role in limiting access. Many UASC have experienced trauma or emotional distress, which affects their ability to engage with learning. Additionally, child labour responsibilities and household duties reduce the time and energy children can devote to schooling.

Language barriers emerged as another challenge, especially where instruction is delivered in languages unfamiliar to the children, limiting comprehension and participation. The absence of consistent parental or adult support was also noted as a factor contributing to irregular attendance and low academic motivation.

Social factors such as discrimination, stigma, and exclusion from peers or educators discouraged some children from remaining in school. Finally, respondents highlighted other systemic issues, including limited awareness of the value of education, poor school infrastructure, and insecurity in and around schools, particularly in refugee-hosting or conflict-affected areas.

"There is a significant lack of trained teachers in schools, with many educators having not undergone formal teacher training. In addition to the shortage of qualified personnel, there is also an overall inadequacy in the number of teachers. Budget constraints have led to frequent teacher layoffs, resulting in a growing imbalance between the number of learners and available teaching staff, which negatively affects learning outcomes." "The quality of education in refugee schools is further hindered by a lack of adequate learning materials and overcrowded classrooms. Even when children are enrolled, limited resources and high student-to-teacher ratios make effective learning difficult to achieve.".

– FGD with Caregivers in Turkana

"Schools do exist, but in some cases, a single classroom holds up to 150 students, which makes it difficult for learners to concentrate and contributes to poor academic performance."

– FGD with Caregivers in Turkana

"Overcrowding is a major challenge in schools, with classrooms often holding between 60 to 100 students per teacher, making individualized learning nearly impossible. This is compounded by a severe lack of resources, including limited textbooks, inadequate learning materials, and rundown school facilities."

– FGD with Unaccompanied and Separated Boys in Garissa

> "There is a serious shortage of teaching aids in schools. For example, essential resources like textbooks are either unavailable or extremely limited. In some cases, a class may have around 100 learners, yet only five mathematics textbooks are available, making it very difficult to effectively teach the subject."
>
> *– KII with a Teacher in Turkana*

Affordability of Education

The assessment revealed that affordability remains a major barrier to education for unaccompanied and separated children. Only 12.7% of caregivers reported being able to finance the education of the children under their care. This was highest in Nairobi (17.0%), followed by Garissa (11.4%), and lowest in Turkana (9.4%). A significant majority (87.3%) of caregivers indicated they were unable to afford the costs associated with education, as illustrated in Figure 22.

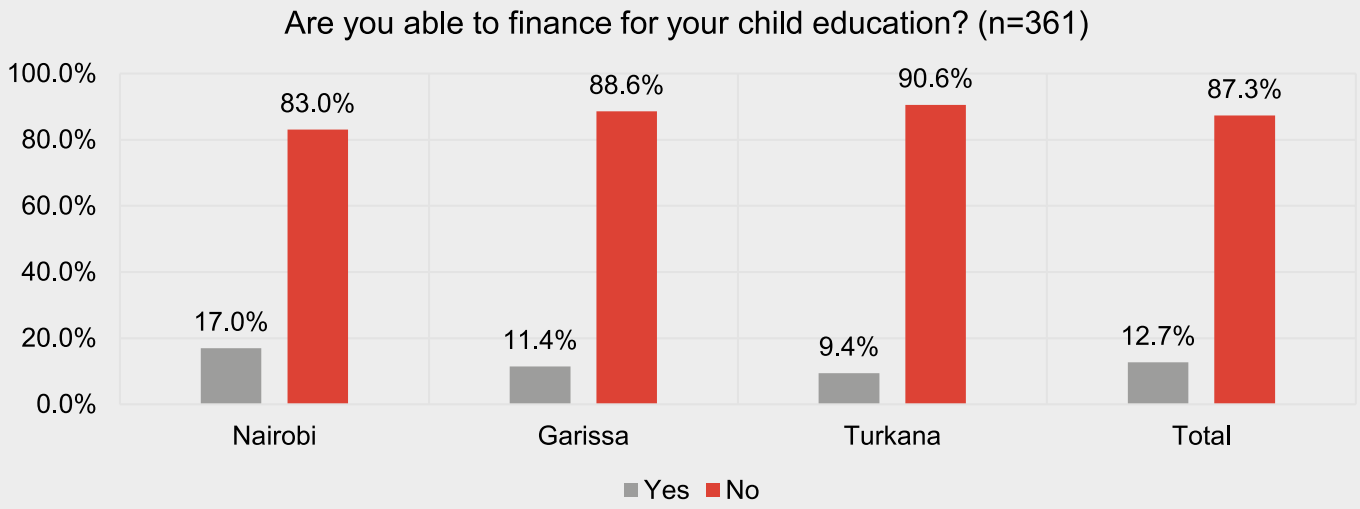


Figure 22: Proportion of Caregivers of UASC with the Ability to finance their Children's Education.

Caregivers who reported being able to support children's education attributed this to several enabling factors. These included formal employment, ownership of small businesses, financial assistance from relatives, and support from NGOs or agencies.

Others cited access to free education in refugee camps, government or community school subsidies, household income pooling, and strong personal commitment to prioritizing education. Additionally, some caregivers credited their resilience, self-responsibility, and a desire to provide a better future for the children as motivating factors.

Conversely, caregivers who were unable to meet education costs identified a range of financial and structural barriers. These included unemployment, lack of livelihood opportunities, and financial instability. Other contributing factors were large household sizes, single parenthood or disrupted family structures, and the high cost of school-related materials. Caregivers also cited limited support systems, poor living conditions, lack of documentation, psychological stress, and the indirect effects of school dropouts. Additional challenges included transportation costs, lack of trained teachers, discrimination, and insufficient humanitarian aid.

> "I don't feel that children truly have access to education, because many are sent home for lack of school fees. While others are in class taking exams or learning new topics, those sent away miss out, which prevents them from accessing quality education."
>
> *– FGD with Female Caregivers in Nairobi*

Access to Learning Materials

The needs assessment examined the extent to which unaccompanied and separated children have access to essential learning materials. Overall, only 33.7% of caregivers reported that the children in their care had access to learning materials. Disaggregated by location, access was highest in Garissa (38.1%), followed by Nairobi (33.0%) and Turkana (30.2%). Conversely, 66.3% of caregivers indicated that children lacked access to these materials, with the highest proportion in Turkana (69.8%), followed by Nairobi (67.0%) and Garissa (38.1%), as shown in Figure 23.

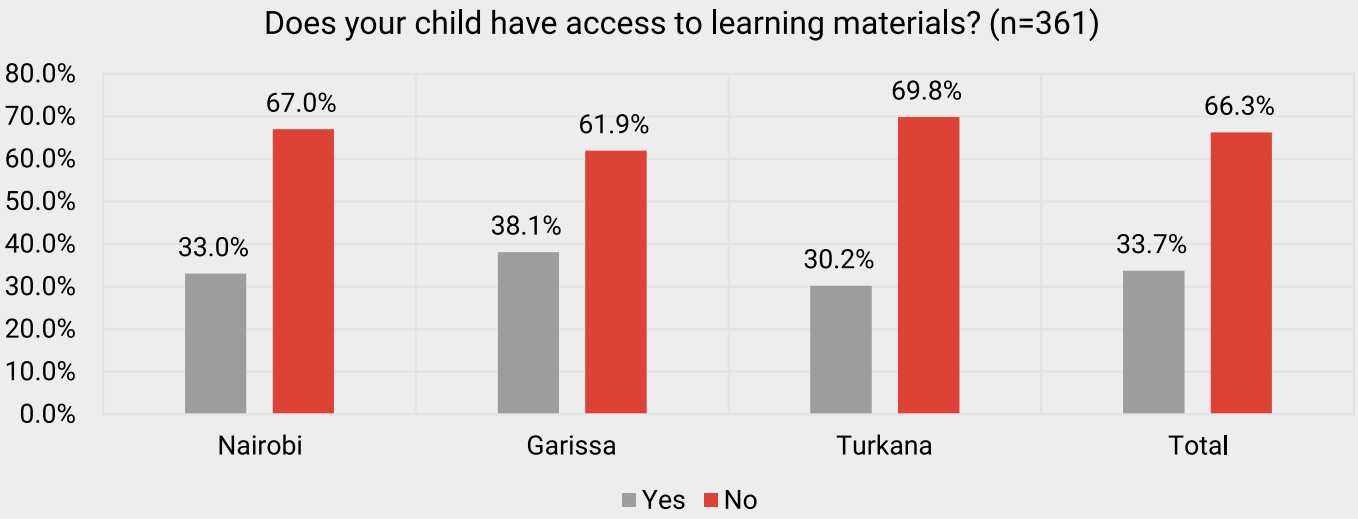


Figure 23: Unaccompanied and Separated Children's Access to Learning Materials

Caregivers who reported access to learning materials identified several sources from which these materials were obtained. Schools were the most frequently cited source (60.6%), followed by families (50.5%), refugee-supporting organizations (40.4%), community-based organizations (26.6%), and government centers (15.6%).

Support to Access Education

The assessment found that 38.7% of caregivers reported that unaccompanied and separated children receive some form of support to access education. This support was reported most frequently in Turkana (53.8%), followed by Garissa (51.4%), and least in Nairobi (12.5%). Conversely, 61.3% of caregivers stated that the children under their care are not supported in accessing education. This was highest in Nairobi (87.5%) followed by Garissa (48.6%) and Turkana (46.2%) as illustrated in Figure 24.

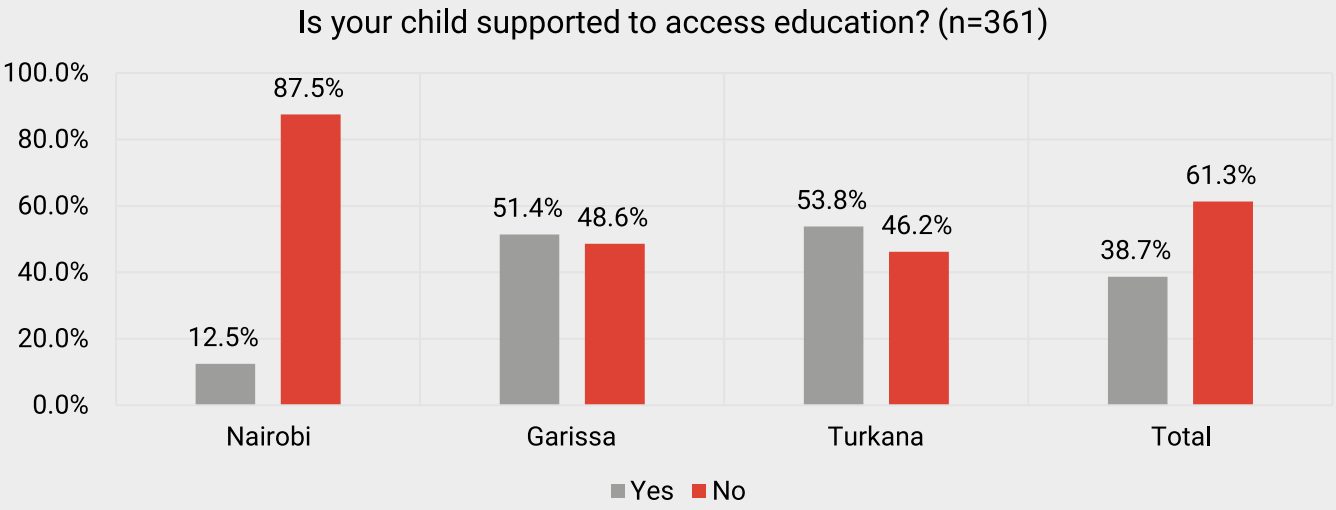


Figure 24: Unaccompanied and Separated Children Supported to Access Education.

