THE YOUNG CHILDREN OF CRSV SURVIVORS

ASPIRATIONS, STIGMA, HEALTH, EDUCATION AND SURVIVOR-LED PATHWAYS FORWARD

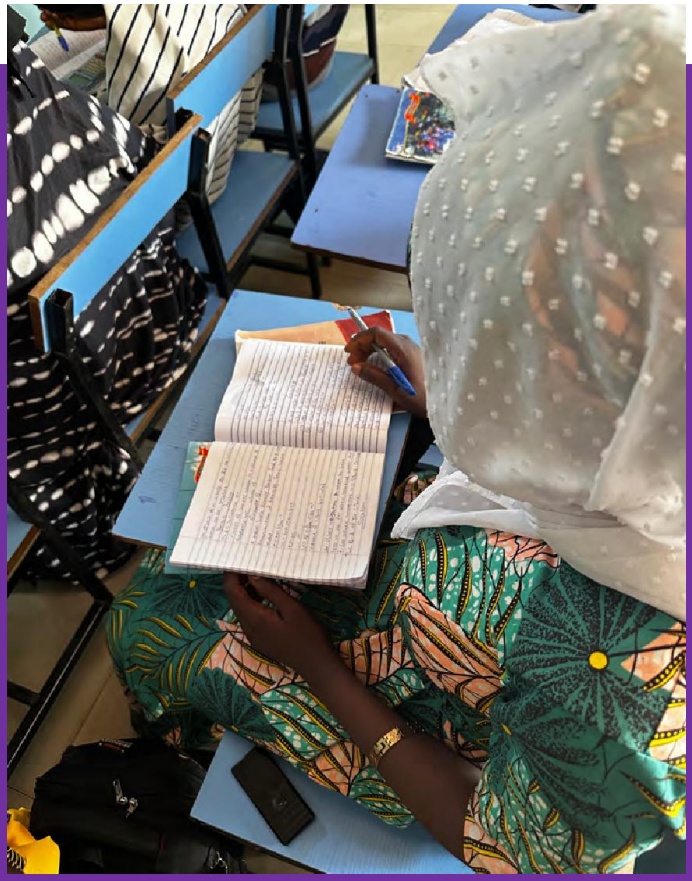
Prepared by the development Research and Projects Centre (dRPC)

A child-focused thematic analysis of CRSV survivor responses

Coverage: Borno State, Nigeria

Evidence base: Big N = 82 survivors · 671 coded references · Questions 1–9

July 2026



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ABBREVIATIONS AND MEASUREMENT KEY

This report uses a consistent set of qualitative measures. Each is defined here and applied uniformly throughout; figures state which measure they use.

Term	Meaning
CRSV	Conflict-related sexual violence
dRPC	development Research and Projects Centre
Big N	The full survivor sample, Big N = 82. The denominator for survivor-level prevalence.
small n	The number of survivors, responses or eligible coded units in which a theme appears (always stated with its unit).
Peak n / 82	The largest number of distinct survivors raising a theme within a single question. The headline prevalence measure.
Coded references	Coded passages indicating weight of evidence. Not people, and not prevalence.
Coding visibility	The share of eligible units in which a theme appears at least once. Shows spread, not population prevalence.
Response-level co-occurrence	Two codes appearing in the same response. Used to evidence linked meanings and pathways.
Coded-reference share	A proportion of all coded references.

EXECUTIVE SUMMARY

Background and origin of the study

The conceptual point of departure for this study, undertaken some three years ago, was reparative education education as a means of making restitution to survivors of conflict-related sexual violence (CRSV). This analysis returns to the same dataset to tease out specific information about the survivors' young children: what mothers and survivors want for them, what challenges the children experience (stigmatisation in particular), what health and education challenges they face, and what the way forward should be. The reparative-education frame remains the lens throughout the findings describe not only what survivors need, but what would make restitution real for the next generation.

This analysis returns to the dataset on survivors of conflict-related sexual violence (CRSV) in Borno State and asks a child-focused question: what does the evidence reveal about the young children in survivors' care, and what do survivors want for them? The study covers all young children survivors are raising children conceived through CRSV and the other young dependants in the household and is closed and data-only, drawing every figure and quotation from 82 survivors' responses (Big N = 82) across Questions 1–9, comprising 671 coded references.