Among those who acknowledged the presence of support, a majority identified non-governmental organizations (NGOs) and humanitarian agencies as the primary providers. Frequently mentioned organizations included the Lutheran World Federation (LWF), Windle International Kenya (WIK), Jesuit Refugee Service (JRS), UNHCR – Kenya, Save the Children, Danish Refugee Council (DRC), Lokado, Finnish Church Aid (FCA), World Food Programme (WFP), Refugee Point, Red Cross, and Terre des Hommes (TDH). Both public and private schools were also noted as contributors.

The types of support provided by these actors were diverse. Caregivers cited interventions such as the provision of free primary and secondary education, learning materials, and school feeding programs. Other forms of support included the construction of educational infrastructure, deployment of teachers, child protection and safety initiatives, psychosocial and counselling services, and provision of school uniforms and hygiene items. Additional support included financial assistance for fees, transportation aid, services targeting marginalized groups, and broader emotional and moral support for children.

Caregivers' Engagement in Education Activities within the Area

The assessment explored the extent of caregiver involvement in education-related activities within their communities. Findings indicate that caregiver engagement is generally low. Specifically, 42.1% of caregivers reported that they are rarely involved in educational activities in their area, 35.3% said they are sometimes involved, 12.1% indicated they are engaged most of the time, and only 10.5% reported always being involved, as illustrated in Figure 25.

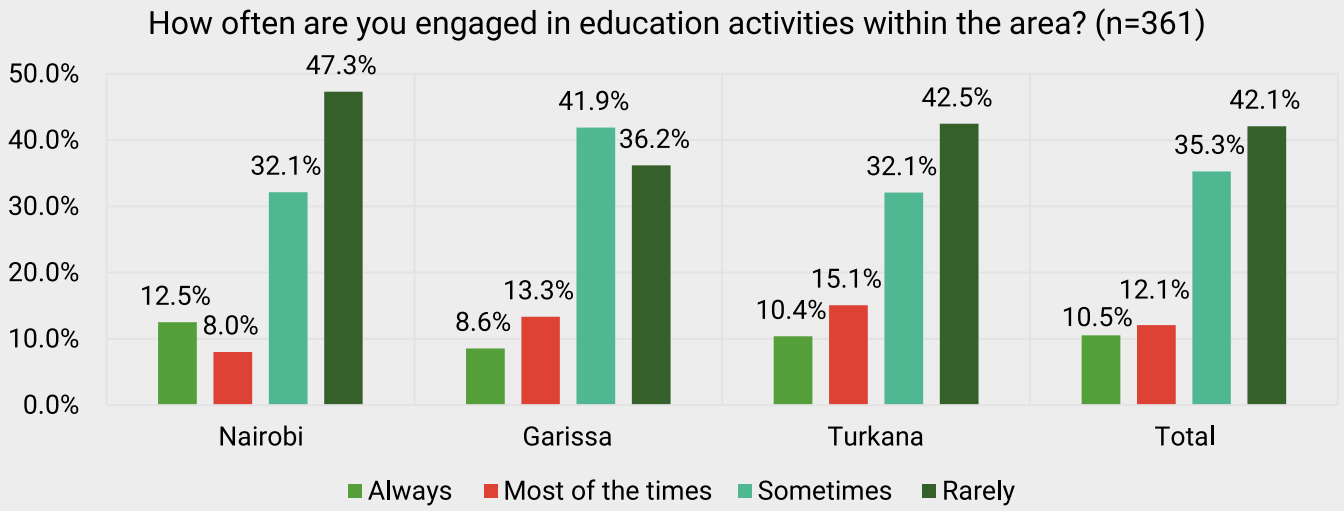


Figure 25: Frequency of Engagement of Caregivers in Educational Activities within the Area.

Caregivers also identified several barriers that hinder their participation in education activities. The most commonly cited factors included poverty and financial constraints, which often force caregivers to prioritize income-generating activities over school involvement. Time limitations due to livelihood pressures and low educational attainment among caregivers were also noted, alongside a general lack of awareness or access to information regarding school activities and parental roles.

Other reported challenges included cultural and gender norms that discourage caregiver involvement, language barriers, and a sense of exclusion or lack of formal invitations from schools.

Social issues such as stigma, discrimination, and marginalization also contributed to limited engagement. Additionally, caregivers cited emotional and mental health challenges, the absence of institutional support, and the burden of child labor and household responsibilities as significant constraints.

Practical challenges, such as long distances to schools, poor infrastructure, and lack of transportation, also played a role. Some caregivers expressed that there were few incentives or opportunities for engagement, while others highlighted political or structural barriers and limited literacy on their rights and responsibilities as contributing to their limited involvement.

4.2.4 Food Security and Livelihoods

This section presents findings on the livelihoods and food security situation of households caring for unaccompanied and separated children (UASC). It highlights income and expenditure patterns, the ability to meet basic needs, household food consumption, and key barriers affecting food access and dietary sufficiency.

Source of Income & Expenditure

The needs assessment revealed that 44.0% of respondents reported having a source of income, while 56.0% indicated that they currently have no regular income. Among those with income, respondents identified a variety of income-generating activities. The most reported source was casual labour (47.9%), followed by small businesses or self-employment (45.8%).

Other sources included relief or donations (16.2%), remittances from family or friends (10.6%), formal employment (9.2%), farming or livestock-related activities (8.5%), and mining (1.4%) as illustrated in figure 26.

Respondents' Main Sources of Income.(n=361)

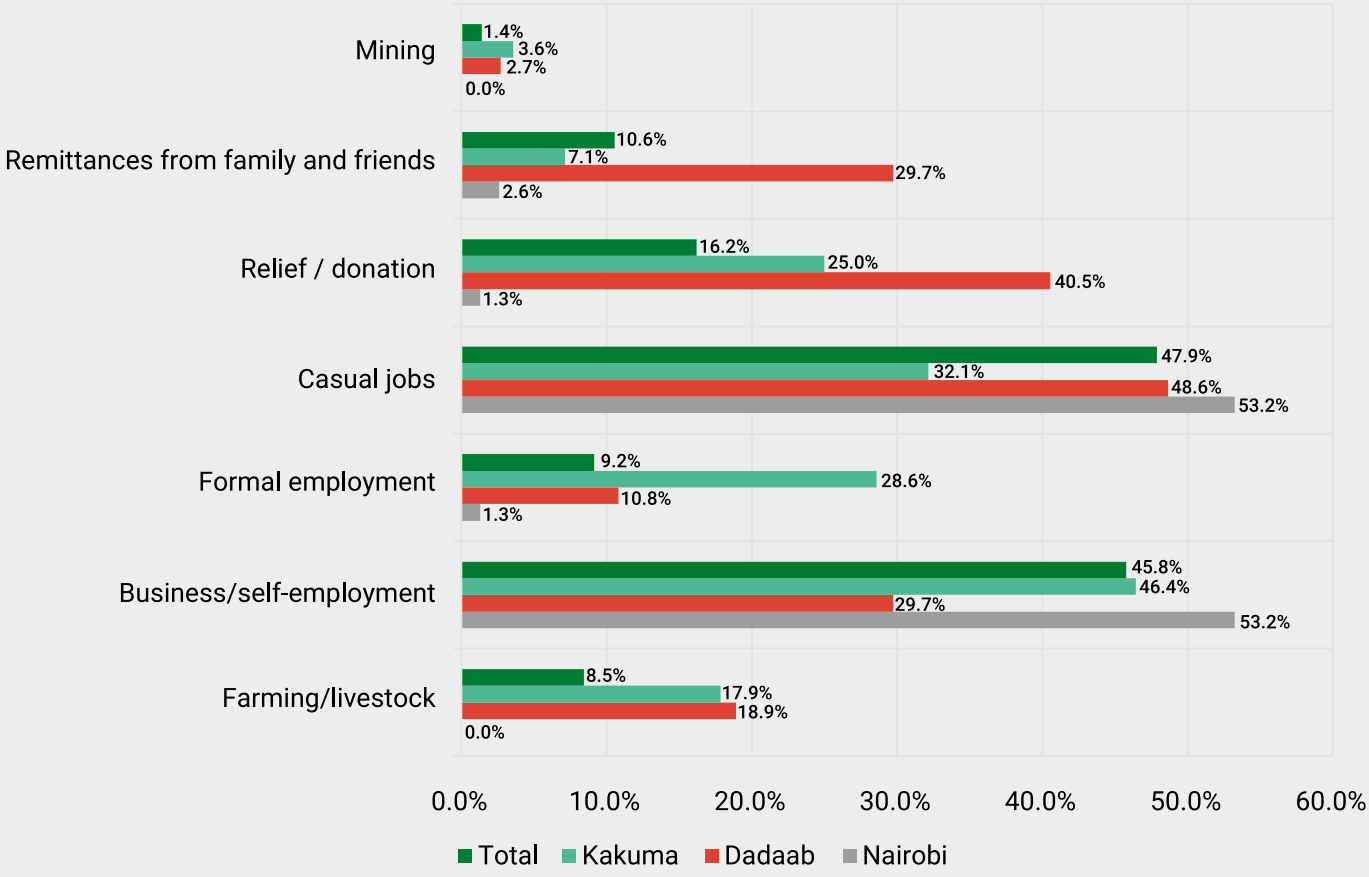


Figure 26: Respondent's Main Sources of Income.

Regarding household income levels, 38.4% of respondents reported an average monthly income ranging between KES 2,501 and 7,500, while 32.2% indicated earning less than KES 2,500 per month. An additional 20.1% earned between KES 7,501 and 15,000, while 8.0% fell within the KES 15,001 to 30,000 range. Only a small proportion of households reported higher income brackets, with 0.9% earning KES 30,001 to 50,000, and 0.3% reporting income above KES 50,000.

In terms of household expenditure, 37.8% reported average monthly spending between KES 2,501 and 7,500, followed by 25.1% who spent less than KES 2,500. Another 25.1% indicated expenditure levels between KES 7,501 and 15,000, while 10.2% reported spending in the range of KES 15,001 to 30,000. A small number of respondents (1.9%) indicated household spending between KES 30,001 and 50,000.

Ability to Meet Basic Needs

The assessment sought to determine the extent to which households responsible for unaccompanied and separated children are able to meet their basic needs.

Overall, only 12.7% of respondents reported being able to afford all essential needs for their households. Disaggregated by county, this included 16.2% in Garissa, 16.1% in Nairobi, and just 5.7% in Turkana. In contrast, a significant majority (86.1%) indicated that they were unable to meet all basic needs, with the highest levels reported in Turkana (93.4%), followed by Garissa (82.9%) and Nairobi (82.1%). An additional 1.2% of respondents were unsure about their household's ability to meet basic needs as illustrated in figure 27.

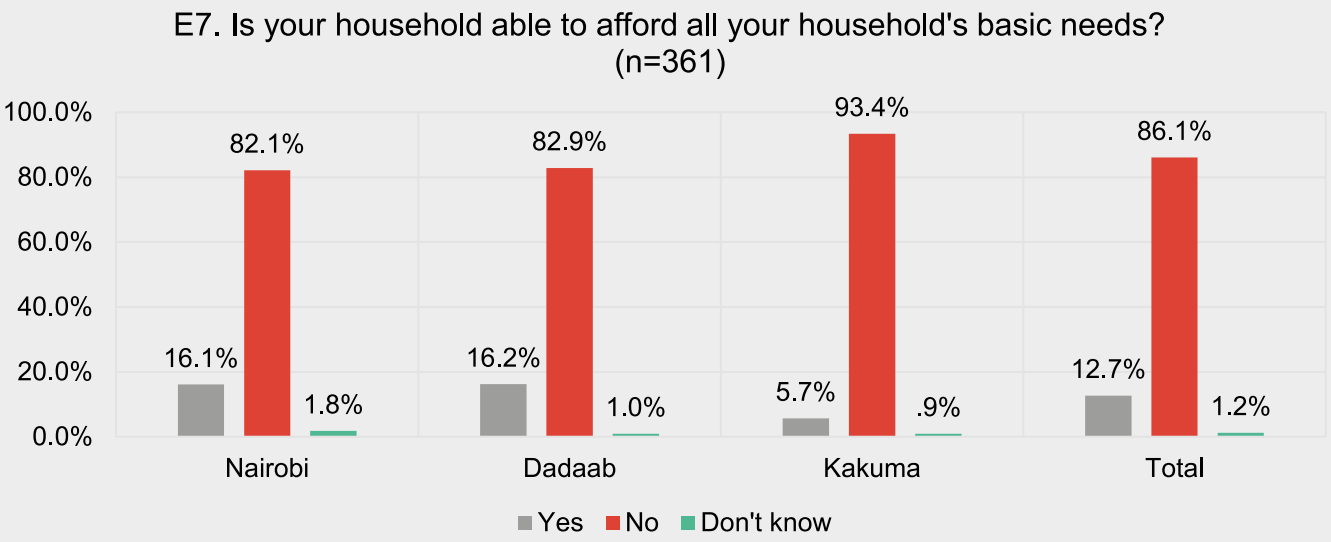


Figure 27: Household's Ability to Afford Basic Needs.

Among those who were unable to meet their household needs, several priority areas were consistently identified as being most affected. These included food (86.3%), clothing (69.8%), healthcare (69.1%), shelter (68.3%), and education-related expenses (62.2%). These unmet needs reflect the wide-ranging vulnerabilities experienced by households supporting unaccompanied and separated children.

In response to these challenges, households reported adopting various coping mechanisms to secure food and other necessities.

Common strategies included reducing the size or frequency of meals, borrowing food or money, buying credit, skipping meals, and asking for assistance from others. Other methods mentioned were engaging in casual work, relying on food aid, careful management of available food, taking loans, and substituting preferred foods with cheaper alternatives.

These coping strategies, while necessary, reflect ongoing economic distress and place additional strain on already vulnerable households.

> "I do not have sufficient food for my family because I depend on food aid provided by organizations when the donors stop or fail to support the organization, we face challenges in accessing food. Some of us even remain hungry or limit meal size for days."
>
> *– FGD with Caregivers in Garissa*

Food Consumption Score

The needs assessment evaluated the food consumption score (FCS) of households caring for unaccompanied and separated children as a proxy indicator for current food security. The FCS combines data on dietary diversity, food frequency, and the nutritional value of different food groups consumed over a seven-day recall period, applying standardized weighting to reflect the relative importance of various food items.

Findings from the assessment revealed concerning trends in dietary adequacy among the surveyed households. Only 9% of households had an acceptable food consumption score, suggesting that their diets were sufficiently diverse and nutritionally balanced. However, 39% of households fell within the borderline category, indicating potential instability in food access and a risk of declining nutrition. Alarmingly, 52% of households were categorized as having a poor food consumption score, highlighting serious and ongoing challenges in maintaining adequate dietary intake.

These results suggest that a significant proportion of households are either at risk of food insecurity or already experiencing it, with limited ability to consistently access or afford a nutritionally sufficient and diverse diet.

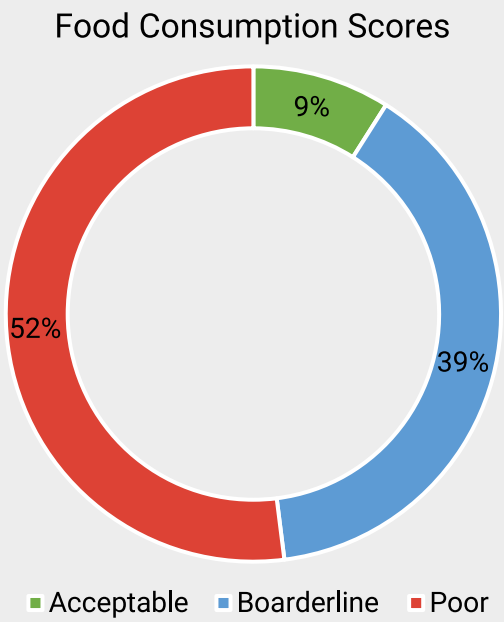


Figure 28: Food Consumption Scores.

Barriers to Food Security

Focus group discussions with caregivers revealed a range of factors that hinder households from attaining food security. A major constraint highlighted was the restriction on movement, particularly within refugee settlements, which limits access to employment opportunities necessary for purchasing food. Additionally, caregivers cited high competition for the limited food resources available within overcrowded camps, further straining household access.

Poor road infrastructure was also mentioned as a significant barrier, affecting the transportation and distribution of food supplies, especially in remote areas which is worse during rainy seasons. Financial support provided to households was described as minimal and insufficient.

Respondents explained that in some cases, families receive an allocation equivalent to KES 20 per day, an amount that barely covers the cost of basic food items. For instance, a single onion can cost between KES 20 and 30, exceeding the daily food allowance and illustrating the severe gap between needs and resources.

Furthermore, the caregivers reported that food donations were inadequate to meet household needs. One example cited was the distribution of 3 kilograms of rice per household per month, which respondents noted is only enough to feed a family for about one week. These shortfalls contribute to chronic food insecurity, forcing families to rely on negative coping mechanisms and deepen their vulnerability over time.

"We don't receive enough support at all. Imagine being expected to survive on just 20 Kenyan shillings per day, that's not fair, and it's simply not enough to meet basic needs. You can't even buy a single onion for that amount; some cost 20 or even 30 shillings. It feels like we're being taken advantage of, but we have no other options. Many of us eat only once a day or end up using the little we get to repay loans."

"In my opinion, the food we receive is not sufficient, but I force myself to manage with what I have. As I mentioned earlier, each person is given only 3 kilograms of rice per month. Just imagine, 3 kilograms to last an entire month. That amount isn't even enough to sustain someone for a week".

– FGD with Caregivers in Turkana

"Our movement outside the camp is restricted, which limits our ability to seek employment or start businesses that could help us become economically independent. During the rainy season, I'm also unable to access the food I need because of the poor road network in this area. In the Dadaab camps, food is generally insufficient, the large refugee population puts pressure on the limited food supplies available, creating intense competition."

– FGD with Female Caregivers in Garissa

4.3. Stakeholder and Service Mapping

4.3.1 Existing Actors per Thematic Area
The study established that there is presence of different organizations within Nairobi, Turkana and Garissa whose core mandates are centered on supporting both refugees and host communities with essential services. The service provision by these organizations vary according to their donor priorities, but their focus revolve around education, livelihood support, child protection and health services which are all considered key to the long term stability and dignity of both populations. Respondents reported that these services were not only described as necessary for survival of these vulnerable populations but also as mechanisms for promoting integration and reducing dependency, reflecting a deliberate effort towards sustainable community development. Different institutions with key roles are as described in the thematic areas shown below.