Percentages reported in figures refer to coded references (weight of evidence) or to peak prevalence (the largest number of distinct survivors raising a theme in a single question, out of 82). They do not measure statistical prevalence in the wider population.

The single integrated pathway

The findings share one underlying logic, set out in Figure 1. The violence and displacement generate two streams of harm for the child stigma and identity injury on one side, hunger and ill-health on the other which converge on the child's schooling, the survivors' highest aspiration and their point of greatest risk. The pathway then turns on the survivor's own protective agency and her demand for a livelihood, resolving into the integrated response survivors themselves describe. Every section that follows fills in the evidence for one stage of this pathway.

The finding that matters most

The finding that matters most is that survivors bind their children's education to their own livelihood security. Education is the master aspiration, but survivors do not treat it as a standalone request: they make it conditional on the means to feed, protect and keep all the young children in their care in school. In 27 responses the schooling aspiration is voiced together with a direct request for education support, and in 17 it is voiced together with the mother's need for a livelihood. The decisive programming implication is that child education support and maternal livelihood support should be designed as one integrated intervention, not two separate activities.

Ten headline findings

- Education is the master aspiration. The wish for a child's schooling is the single most-referenced code in the dataset (107 references; peak 21/82) and recurs across many questions, not only education prompts.
- Survivors speak the language of normality. They repeatedly ask that their children be schooled "like any other children" education is sought as re-inclusion and dignity, not only instruction.
- Stigmatisation is the leading child-protection risk. It is the most prevalent challenge theme (peak 34/82, 41.5%, in Q1.3), operating through perpetrator labels, community ostracism, kin rejection and identity confusion.
- Stigma works through naming. Children are labelled "Boko Haram children" and worse; the label travels into peer relationships and the receiving community, damaging belonging.
- Hunger and healthcare are the immediate burdens. Hunger/feeding (47 references) and healthcare access (32 references) dominate the health evidence and are repeatedly tied to displacement.

- Weight and prevalence diverge, and the divergence is informative. Hunger carries the greatest evidentiary weight but a modest peak (6/82); perpetrator labelling carries less weight but a higher peak (14/82). Reading either measure alone would mislead.
- Barriers are under-volunteered relative to aspiration. Survivors translate hardship into aspiration, speaking first of what the child should become and only second of the obstacles — the aspiration–barrier gap.
- Maternal protective agency is a central asset. Survivors claim, shield and plan for their children despite stigma; interventions should build on this rather than treat survivors only as victims.
- Sensitive disclosures point to a child-protection emergency. References to abortion linked to stigma and to maternal ambivalence, though few, mark where confidential, trauma-informed care is most needed.
- Survivors articulate a coherent way forward. Education support, maternal livelihood, health and nutrition, anti-stigma sensitisation and child protection form a survivor-led agenda, peaking at 35/82 (42.7%).

Four questions, one dataset

The analysis is organised around the four questions the study set out to answer. Each maps to a theme in the coded framework, and each is addressed in its own section below.

	Question	What the evidence covers	Weight
1	What do mothers want?	Aspirations for the child - above all, education	RQ1 · 168 refs
2	What challenges do children face?	Stigmatisation, labels, ostracism, identity confusion	RQ2 · 129 refs
3	What are the health and education challenges?	Hunger, healthcare access, out-of-school	RQ3+4 · 107 refs
4	What is the way forward?	What survivors themselves say should be done	RQ5 · 119 refs

How to read this report

Every figure states the measure it uses. In brief: weight of evidence counts coded references (what survivors dwell on); peak prevalence is the largest number of distinct survivors raising a theme in a single question, written as peak n / 82 (how widely it is shared); coding visibility shows where a theme surfaces across the interview; and response-level co-occurrence counts codes appearing together in the same answer (how meanings connect). Coded references are never presented as if they were numbers of survivors. Big N = 82 is the denominator for every prevalence figure.

METHODOLOGY

How the analysis was designed, coded and measured.

Research objectives

Building on the study's reparative-education foundation, this child-focused analysis addresses four objectives: (1) to establish what mothers and survivors want for their young children; (2) to identify the challenges those children experience, stigmatisation in particular; (3) to examine the children's health and education challenges; and (4) to determine the way forward. Each objective maps to a theme in the coded framework and is addressed in its own findings section.