A. Child Protection

Different institutions playing a role in child protection include; UNHCR, United Nations Children's Fund (UNICEF), Danish Refugee Council (DRC), Lutheran World Federation (LWF), Terre des Hommes (TdH), Hebrew Immigrant Aid Society (HIAS), Save the Children, International Rescue Committee (IRC), Children's Office (Government of Kenya) and refugee led organizations (RLOs).

a. UNHCR: UNHCR has been operational in Kenya in line with its international mandate and on invitation from the government of Kenya for over fifty years. UNHCR provides overarching protection and support for refugees including coordination of child protection actors. In the refugee camps in Turkana and Dadaab, UNHCR offers services such as protection of children from child abuse, promoting family unity and protecting unaccompanied and separated children, preventing and responding to early marriages, protecting children at risk of detention, increasing formal, non-formal, vocational and tertiary education opportunities for adolescents, protecting children from exploitation and survival sex where unaccompanied, separated and refugee children are lured to engage in sexual activities to get basic needs and services due to the high poverty levels within the refugee camps.[18]

b.UNICEF: UNICEF works to protect the rights of every child, especially the most disadvantaged and those hardest to reach. This Key UN agency supports children through advocacy, service provision, and child rights campaigns. In Kenya, UNICEF collaborated with the Government of Kenya (GoK) to increase protection for children and adolescents from violence, exploitation and abuse, neglect as well as harmful cultural practices. UNICEF provides mental health and psychosocial support to children and caregivers, including through the national child helpline 116 or visiting Childlinekenya.co.ke to get one-on-one counselling and connect children with support services in their communities. UNICEF also supports affected children and families, including child-headed households, and they are actively engaging with different partners to ensure that children in refugee camps continue to access child protection services.[19]

c. DRC: This is a private humanitarian organization, founded in 1956. The organization offers protection services, community-based support, and works with other actors on child protection programming. DRC offers various chid protection services to unaccompanied, separated and refugee children in Kenya, focusing on prevention, response and strengthening community-based protection. Key services offered include supporting unaccompanied and separated children, providing access to family tracing and reunification services, and establishing Child Friendly Spaces such as Furaha Spaces in Kakuma and Kalobeyei refugee camps.[20]

18 Child Protection Strategy Kakuma Refugee Camp Kenya.
19 Impact Report 2014-2018 UNICEF
20 https://help.unhcr.org/kenya/kakuma/child-protection/#:~:text=Village%201%2D%20Child%20Protection%20Field,see%20Legal%20Advice%20and%20Documentation

d.LWF: LWF is a global communion of churches in the Lutheran tradition, living and working together for a just, peaceful, and reconciled world. The organization is not only engaged in child protection, but also in education, psychosocial support, and case management in refugee settings. In Kenya, LWF offers various child protection services to refugee children, focusing on creating safe and supportive environments. These services include establishing child-friendly spaces, supporting community-based protection systems, facilitating foster care for unaccompanied and separated children, and establishing reporting mechanisms for child rights violations. LWF also advocates for children's rights at local, national, and international levels.[21]

e. TdH: As the leading Swiss organization for children's rights, created in 1960, the Terre des hommes foundation is committed to protecting children's lives and their rights, and improving their well-being. TDH is a widely recognized NGO offering child protection, psychosocial support, and safe spaces across various camps and communities. In Kenya, TdH focuses on prevention and response to child protection needs within refugee camps and surrounding host communities. TDH's interventions aim to strengthen formal and informal protection mechanisms, educate parents and communities, and build the capacity of local structures to prevent, detect, report, and respond to child exploitation. It operates in Dadaab and Kakuma refugee camps, as well as the Kalobeyei settlement in Garissa and Turkana Counties, alongside the surrounding host communities. In Nairobi, TdH is implementing an early childhood development project adopting the socio-ecological model aiming at expanding the protective space for children between 0-6 years old in the Korogocho informal settlements.[22]

f.HIAS: This is a Jewish American nonprofit organization that provides humanitarian aid and assistance to refugees. It was established on in 1881 to help Russian Jewish immigrants to the United States escaping anti-Semitic persecution and violence. In Kenya, HIAS offers a range of child protection services to refugee children, including identifying unaccompanied and separated children, providing case management, and facilitating access to essential services like family tracing, reunification, and alternative care. They also engage in community outreach, education, and psychosocial support, with a focus on preventing and responding to child abuse, exploitation, and neglect.[23]

g. Save the Children: Save the Children is the world's first and leading independent children's organization – transforming lives and the future we share. Save the Children in Kenya provides a range of child protection services to refugee children including case management, psychosocial support, alternative care for unaccompanied and separated children, and efforts to prevent violence, abuse, neglect, and exploitation of children.[24]

h. IRC: Formed in 1933, IRC delivers lasting impact by providing health care, helping children learn, and empowering individuals and communities to become self-reliant, always with a focus on the unique needs of women and girls. IRC supports child-friendly spaces, case management, health, and protection for children, especially those at risk. In Kenya, IRC provides various child protection services to refugee children, focusing on preventing and responding to risks they face. These services include individual support for at-risk children, family tracing and reunification, alternative care for unaccompanied or separated children, and access to safe healing and learning spaces.[25]

i. Refugee Led Organizations (RLOs): These organizations play crucial roles in bridging the gap between refugees and broader communities, providing vital services, and advocating for refugee rights. In Turkana, different RLOs that support child protection

21 Policy Brief Pre-Primary Education for Refugees in Kenya.
22 Child Protection Needs Assessment in Turkana and Garissa by TdH.
23 Fact Sheet by HIAS in Kenya.
24 https://www.savethechildren.net/kenya/kenya-child-protection#:~:text=Save%20the%20Children%20Kenya%20has%20made%20strides,%2D%20a%20community%2Dbased%20child%20abuse%20reporting%20platform.&text=At%20the%20child%20level%2C%20working%20through%20and,care%20arrangements%20for%20unaccompanied%20and%20separated%20children.
25 IRC Website

services include; Lead the Child, She Can Initiative and United Safe Environment Creators (USEC).

j. NRC: The Norwegian Refugee Council (NRC) is an independent humanitarian organization helping people forced to flee. The organization protects displaced people and supports them as they build a new future. NRC is a determined advocate for displaced people and promotes and defends displaced people's rights and dignity in local communities, with national governments and in the international arena. NRC plays a significant role in child protection in Kenya, focusing on education, legal assistance, and psychosocial support for refugee and displaced children. It works to ensure that displaced children have access to quality education, legal documentation, and psychosocial support services to mitigate the impact of displacement on their well-being and development.

B. Health, Nutrition, and Reproductive Health (RH)

UNHCR: This institution plays a major role in coordination of different organizations who provide services to refugee and displaced children. In addition to this, it provides services such as access to free healthcare at designated facilities in Kakuma, Kalobeyei and Dadaab refugee camps, targeted supplementary feeding programs, and support for managing acute malnutrition.

IRC: IRC provides essential health and nutrition services in Kakuma and Dadaab refugee camps to refugees escaping conflict and natural disaster in Somalia, South Sudan, Ethiopia and other neighbouring countries, with an aim to address malnutrition. IRC's nutrition programs encompass a range of interventions, including therapeutic feeding, nutritional counselling and provision of essential supplements.[26]

Medicins Sans Frontieres (MSF): This translates to 'doctors without borders. MSF provides medical assistance to people affected by conflict, epidemics, disasters, or exclusion from healthcare. MSF also offers emergency medical care, psychological support, and treatment for malnutrition. In Kenya, MSF provides care to communities in and around the Dadaab refugee camp. In its 100-bed hospital in Dagahaley, part of the Dadaab refugee camp, MSF teams conduct outpatient consultations, and admit patients to the hospital, including children with severe malnutrition.[27]

Kenya Red Cross Society (KRCS): The KRCS was founded in 1965 under the Kenya Red Cross Society Act (Chapter 256 Laws of Kenya) and officially acknowledged by the Kenyan government as a voluntary aid society working alongside public authorities. It holds the distinction of being the sole National Red Cross Society in Kenya. KRCS offers medical aid, first response, and community health outreach, especially during crises.

Save the Children: It focuses on scaling up evidence of high-impact nutrition interventions through integrated and multi-sectoral approaches to address the many underlying causes of malnutrition and evidence-based strategies to improve access to safe and nutritious food through nutrition-sensitive agriculture, water, sanitation, and hygiene (WASH), social protection, livelihoods, and school health and nutrition interventions.[28]

UNICEF: In collaboration with GoK and other partners, UNICEF provides a range of health and nutrition services to refugee children in Kenya. These services include treatment for severe acute malnutrition (SAM), support for integrated health interventions, and access to essential nutrition commodities like Ready-to-Use Therapeutic Food (RUTF). UNICEF also focuses on strengthening community health systems and building the capacity of healthcare workers to better serve refugee populations.[29]

26 https://african.business/2023/06/apo-newsfeed/international-rescue-committee-irc-urges-immediate-action-to-address-alarming-rise-in-malnutrition-cases-threatening-refugees-in-kenyan-camps#:~:text=The%20IRC%2C%20a%20global%20humanitarian,the%20content%20of%20this%20announcement.
27 https://www.msf.org/kenya
28 Save the Children Website
29 https://www.unicef.org/kenya/stories/lifeline-baby-analia#:~:text=With%20EU%20humanitarian%20aid%20support%2C%20UNICEF%20is,nutrition%20support%20to%20children%20such%20as%20Analia.&text=Since%202021%20the%20programme%20had%20been%20catering,with%20lifesaving%20nutrition%20commodities%20and%20health%20services.

Humanity & Inclusion (HI): Founded in 1982, Humanity & Inclusion is an independent and impartial organization working in situations of poverty and exclusion, conflict and disaster. The organization works alongside people with disabilities and individuals living in situations of extreme hardship. HI also provides refugees with rehabilitation and psychosocial support services, training professionals to detect needs and providing psychological first aid. HI runs four care centres in the Dadaab refugee camp, where people with disabilities can receive mobility aids such as walking sticks, prostheses and walkers.[30]

Jesuit Refugee Services (JRS): This is an international Catholic organization with a mission to accompany, serve, and advocate on behalf of refugees and other forcibly displaced persons that they may heal, learn, and determine their own future. JRS delivers mental health, basic healthcare, and educational support for refugee children. JRS is committed to working for the wellbeing and hope of refugees. It runs pastoral care and psychosocial support programmes in refugee camps.[31]

NRC: This organization also plays a significant role hygiene promotion for the displacement-affected refugee populations in Dadaab, Kakuma and Kalobeyei refugee camps and settlements as well as promotion of access to safe and sufficient water and sanitation facilities in the camps. The collaborates with other key actors and government agencies to ensure that refugee and host communities are supported through suitable sanitation and hygiene interventions for a better living.

TdH: TdH provides group therapy, mental health and psychosocial support sessions, and peer-to-peer parenting programs to contribute to the overall well-being of vulnerable children.

C. Education

DRC and NGO Partners: According to literature findings, DRC in Kenya provides a range of education services to refugee children, including supporting access to formal and non-formal education, facilitating scholarships for higher education, and advocating for the inclusion of refugee learners in the national education system. Through partnerships with other organizations such as LWF, FCA, WIK and JRS, DRC manages and offers free primary education in both Dadaab and Kakuma refugee camps. They also offer quality education programs such as Accelerated Education for those who missed schooling as well as scholarships for higher education among the refugees and other vulnerable groups. These activities are overseen by UNHCR.

Save the Children: The organization helps young children access early education (both pre-primary and primary), which allows them to develop literacy and numeracy skills through play. Save the Children also help out of school children in Dadaab refugee camp access primary education through the Alternative Basic Education centres. This institution also works with UNICEF and the Minsitry of Education (MoE) to advocate for education reforms, including reforms for education in emergencies.[32]

UNICEF: In education, UNICEF is working with partners to improve the quality of learning and to support newly-enrolled students in drought-affected countries and in refugee settlements; training teachers; providing learning materials; and helping to renovate school latrines.[33]

JRS: JRS manages and supports the running of secondary schools in Kakuma. This involves recruiting and employing teachers, making sure there is access to materials like textbooks, exercise books, IT equipment, and stationery, building physical classrooms, and WASH facilities.[34]

NRC: In Kenya, NRC supports children's educational and psychosocial needs through AEP and Better Learning Programme (BLP), with the eduation programmes targeting Over-age Out of School Children (OOSC) aged 10 to 18 years who have never been to school or have dropped out of school before completion of primary school.[35]

30 https://www.hi.org/en/country/kenya
31 https://apr.jrs.net/en/our-work/programmes/
32 https://www.savethechildren.net/kenya#:~:text=Health%20and%20Nutrition:%20We%20work%20with%20the,providing%20life%20skills%20training%20to%20young%20people.
33 https://www.unicefusa.org/what-unicef-does/where-unicef-works/africa/kenya
34 https://jrs.net/en/country/kenya/
35 https://www.nrc.no/countries/africa/kenya#:~:text=NRC%20in%20Kenya%20supports%20children's%20educational%20and,and%20the%20Better%20Learning%20Programme%20(BLP)%20respectively.&text=NRC%20provides%20access%20to%20safe%2C%20quality%20and,them%20to%20catch%20up%20with%20their%20peers.

D. Food Security and Livelihoods

World Food Programme (WFP): This is an international organization within the United Nations that provides food assistance worldwide. It is the world's largest humanitarian organization and the leading provider of school meals. Founded in 1961, WFP provides food assistance including general food distribution, school feeding, and supplementary nutrition for malnourished children. In Kenya, WFP provides food assistance to refugees in the Dadaab and Kakuma refugee camps and Kalobeyei settlement comprising in-kind distributions of cereals, pulses, and vegetable oil, and cash-based transfers (CBT). The study noted that WFP committed to continue supporting the GoK to expand the National School Meals Programme to 10 million school children by 2030, among the targeted children being the vulnerable groups in the refugee camps and settlement areas.[36]

HI: In Kenya, HI works in refugee camps to improve the living conditions of refugees, particularly the most vulnerable among them, seeking to provide them with equal and protected access to healthcare, training and employment opportunities and civic engagement. In particular, HI's programme is running a project aimed at micro-entrepreneurs to help them develop their activities. Participants receive training in communication, management and business administration, meet financial institutions and potential partners at events organized by HI and take part in peer exchange groups.

NRC: NRC's proactive role in supporting livelihoods and food security is also evident. It supports refugees and surrounding host communities to form community groups and obtain business licences and other legal documentation for businesses to ensure that the communities, especially the refugees access jobs and self-employment for improved living. The study noted that despite some organizations having specific projects or interventions targeting child protection, health care services, education and food security for the unaccompanied, separated and refugee children and their communities, many of these organizations provide equal efforts around these four areas and it would be inaccurate to report their efforts on one area. For instance, HI not only support healthcare provision among the refugee groups but also acquisition of training and employment opportunities and civic education as well as rehabilitation and psychosocial support services for the refugee populations.

4.3.2 Gaps in Service Delivery

A. Child Protection

Existence of Resource Gaps in Multisectoral Services: Discussions with respondents established that despite the provision of child protection services by a mix of national and international actors among the refugee communities, children still face delays in accessing support due to the existing long referral chains, revealing the need for streamlining coordination among the related service providers.

It was indicated that children with complex needs such as unaccompanied and separated children with disabilities suffer most due to their needs for specialized care, despite the existence of few institutions who provide such services such as HI. Existing Poverty and Harmful Traditional Practices: The study established that poverty, traditional norms, low educational levels, and limited access to services are the leading drivers of child abuse and rights violations of unaccompanied, separated and refugee children. Practices like early marriage are sometimes justified by economic survival strategies.

Child protection officers highlighted that ignorance about child rights among caregivers perpetuates abuse. Respondents also reported that some communities still normalize violence and exploitation, hence neutralizing the efforts put in place by different institutions to combat child rights abuse and protect the children from harm.

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36 https://reliefweb.int/report/kenya/wfp-kenya-country-brief-january-2025#:~:text=WFP%20provided%20food%20assistance%20to%20695%2C444%20refugees,and%20vegetable%20oil%2C%20and%20cash%2Dbased%20transfers%20(CBT).&text=WFP%20will%20continue%20supporting%20the%20Government's%20commitment,Programme%20to%2010%20million%20schoolchildren%20by%202030.

> I have a brother who is in Kakuma, whose daughter got married at the age of 15. The girl gave birth and has a child. She is staying with her husband. As a community, we just accepted the situation since we had no alternative. Sometimes when such cases occur, we sit as a family and find ways of preventing such cases from happening again but we rarely report the ones that have already occurred.
>
> *– KII with a caregiver from Kalobeyei.*

Partial Awareness on the Existing Reporting Mechanisms: Findings revealed that while some community members possess basic knowledge of child protection, many still lack a deeper understanding of the legal and psychological aspects of abuse. Discussions with child protection officers noted that while awareness campaigns have made some impact, the internalization of child protection norms remains low. Additionally, misconceptions about abuse and reporting persist, especially among elders and less-educated caregivers.

Operational Gaps in Child Protection Mechanisms: The findings established that current child protection services are moderately effective in addressing the needs of children. Discussions with child protection officers from different institutions indicated that service delivery around child protection is still constrained by limited staff, funding shortages, and delayed referral processes. As a result, some urgent cases go unaddressed or receive delayed responses. The existing support systems are not yet fully reliable or scaled to meet the needs of the community. There is also a perceived lack of feedback to the community once cases are reported, hence hindering follow-up efforts to ensure children receive justice and legal action taken against the perpetrators.

Fear, Stigma and Systemic Weaknesses: Some of the major obstacles hindering reporting of child abuse cases reported by caregivers include the fear of retaliation, social stigma, and a general lack of trust in formal institutions, where caregivers believe that the perpetrators would identify them and harm them together with the affected children.

> Main obstacles include fear of retaliation, stigma, and lack of trust in formal systems. Many caregivers believe that the perpetrators can collude with the security agencies and trace them and further target them with their children. Additionally, some caregivers lack knowledge about reporting mechanisms.
>
> *– KII with a caregiver from Kakuma.*

B. Health, Nutrition, and SRH

Distrust and Misinformation: One of the major gap that hinder acquisition of health services is the presence of distrust among refugee populations. This often results in the provision of incorrect or misleading information when seeking services, limiting the effectiveness of diagnosis and treatment. The underlying causes include cultural beliefs, past trauma, and fear of being reported or stigmatized. These attitudes create communication breakdowns between providers and clients, making it difficult to offer appropriate psychosocial support.

Underreporting and Cultural Silence: The study established from discussions held with the respondents that reproductive health issues, particularly violence against women and girls , are prevalent but severely underreported in refugee communities. Cultural norms and fear of stigma lead to silence among victims, making it difficult for service providers to offer timely support. Although trained personnel such as GBV officers and CHPs are available to respond to these cases, their impact is curtailed by the reluctance of survivors to come forward. This creates a substantial gap between existing services and actual needs.

Poor Access to Quality Healthcare Services: The assessment revealed from discussions held with children that access to healthcare is severely limited for refugee and vulnerable children due to distance, inadequate staffing, unavailability of medicine, and discriminatory practices in hospitals. Many reported having to travel long distances to larger towns like Eldoret or Kitale for treatment, which most families cannot afford. Hospitals in their areas are often poorly equipped, and caregivers are sent to buy drugs from private pharmacies. There's also a gap in skilled personnel, especially for children with specialized needs. Furthermore, the inconsistency of humanitarian health outreach such as specialists visiting only occasionally leaves many children untreated.

> Accessing health services is another major challenge. The health center is often overcrowded, and as a minor without parents or guardians, I sometimes face difficulties in getting treatment or medicine. When someone falls ill and goes to the hospital, everyone is given the same available medication regardless of their different conditions.
>
> *– Case Study with a male child in Dadaab.*

Lack of Coordinated Nutritional Data: Although nutritional challenges among refugee children are acknowledged, there is limited direct information available due to coordination constraints. The responsibility for tracking and addressing nutritional health is largely left to dedicated nutritionists, and field-level staff are not always informed about the specific trends or interventions. This disconnect points to a broader issue of siloed service provision where frontline workers are not fully engaged in nutrition-focused programming.

Discrimination and Unequal Treatment in Health Facilities: The study revealed that many refugee children face discrimination in healthcare settings, being denied the same level of service given to Kenyan citizens. Even within public hospitals, refugees are often served last, spoken to rudely, or denied access to programs like SHIF or Linda Mama due to lack of national identification.

This systemic marginalization creates both real and perceived barriers to care, causing many families to avoid hospitals altogether unless the case is critical. The documentation gap also affects health insurance coverage, rendering health services inaccessible for the most vulnerable.

C. Education

Inadequate Learning Materials and Support: The assessment revealed that a lack of essential learning materials significantly affects the academic engagement of refugee and vulnerable children. Many of these children cannot afford the basic tools required for effective learning, such as books and writing materials. This situation demoralizes learners and creates a visible gap between them and their peers. The lack of materials also contributes to absenteeism and low performance among affected children, as they often feel isolated or discouraged.

> Some schools in the refugee camps have desks, but the desks are not enough. In our school, you will find that from grade 4 and above they use desks, but grades 1, 2, 3 learners just sit on the floor due to insufficient desks. Also, for those who are using a desk, you will get that one desk carries at least four learners, making writing difficult for them. The schools are also overpopulated hindering effective learning as teacher student ratio is so big.
>
> *– KII with a teacher in Kakuma Refugee Camp.*

Language and Communication Barriers: The study established from discussions held with the teachers that one of the critical challenges in child protection efforts is the language barrier between guardians and school staff or community service providers. Some guardians, especially those from refugee backgrounds, do not speak the local language fluently, which limits their ability to understand school guidelines, laws, or how to seek help. This communication gap leads to isolation and unawareness of protective systems in place, contributing to children's vulnerability. Additionally, children from the countries that do not speak English or Swahili such as Somalia find it difficult to learn in the available schools that offer curriculum designed in English and Swahili.

Financial Barriers and Lack of Documentation: The study revealed that financial constraints remain a primary challenge affecting refugee children's access to education. Many of their guardians lack a source of income, rendering them incapable of paying school fees or meeting school-related expenses such as uniforms and remedial tuition, especially in urban schools in Nairobi. Compounding this issue is the lack of proper documentation, such as birth certificates and urban registration documents, which are often prerequisites for enrollment and receiving support from aid organizations. Without these documents, and lack of awareness on organizations supporting vulnerable groups in the urban areas, children are excluded from available assistance programs, further marginalizing them from formal education systems and critical services.