Research design and evidence base

The study adopts a qualitative, thematic-analysis design. The data-only analysis of survivor responses to Questions 1-9 of the CRSV dataset. The survivor sample is Big N = 82, and the unit of analysis is the survivor response. The framework comprises 28 codes within six themes and 671 coded references; a single response may carry several codes where it expresses several meanings.

Coding process

Coding combined a deductive codebook aligned to the research questions (RQ1 aspirations, RQ2 stigma, RQ3 health, RQ4 education, RQ5 way forward) with inductive codes capturing meanings that emerged from the transcripts, including the education-as-normality frame, the aspiration-barrier gap and the household lens. The process followed familiarisation, deductive application, inductive extension, matrix comparison by question, and review of quote-ready extracts to ensure each major claim is supported by traceable evidence. Each coded reference records its source question, response number, code lineage and the text pattern that triggered it.

How the measures are calculated and read

Because qualitative counts are easy to misread, the report distinguishes measures carefully. Weight of evidence is the number of coded references coded passages, indicating salience, not people. Peak prevalence is the largest number of distinct survivors raising a theme within a single question, expressed as peak n / 82; this is the defensible survivor-level figure. Coding visibility is the share of eligible units in which a theme appears, shown here as distinct-survivor salience by question. Response-level co-occurrence counts codes appearing together in the same response, and is used to evidence pathways. Coded references are never presented as if they were the number or percentage of survivors.

The child burden pressure view

To compare burdens on a like-for-like basis, the report places each burden's weight of evidence beside its peak prevalence (Figure 4). This is a presentational device, not a new statistic: it simply shows the two measures together so that a burden which is frequently mentioned but by few survivors can be distinguished from one mentioned by many. It is built entirely from the coded register.

Ethics, sensitivity and quality assurance

Sensitive codes maternal ambivalence or difficulty bonding, and abortion considered or forced in connection with stigma are reported only in aggregate, without graphic detail. Quotations convey analytical meaning rather than distressing detail and are attributed by question and response number only; no identifying information is reproduced.

SECTION 1: SETTING THE CONTEXT — WHO THE SURVIVORS ARE, AND WHY A HOUSEHOLD VIEW

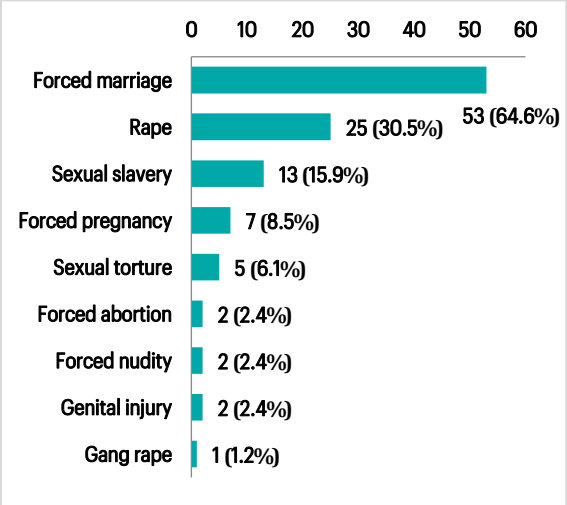
Whose children are these, what did the survivors endure, and why must the analysis take a household view?

Who the 82 survivors are

The survivors are 82 women interviewed in Maiduguri, Borno State, in October 2023. All were subjected to conflict-related sexual violence, and in every case the perpetrator group was Boko Haram. They are young: 58.5% are aged 18–24 and a further 32.9% are aged 25–35, so more than nine in ten are under 35. Ninety per cent (74 of 82) belong to a survivor group or civil-society organisation a detail that matters for the survivor-led framing of this report, because these are women already organised around their own recovery.

The forms of violence they report are set out in Figure 2. Forced marriage is the most common, reported by 64.6% (53 of 82), followed by rape (30.5%) and sexual slavery (15.9%), with forced pregnancy, sexual torture, forced abortion and other forms also recorded. Many survivors experienced more than one form, and the figure therefore sums to more than the sample.