> Being unaccompanied child exposes me to numerous risks and challenges. Like many other separated children, especially those aged below 16 years, I am vulnerable to harassment, exploitation, and emotional distress. Life is not easy. I spend most of my day trying to secure food, water, and basic hygiene supplies. I also try to attend informal learning sessions whenever possible, but balancing survival and education is a daily struggle, hence I don't pay much attention to my education so that I can get the basic needs that I need to survive.
>
> *– Case Study with a 14 year old girl in Dadaab.*

Cultural and Attitudinal Barriers to Education: The study discovered from discussions held with the teachers that deeply entrenched cultural beliefs and negative parental attitudes toward education are significant barriers to protecting refugee and unaccompanied children. Some parents devalue formal education, often stating that they never attended school themselves and therefore see no importance in their children doing so. This leads to a lack of support for the child's academic journey and increases vulnerability to exploitation or child labor.

Systemic Gaps in Education: The assessment revealed from discussions held with the respondents

that several systemic gaps hinder educational quality: shortage of infrastructure, inadequate teaching personnel, and lack of learning materials. Additionally, children who qualify for secondary school or tertiary education often fail to enroll due to lack of documentation or funds, missing out on opportunities to extend their learning to higher levels. This is further exacerbated by the limited number of organizations supporting higher educations among the refugee populations, hence killing the morale of children to work hard at the lowest level of learning like primary schools.

D. Food Security and Livelihoods

Inadequate Nutritional Support: The study revealed from discussions held with the caregivers that nutritional services for children in the camps are grossly inadequate. Although food distribution by humanitarian agencies such as UNHCR is in place, caregivers noted that the quantity and quality of the food provided fall short of meeting children's nutritional needs. A recurring concern was the lack of balanced diets, with families often relying on monotonous meals like rice or maize for prolonged periods. Moreover, the nutritional supplements given, such as Plumpy'Nut and CSB, were inconsistently distributed and sometimes insufficient for all eligible children. Moreover, children not enrolled in formal nutrition programs were said to be at a higher risk of malnutrition due to the absence of follow-up or individualized support. These gaps have left many children consuming only one meal a day, often sourced through the goodwill of neighbors, which signals systemic weaknesses in food security and nutrition programming.

Provision of Non-livelihood Specific Support: Respondents informed the study that a section of children and youth in refugee communities receive limited support from humanitarian organizations, however, the interventions are not specifically focused on livelihood improvement. Supports such as hygiene kits, school uniforms, psychosocial services, and minimal financial aid (e.g., money to buy soap) have been helpful, although they addressed the broader structural needs that define livelihood stability such as sustainable food access, vocational skills training, or secure shelter for homeless groups. Respondents emphasized that these supports are short-term and fall short of facilitating genuine transformation in their lives.

> I have received minimal support so far. Once, I was given money to buy soap, though I don't know who provided it and it was not enough as well. The World Food Programme offers us "Bamba Chakula" at 1,050 monthly, yet this assistance falls far short of meeting our needs. At school, my child received a uniform once. The World Food Programme provides us with some food, but there has been no other assistance. Additionally, we have never received support from anyone more than that provided by UNHCR.
>
> *– Case sudy with a 28 year-old caregiver in Dadaab.*

4.3.3 Existing Collaboration Mechanisms among Stakeholders

The study findings established that organizations and community-based actors actively collaborate with both international and local NGOs to support unaccompanied, separated and refugee children.

Stakeholders mentioned established partnerships with organizations such as Terre des Hommes (TdH), HIAS, RefugePoint, UNHCR, and RCK. These stakeholders are perceived as resourceful allies offering specialized services that local actors may not be able to handle.

The collaborations often fill critical gaps, especially in areas such as resettlement, protection, and health services for this group of vulnerable children.

These organizations were described as central pillars in enabling a wider safety net for children in distress and improving access to essential services. The mention of international organizations such as UNHCR pointed to a strong reliance on international protection mechanisms that respond to the unique needs of unaccompanied, separated and refugee children.

Different organizations have built strong partnerships with other institutions to effectively support these vulnerable groups of children in different thematic areas. This is as discussed below.

A. Child Protection

Child protection services for unaccompanied, separated and refugee children are provided through joints efforts of national and international actors. The services offered include case management, psychosocial support, family tracing, reunification and legal aid.

While the GoK leads the response to provision of these services in the country, UNHCR as the refugee agency coordinates the efforts of UN agencies and partners to support Kenya's response to refugee related services to avoid gaps in assistance. It also provides direct operational support, capacity building and technical advice to the Kenyan authorities on matters unaccompanied, separated and refugee children and their families. [37]UNHCR partnered with different institutions to ensure unaccompanied, separated and refugee children are identified and supported.

The organizations include The Foundation for Health and Social Economic Development (HESED Africa), Hebrew Immigrant Aid Society (HIAS), Kenya Red Cross (KRC), Kituo Cha Sheria (KCS), National Council of Churches of Kenya (NCCK), Refugee Consortium of Kenya (RCK), RefugePoint, RefuSHE and Windle International Kenya (WIK). These institutions play a key role in family tracing alongside implementation of other projects targeting different vulnerable children. Family tracing requests are then referred to KRC who then review the case and determine whether tracing can be initiated. [38]

The assessment also noted that Save the Children co-leads the National Child Protection Cluster alongside UNICEF and offers technical support to the Child Protection in Emergency technical working group on conducting child protection assessments and mental health and psychosocial support (MHPSS). Save the Children also provides leadership and coordination for all child protection actors involved in different responses during humanitarian crisis to ensure reunification of unaccompanied and separated children with their families.[39]

In Turkana, the study revealed that UNHCR in partnership with DRC and TdH play a vital role in delivering child protection case management services in both Kakuma and Kalobeyei, where DRC oversees operations in Kakuma Refugee Camp while TdH oversees operations in the Kalobeyei settlement scheme.[40]

The study through literature further noted that RefugePoint through its Urban Refugee Protection Program (URPP) in Nairobi identifies unaccompanied and separated refugee children and adults and supports their safe resettlement or reunification with their families. RefugePoint also partners with other institutions who offer other legal services and address other direct services to these vulnerable groups.[41]

B. Health, Nutrition, and RH

In provision of nutrition and health related services, UNHCR works with the Ministry of Health (MoH), International Rescue Committee (IRC), Kenya Red Cross Society (KRCS) and other local based institutions to provide free health and nutrition services to asylum seekers, refugees and members of the host community at health facilities in Dadaab and Kakuma refugee camps and the Kalobeyei Integrated Settlement.

In Kakuma, there is one general hospital, two health centres and five dispensaries (health clinics). In Dadaab, there are four hospitals and seven operational health posts. There was however limited data on specific health facilities supporting refugees and asylum seekers as they depend on the health services provided at national and private healthcare facilities. This hinders their acquisition to health services as they are not able to raise the money to pay for the services in these health facilities.

C. Education

The study noted that several partnerships and collaboration efforts have been forged to support education for refugee children in Kenya by different institutions. These opportunities range from primary, secondary and tertiary education. For instance, through Albert Einstein German Academic Refugee Initiative (DAFI) scholarship programme, WIK works in partnership with UNHCR, Government of Kenya, organizational and institutional partners and marginalized communities in Kenya to provide education to all at pre and post-secondary levels.

In addition, through the partnerships with the University of Nairobi, different refugee students have been registered in the university to acquire higher education learning.[42]

37 https://help.unhcr.org/kenya/about-unhcr-in-kenya/
38 https://help.unhcr.org/kenya/kakuma/child-protection/
39 https://www.savethechildren.net/kenya/kenya-child-protection#:~:text=Save%20the%20Children%20Kenya%20has%20made%20strides,%2D%20a%20community%2Dbased%20child%20abuse%20reporting%20platform.&text=At%20the%20child%20level%2C%20working%20through%20and,care%20arrangements%20for%20unaccompanied%20and%20separated%20children.
40 https://help.unhcr.org/kenya/kakuma/child-protection/
41 https://refugepoint.org/blog/refugepoints-commitment-to-child-protection/#:~:text=RefugePoint%20is%20committed%20in%20identifying,to%20address%20other%20direct%20services
42 https://www.uonbi.ac.ke/news/refugee-students-benefit-uon-unhcr-and-wik-partnership#:~:text=Refugee%20students%20to%20benefit%20from,WIK%20partnership%20%7C%20University%20of%20Nairobi

WIK also partnered with Refugees In Schools (RIS) and other well-based technical colleges in Kenya to provide comprehensive vocational education to refugee scholars in Nairobi, Dadaab and Kakuma refugee camps. Through this joint effort, RIS supports students with counselling, monitoring their academic performance, supporting their mental health and medical needs to ensure their academic excellence.

Other organizations such as Finn Church Aid (FCA) Kenya and Save the Children also demonstrate their dedicated efforts in providing access to quality education for children and youth in the refugee camps, especially in Kakuma and Dadaab refugee camps.

They have also been actively involved in constructing and rehabilitating child-friendly learning facilities with the camps. These academic services are not provided in silos but through partnerships with UNHCR, United Nations Children's Fund (UNICEF) and other local based organizations.[43]

Overall, despite the scarce opportunities available for tertiary education, basic education is readily available and vulnerable children such as refugee children can access pre-primary and secondary education in the refugee camps. Primary education is largely managed by UNHCR and other NGOs such as LWF, FCA, WIK and Jesuit Refugee Service (JRS).

There is also an Accelerated Education Programme (AEP) for out-of-school and over-age learners-provided in selected schools and learning centers to bridge educational gaps among these populations. There is however, no distinct schools for unaccompanied, separated and refugee children in urban area (Nairobi) and these vulnerable groups are forced to attend primary and secondary schools available that rarely focus on their critical unique needs.

D. Food Security and Livelihoods

The study noted that World Food Program (WFP) is the major organization focused on addressing hunger and promoting food security among the vulnerable groups in Kenya, especially the refugee and internally displaced persons (IDPs).

It not only strives to save lives in emergencies but also uses food assistance to build pathways to peace, stability and prosperity. The literature established that WFP in partnership with the Government of Kenya (GoK) provides food and nutrition assistance to ensure crisis-affected populations are able to meet their food and nutrition needs.

[44] WFP also partnered with different institutions to aid food distributions in different parts of Kakuma refugee camp and Kalobeyei settlement areas. For instance, through contractual agreements with WFP, LOKADO conducts food distribution in Kakuma Centre 1, SAPCONE in Kakuma Centre 4, and World Vision in Kakuma Centre 3 and Kalobeyei settlement area.

The study further noted that in Kalobeyei settlements, Kakuma and Dadaab camps, WFP provides food assistance, primarily in the form of dry rations, to meet the basic needs of the refugees. The rations provided include cereals, pulses, and vegetable oil. These rations, are, however, less than the demand, hence are not sufficient for the targeted populations.