Figure 1: Forms of sexual violence suffered by the 82 survivors



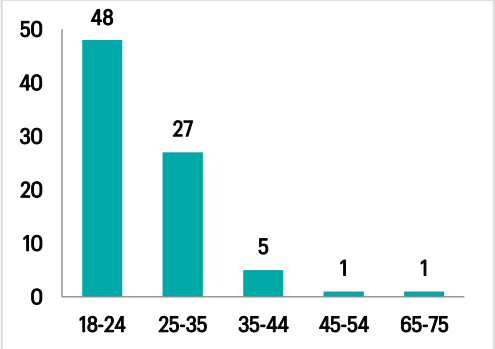
Evidence note. *Bars show the number of survivors reporting each form; a survivor may report several, so counts sum to more than 82. Big N = 82; unit = survivor; measure = demographic proportion. .*

Figure 1 shows a sample defined above all by forced marriage, which frames much of what follows: for many survivors, the child they are raising was born into a marriage they did not choose, and the questions of the husband's role, the child's legitimacy and the mother's means to provide are therefore never far from the surface.

A finding hidden in the profile: half were children themselves

One demographic fact reframes the entire study. Asked whether the survivor was a child or an adult when the violence took place, 53.7% (44 of 82) were children under 18 at the time. Many of the "mothers" whose aspirations, burdens and recommendations this report analyses were themselves girls when they were victimised. Figure 2 sets this out alongside the age profile.

Figure 2: Age range of survivors, and whether a child or an adult when the violence occurred.



Evidence note. *Left: age range now (n/82). Right: child or adult at the time of the violence (n/82). Big N = 82; unit = survivor; measure = demographic proportion.*

Figure 3: Child or adult when victimised

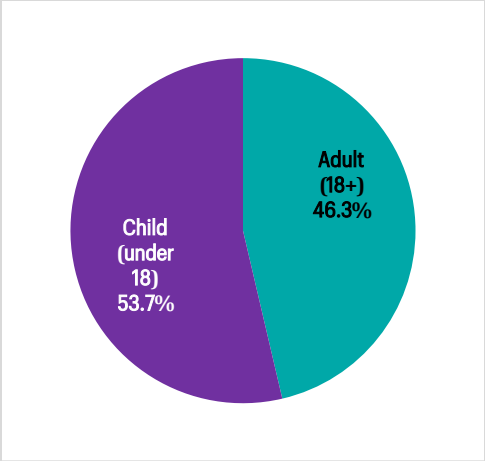


Figure 2 has direct implications for how the findings should be read. When a survivor speaks of wanting her child schooled "like any other children," she may be speaking as someone whose own schooling was cut short by abduction and forced marriage while she was still a child herself a point the education evidence in Section 3 bears out. It also sharpens the child-protection framing of the sensitive disclosures discussed in Section 4: the dataset concerns not only the children of survivors but, in more than half of cases, survivors who were children. Programmes should treat the mother's own interrupted childhood and education as part of the intervention, not merely as background.

Why the analysis takes a household view

The survivors are mothers raising young children under conditions of poverty, displacement and intense social stigma. Many were abducted and held in captivity, gave birth to children fathered by perpetrators, and returned to displacement or camp settings. The evidence they give is rarely about a single child. Of the 671 coded references, 267 (39.8%) speak to siblings or other young dependants a coded-reference share that establishes the household lens used throughout this report.

This is not an abstract coding observation. Survivors describe their circumstances in the plural, as mothers of several young children whose needs are entangled. One survivor's account of her situation moves directly from the violence to the children she must now raise:

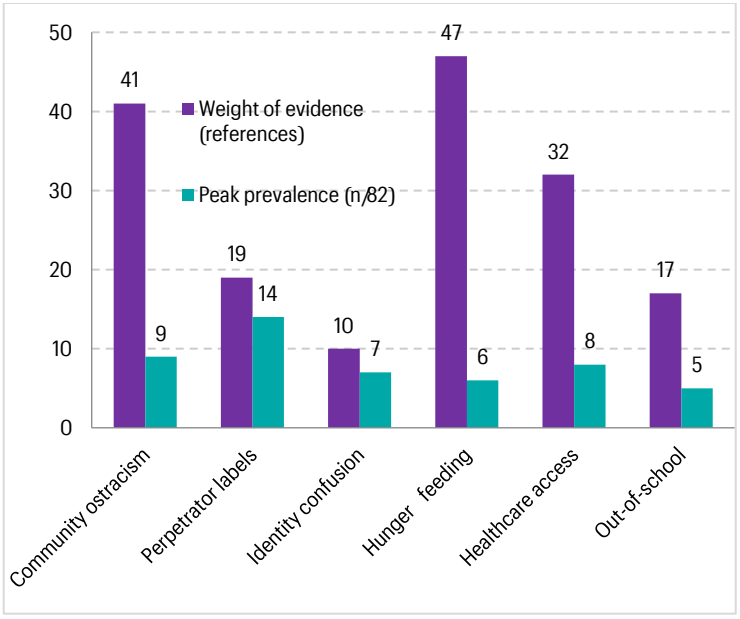
> *"This was how we found ourselves in a situation that I don't think I can forget because I grew up in suffering environment and now with five children I don't even know what to do."— Q1.1 · response #4*

The reference to "five children" is analytically important. The burdens documented in the sections that follow stigma, hunger, the struggle to school a child — fall on a household, not on an individual. A second survivor names the same household reality through loss:

> *"I gave birth twice to different husbands and the two children died because of hardship and no enough food to take."— Q1.1 · response #16*

This account fuses the household lens with the health burden examined in Section 4: child mortality is attributed directly to deprivation across the household. The implication for programme design is structural. Support organised around a single identified child typically the child conceived through CRSV will miss the wider burden and may create tension among siblings where one child receives assistance and others do not. The appropriate unit of support is, in most cases, the survivor's child household.

Figure 4: Child burden pressure- weight against prevalence against peak prevalence, by burden



Evidence note. *Bars show coded references (weight of evidence) and peak distinct survivors (peak n/82). Big N = 82; units are coded reference and survivor respectively. Reading limit: the two measures answer different questions - how much is said, and by how many - and should not be summed.*

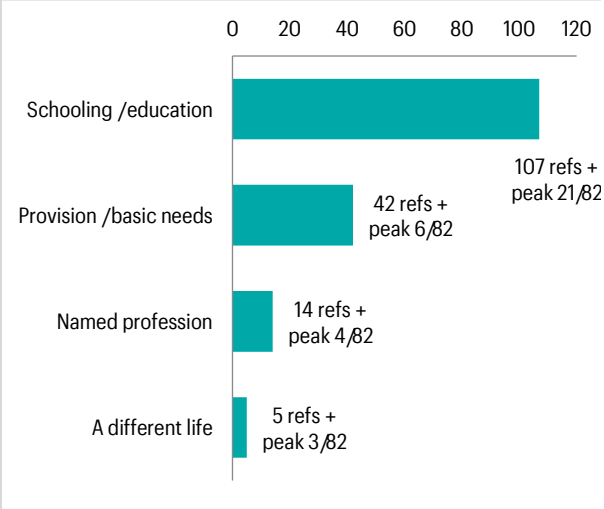
Figure 4 introduces a distinction that recurs throughout the report. Hunger and feeding carry the greatest weight of evidence of any child burden (47 references) yet peak at only 6 of 82 survivors in a single question, because hunger is mentioned repeatedly and across many questions rather than concentrated in one. Perpetrator labelling shows the opposite profile fewer references (19) but a higher peak (14/82) because it is raised sharply and by many survivors at the single question about the challenges children face. The lesson for interpretation, and for programming, is that neither measure alone is sufficient: weight reveals what survivors dwell on, prevalence reveals how widely a concern is shared, and the two must be read together.

SECTION 2: RQ1 — WHAT DO MOTHERS WANT FOR THEIR YOUNG CHILDREN?

What future do survivors describe for their children, and why does one aspiration dominate?

RQ1 carries 168 coded references, the largest weight of any theme. When survivors speak of their children's futures, one aspiration dominates: education. The wish for a child's schooling (code 01.01.01.a) is the most-referenced code in the entire dataset, with 107 references and a peak of 21 of 82 survivors in a single question. Figure 5 sets out the hierarchy.

Figure 5: The aspiration hierarchy - coded references with peak survivor figures.



Evidence note. *Bars show coded references (weight of evidence); peak figures show distinct survivors in a single question. Big N = 82; unit = coded reference. Reading limit: reference counts are not survivor counts.*

Figure 5 shows education outweighing every other aspiration by more than two to one in references. Material provision food, shelter and basic care is second, and the wish for a named profession or for "a different life" from the mother's own is voiced by fewer survivors but expresses the emotional core of the others. The structure is that of an instrument and a goal: schooling and provision are the means; a different future is the end.