43 https://www.fcakenya.co.ke/articles/news/a-journey-of-hope-and-resilience-empowering-refugees-through-education/#:~:text=FCA's%20commitment%20to%20education%20goes,empowerment%20that%20knows%20no%20boundaries.

44 https://reliefweb.int/report/central-african-republic/wfp-calls-support-build-resilient-communities-central-african-republic-millions-set-face-hunger-2025#:~:text=WFP%20(%20World%20Food%20Programme%20)%20also,to%20meet%20their%20food%20and%20nutrition%20needs.

5.0 Conclusions And Recommendations

5.1 Conclusions

Child Protection.

This needs assessment underscores the multi-dimensional vulnerabilities faced by unaccompanied and separated children aged 10–14 years across the refugee and host communities of Garissa, Turkana, and Nairobi.

Despite the existence of policies and frameworks aimed at promoting child rights and refugee inclusion, the findings reveal significant gaps in service provision and systemic protection for unaccompanied and separated children, especially in key areas such as child protection, healthcare, nutrition, education, and livelihoods. Unaccompanied and separated children continue to face heightened risks, including physical and emotional abuse, child labour, neglect, and early marriage.

Barriers such as poverty, lack of documentation, stigma, and overburdened services exacerbate their vulnerability and limit access to care, education, and psychosocial support. Health and nutrition indicators point to concerning trends, with high reported cases of malnutrition and limited access to quality healthcare. rReproductive health issues remain under-addressed, particularly for adolescent girls. Psychosocial stress affects both children and caregivers, with few resources available for emotional support or mental health care.

The findings revealed the existence of reporting mechanisms for child related cases, with respondents mentioning humanitarian workers, child protection workers, police agencies and family members. There was however low efforts in addressing child related cases in communities, identifying a gap in utilization of these structures within the communities.

There is a need to strengthen coordination among stakeholders, expand inclusive and accessible services, and invest in community-based, child-centered solutions that promote resilience, safety, and dignity. Addressing the protection and development needs of unaccompanied and separated children requires an integrated, multi-sectoral approach that is informed by evidence, responsive to context, and sustained through strong partnerships between government, humanitarian actors, and communities.

Health and Nutrition.

Reproductive health , mental health, and nutrition services for refugee children are faced with severe access barriers based on discrimination, distance, lack of personnel, and inter-sector coordination imbalances. Efforts to mainstream refugees into national health systems notwithstanding, silence and stigma about issues like violence against women and girls and mental health continue to impede access and impact. Stigma-free, well-funded, and inclusive health systems need to be developed that recognize refugees' psychosocial and physical health issues in order to enhance general well-being.

The study noted the existence of health facilities within the refugee centers that aim towards promotion of accessible health services.
The services however, remain inaccessible to most UASC populations as the capacities of the health facilities do not match the demand within the camps. This leads to delayed acquisition of health services.

Furthermore, lack of personnel, medical equipment and medicine exacerbates the suffering of community members in accessing quality health services. With many organizations and service providers targeting UASC, study respondents called for partnerships and enhanced coordination mechanisms to ensure quality health services are provided through stocking of medicine and recruitment of more competent human resource in the health facilities.

Education.

Access to effective education for unaccompanied, separated and refugee children is hampered by a set of systemic deficits—infrastructure, materials, and documentation—and socio-cultural processes like parental attitudes and language.

Despite the commitment of humanitarian efforts and local institutions, teachers labor without adequate support in effort towards provision of education services in schools. Interventions in resource allocation, parent engagement, language-access strategies, and legal status within national education systems will close these education gaps for refugee children.

Food Security.

The study noted that many community members still rely on the relief donations majorly provided by WFP in the refugee camps. The relief food is however less than the demand hence exposes many households to hunger, with the most affected being children. This causes acute malnutrition and

nutrition related diseases hindering healthy growth among the children. Respondents reported that different institutions need to come forward to support the community members with other alternative mechanisms to generate extra income or other mechanisms of producing vegetables and other food types not provided through relief aid. The refugee in the urban set up indicated their need for economic empowerment to ensure they can raise money to purchase food as they do not get relief food provided to the refugees in the refugee camps.

Overall, the findings revealed that structural and socio-economic constraints within communities, such as limited income sources, food insecurity, and overcrowded or under-resourced schools, compound the daily struggles of unaccompanied and separated children and their caregivers. While community actors and institutions offer varying degrees of support, these efforts are often fragmented, inconsistent, and insufficient to address the scale and complexity of unaccompanied and separated children's needs.

6.1 Child Protection

The study revealed that the most prevalent challenges faced by UASC in Nairobi, Kakuma and Dadaab are child labour and physical abuse at 71.6% and 70.9% respectively. These children reported involvement in different activities to raise income to support the families.

In addition, children were severely punished with some of the caregivers for simple mistakes. According to the children, these affected their emotional and mental wellbeing. With the communities normalizing these practices and unaware of their negative impacts to the child's life, children continued suffering with no support.

To address this, the study recommends different initiatives to protect UASC children. These include:

Strengthening Community-Based Child Protection Mechanisms: ChildFund Kenya, in collaboration with Sub-County Children Officers and local partners, should prioritize the establishment and strengthening of community-based child protection strucutres. These structures should include trusted local figures such as teachers, religious leaders, elders, and youth representatives. They should be trained on case identification, safe referral, basic psychosocial support, and child safeguarding principles, and be embedded within broader formal protection systems for sustainability and accountability.

Expanding Case Management and Psychosocial Support Services: The Department of Children Services (DCS), in collaboration with ChildFund Kenya and other child protection actors should expand individualized case management for unaccompanied and separated children, particularly those exposed to violence, neglect, or trauma. This should include the recruitment of trained caseworkers and the integration of psychosocial support services within schools and child-friendly spaces. Structured mentorship and life skills programs should also be rolled out to promote resilience and long-term wellbeing.

Creation of Child-friendly Spaces: The study findings revealed that child-friendly spaces were idenfied as some of the core needs required to keep children safe and active, especially among the children who are not granted time to play and interact with other children at home. The study recommend establishment of these safe spaces that will not only ensure that children are not safe but also interact with other children to nurture their talents, skills and challenges they face for more support.

Awareness Creating among Adults and Children: One of the gaps cited during the study that promoted sexual abuse among children was lack of knowledge on their rights and the available reporting mechanisms to ensure they receive support and protection from any form of sexual abuse. Furthermore, It was evident from discussions with respondents that the communities normalized sexual abuse among the children as many lacked knowledge on the negative impacts of these practices in the lives of children.

To address these gaps, the study recommends the following:

- Creation of awareness of the available reporting pathways for children who experience protection concerns and making protection actors more accessible to children and caregivers by removing any barriers to accessibility.
- Conducting child rights awareness campaigns within the communities and teaching the caregivers on how to protect children in their households from child abuse or exploitation.
- Conducting training for children on how to protect themselves from harm and also comprehensively following up protection cases reported by children.
- Creating awareness of the importance of reporting protection concerns among children and caregivers.

Promote Education on Child Rights: To ensure that children are able to distinguish between child rights violation activities and normal activities to be supported by children at home, there is need to teach children on their rights and freedom, including raising their voices towards preservation of child rights within the community. The study recommends establishment of child groups to attract children to convene and lean about their rights and their responsibilities in identifying and reporting forms child abuse and exploitation.

Capacity Strengthening for RLOs supporting grassroots child protection services: The assessment noted that there are active RLOs and CSOs who actively support child protection services, such as She Can Initiative USEC RLOS in Kakuma that provide a safe space for children to interact, learn share ideas for their growth. The institutions, however, face a lot of challenges due to lack capacity strengthening programs and resources to deal with merging issues related to child protection. ChildFund can prioritize capacity strengthening to such institutions to ensure they are up-to-date with the required skills in combating different challenges and issues that prevent children from growing happily and safely within the communities.

6.2 Health, Nutrition, and Reproductive Health

Improving Access to Integrated Child Health and Nutrition Services: The study findings revealed that due to lack of protection and care, many UASC witin the urban set ups are not able to access quality health and nutrition services. In the refugee camps, despite the health facilities; availability, they are never enough to serve the high number of people visiting the facilities daily. This leaves most of the patients unattended to or referred to other health facilities far away from their dwelling places. This limits their access to health services.

To address this gap, The County Health Departments, in partnership with ChildFund Kenya, health-focused NGOs and Community Helath Promoters (CHPs), should invest in mobile clinics and outreach services in refugee and underserved host communities. These services should deliver immunizations, treatment for common illnesses, growth monitoring, and nutrition counselling for UASC and their caregivers. CHPs should also be equipped to conduct regular household visits for early detection and referral of malnourished or ill children.

Enhancing Adolescent-Responsive RH Services and Education: According to the survey findings, there was presence of RH challenges facing UASC as was reported by 75.7% respondents from the three counties. Specifically, there were prevalent cases of teenage pregnancies, sexual abuse cases and poor menstrual hygiene management. This indicates a significant gaps in the SRH space, with the girls being the most affected.

To address this, The Ministry of Health, Ministry of Education, working with ChildFund Kenya and other key actors, should scale up access to age-appropriate reproductive health education in schools and community settings.

This should include menstrual hygiene support, information on bodily changes, and safe reporting mechanisms for abuse. Adolescents should also have access to confidential, non-discriminatory SRH services at health facilities, with a focus on girls' safety and dignity.

Furthermore, in partnership with other service providers, such as local CSOs and NGOs, community education should be scaled up to reach children through out of school activities during holidays on SRH education. Sanitary pads should also be provided to the girls whose caregivers cannot afford the costs of these sanitary materials due to poverty.

Improving Medical Supply Support: One of the gaps identified within the health facilities was lack of adequate medicine, with some health facilities forced to provide similar medication to different illnesses and conditions.

The study recommends the need for supply of drugs and medical equipment in the health facilities within the refugee communities to improve access to healthcare services. ChildFund should establish partnerships with different partners who are already operating in the areas of Dadaab and Kakuma refugee camps and Kalobeyei settlement areas.

Specifically, to ensure that the facilities are well equipped and support health services even to UASC effectively, ChildFund should:

- Hold advocacy for recognition of unaccompanied and separated children and their caregivers in the urban set up to ensure they are recognized and given equal opportunities to access health services within the health facilities in the urban set up.

- Partner with the national government through the MoH and the county governments to ensure that the facilities are well equipped and supported to provide common health services to the UASC at reduced costs, considering that most of the households where UASC come from face poverty.

Recruitment of more healthcare workers: The health facilities offering health services to unaccompanied, separated and refugee children face shortage of trained healthcare personnel, leading to delays in service provision and long queues in health centers. This further leads to poor health services as the health workers stretch their working period beyond the recommended working hours to serve the large number of patients. There is need to recruit and employ more qualified health personnel in the refugee centers. Strengthening human resource capacity will not only reduce staff burnout but also to enhance patient satisfaction and care outcomes.

6.3 Education

Provision of Holistic Educational Support for Unaccompanied and Separated Children: ChildFund Kenya, in partnership with the Ministry of Education and school management committees, should provide comprehensive educational support packages to enable continued school attendance by unaccompanied and separated children. These should include school uniforms, stationery, tuition support, and school meals.

Improving School Infrastructure and Teacher Capacity: County education departments, in collaboration with ChildFund Kenya and development partners, should prioritize investment in school infrastructure in overcrowded and poorly resourced schools. This includes construction of additional classrooms, gender-sensitive WASH facilities, and playgrounds.

Capacity Building and Recruitment of More Teachers: The study findings revealed that many schools in the refugee camps face shortage of teachers to support learning among the learners in the schools. Considering that the refugee camps are located in the ASAL regions of the country, these areas attract less teachers.

The study recommends improvement of compensation and working conditions for teachers recruited in the refugee camp schools to enhance motivation and retention. Furthermore, they should be provided with opportunities for professional growth to ensure they effectively navigate the complex challenges of teaching in the refugee set ups.

Address Existing Language and Communication Barriers: Many UASC come from different backgrounds, some of which are not conversant with English and Swahili languages. When enrolled in schools in Kenya, however, they are combined with the other learners who have no challenge with the two languages, which are the primary languages used in implementing the school curriculum. This hinders the effectively learning of such children.

To address this gap, the study recommends adoption and utilization of linguistically appropriate teaching and learning strategies and materials to address the language and communication barriers. The learning strategies should also incorporate remedial programs to improve foundational literacy skills among the children, by potentially exploring the use of mother tongue and primary language in the early stages of learning.

Strengthen Stakeholder Coordination: The study established that there are numerous comprehensive education-related services offered in refugee camps and in Urban set ups in Nairobi, targeting UASC. However, these services are not effectively coordinated and therefore provides disjointed support among the refugee populations. This hinders their effectiveness to promote quality education.

In order to address this gap, ChilFund should enhance coordination and collaborations among the key stakeholders involved in education services among the refugee populations. These actors include UNHCR, government institutions, national and international NGOs, CSOs, and RLOs. The institution should also support active participation of refugees in decision-making processes to ensure education-related activities are designed to their needs and the needs of their children.

Promote Equity and Inclusion in Education: According to the findings, there was a notable gap in acquisition to education among the girls, who are the higher risks of dropping out of schools due to risks and disruptions such as child marriage and neglect. This calls for an urgent action to be taken to ensure that education is not only provided but designed to target the girls who are disproportionately affected by the existing systemic barriers discussed above.

The study recommends a need to develop and implement targeted programs specifically aimed at promoting girl's enrolment and retention by providing education and creating safe spaces and mentorship programs.

Additionally, ChildFund should actively engage the community, caregivers and UASC children that challenge harmful cultural practices and emphasize the value of girls' education.

Advocate for Effective and Sustainable Funding: The analysis of the literature findings established that education in the refugee camps is heavily reliant on financial support from international donors and humanitarian organizations, with limited financial support from the government. This puts education in refugee camps at risk as this funding is characterized by instability and can be subject to reductions, hence directly impacting the availability of resources to manage and run education programs.

To ensure that this gap is addressed, ChildFund needs to advocate for active engagement and role play by the government in supporting education for UASC in both the refugee camps and the urban set ups, through budget allocations and improvement of infrastructure.

Furthermore, ChildFund should explore other innovative funding mechanisms and partnerships with private sector entities and benevolent institutions to diversify refugee education funding and enhance long term financial stability of refugee-targeted education programs.

6.4 Food Security and Sustainable Livelihoods

Strengthening Food Security through Cash Assistance and Food Support: To address high levels of food insecurity, ChildFund Kenya, in partnership with county social protection departments, should expand targeted cash transfer and voucher programs for households caring for unaccompanied and separated children. These interventions should be needs-based, predictable, and supported by basic training in budgeting and household resource management.

Promoting Livelihood Opportunities and Economic Empowerment: County governments, in collaboration with ChildFund Kenya and vocational training centers, should design and implement skills-building and income-generation programs for caregivers. This includes vocational training, access to start-up capital or equipment, financial literacy training, and linkages to savings and loan groups. Priority should be given to caregivers supporting multiple dependents.
To ensure that the refugee household are not limited or disadvantaged towards promotion of their livelihoods, ChildFund in partnership with other institutions such as NRC should:

- Conduct advocacy for the government of Kenya to recognize the refugees' rights to freedom of movement within Kenya, including uncompromised out of the camps and support for them to engage in income-generating activities for the improvement of their livelihoods.
- Create awareness among the refugee populations on the significance of registration with the Department of Refugee Services. ChildFund can also support refugee in the urban settings with clear simplified procedures and guidance on how to register themselves.

Promoting Sustainable Farming and Livelihood Skills: The study revealed from discussions held with the community leaders that Turkana and Garissa counties hosting refugee communities face arid and semi-arid climatic conditions that hinder agricultural activities hence hindering agricultural activities to support food availability. This calls for modern interventions to ensure that agricultural production is promoted withihn these areas.

The study therefore recommends sustainable agricultural practices to improve food security in these communities. Families should be equipped with the capacity to grow their own food and generate income, thereby reducing dependency on aid. ChildFund and other key partners can introduce farming technologies that can withstand local climatic conditions and offer year-round food production. These may include kitchen gardening, small-scale irrigation, and training in drought-resistant crops.

Advocate for Vocational Training: Participants also advocated for vocational training in food processing and small enterprise development. Such skills would enable community members to sell surplus produce, improving both food access and economic wellbeing.

6.5 Advocacy and Systems Strengthening

Advancing Policy and Legal Reforms to Protect Unaccompanied and Separated Children: ChildFund Kenya, working with national child rights coalitions and the National Council for Children's Services (NCCS), should advocate for policy reforms that ensure the inclusion of unaccompanied and separated children in service delivery frameworks. These efforts should focus on birth registration, alternative care policy, and the enforcement of laws related to abuse, neglect, and early marriage. Child participation in advocacy processes should also be encouraged to ensure their voices are heard in decision-making spaces.

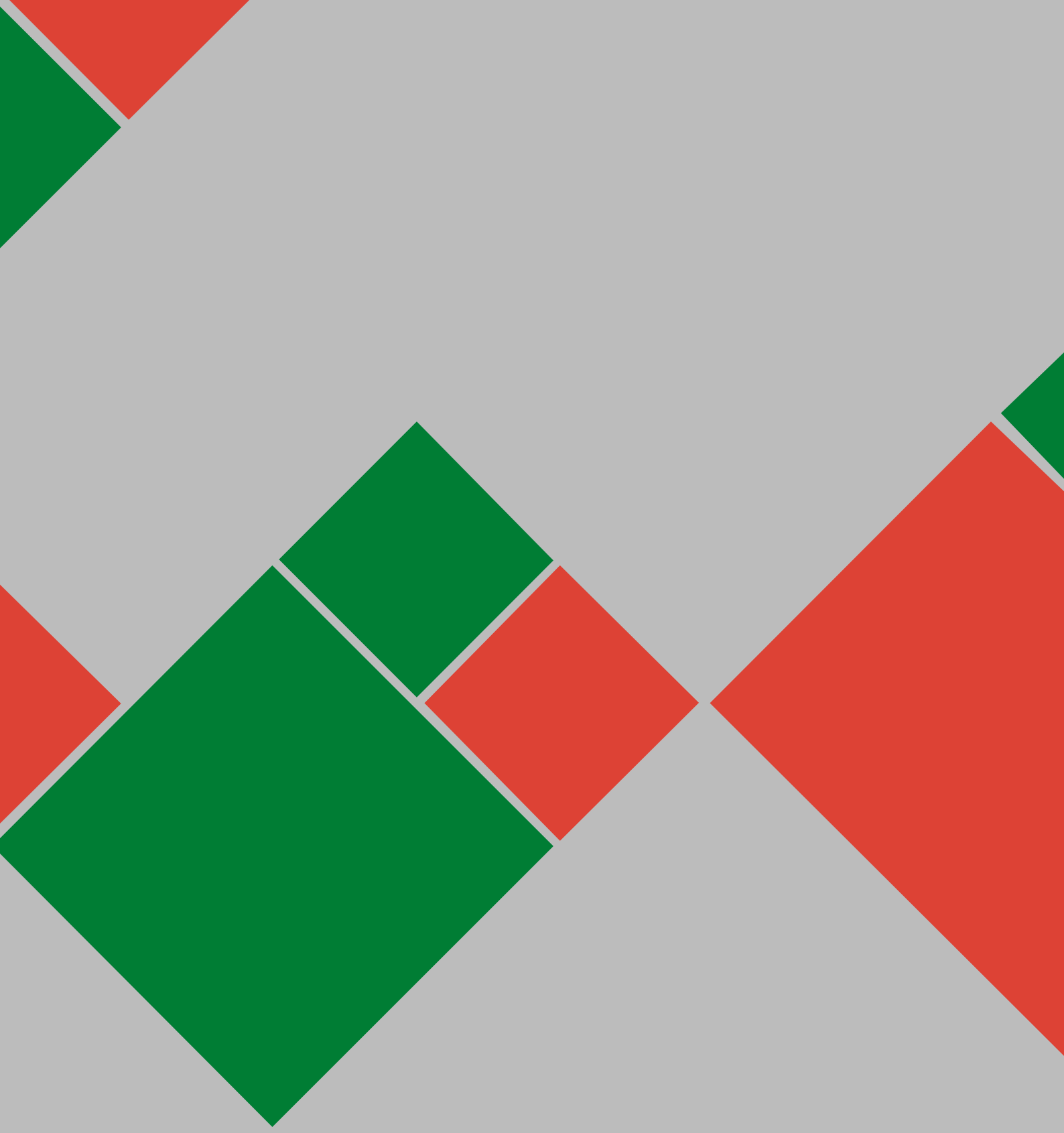
Strengthening Data and Information Management Systems: The Department of Children Services, in collaboration with UNHCR and ChildFund Kenya, should prioritize the expansion and use of the Child Protection Information Management System (CPIMS) across all target counties. Training should be provided to frontline child protection officers, teachers, and health workers on data entry, analysis, and use for decision-making. Strengthening these systems will ensure more accurate tracking of cases, better targeting of interventions, and improved monitoring and evaluation.

Right to **life.**
Right to **safety.**
Right to **food.**
Right to **health.**
Right to **education.**
Right to **justice.**
Right to **nationality.**

These – and more – are fundamental human rights for **children in displacement.**

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