Education as dignity and re-inclusion, not only instruction

What survivors mean by education is broader than schooling. A recurring phrase makes the meaning explicit the wish for children to be educated *"like any other children"*. The comparison is the analytical key: education is sought as a route back to normality and belonging for children otherwise marked as different.

> *"Giving them support or assistance with their parents, and enrolling them into school and becoming educated will brighten up their lives and their status will be upgraded in the society."— Q4.6FU · response #9*

This account frames education in explicitly social terms "status… upgraded in the society" rather than economic ones. The mechanism the survivor describes is re-inclusion: schooling is the means by which a stigmatised child is restored to standing in the community. A second survivor makes the same move while connecting education to moral repair:

> *"The children born of rape, they were only born, they don't know how they were born; the best program for them is… education should be considered so they can grow up to be better people."— Q4.6FU · response #28*

Two analytical points follow. First, the survivor explicitly separates the child from the circumstances of conception "they were only born, they don't know how they were born" and positions education as the answer to a question of identity, not merely of skills. Second, this is the same logic identified in Section 3 on stigma, viewed from the other side: where stigma marks the child through naming, education is proposed as the counter-process that re-establishes worth. The programming implication is that education offers for these children are simultaneously an anti-stigma intervention, and should be designed and messaged as such rather than as standalone schooling support.

Because education carries these meanings, survivors reach for it throughout the interview, not only when asked directly about schooling. The salience map in Section 6 (Figure 11) confirms that the schooling aspiration appears across a wide spread of questions,

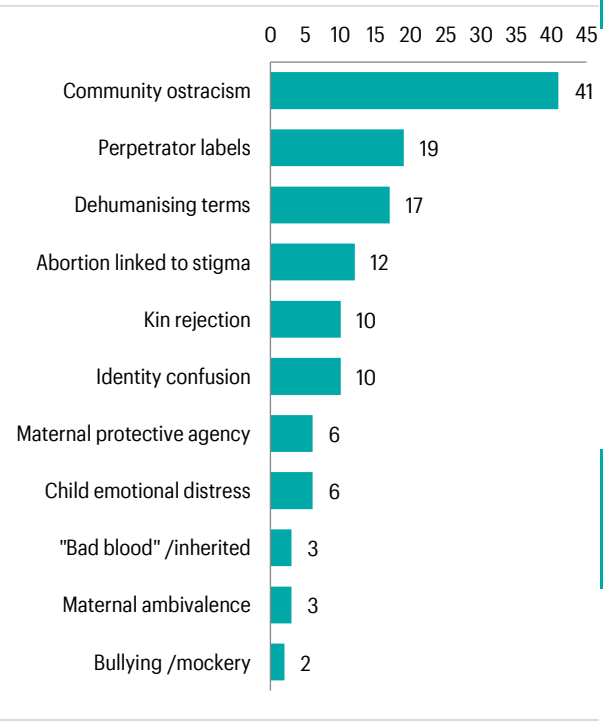
where most other codes concentrate in one. This distribution is itself evidence that education is the survivors' organising frame for a safe future.

SECTION 3: RQ2 — WHAT STIGMATISATION AND SOCIAL CHALLENGES DO THE CHILDREN FACE?

How does stigma operate against the child, and where are the limits of survivor protection?

RQ2 carries 129 coded references and is the most prevalent challenge theme, reaching 34 of 82 survivors at its peak in Q1.3 the question about the challenges children face. Stigma is not a single experience but a cluster of overlapping harms, set out in Figure 6.

Figure 6: The anatomy of stigma — coded references by form, with maternal protective agency as a counter-theme.



Evidence note. *Bars show coded references (weight of evidence), ranked by salience. Big N = 82; theme peak 34/82 in Q1.3. Unit = coded reference. Reading limit: references are coded passages, not counts of children affected.*

Figure 6 shows community ostracism as the most heavily evidenced form, frequently extending to rejection by the survivor's own family, with perpetrator labelling the most survivor-prevalent single form. The sections below trace how the cluster operates.

Stigma operates first through naming

The most consequential mechanism in the dataset is naming. A child is socially tied to the perpetrator group through a label, and the label travels into peer life and the receiving community.

> *"Children born as a result of rape face so many challenges; they're referred to as Boko Haram children among their friends, some even referred to them as bastard."— **Q1.3 · response #3***

This is the clearest single statement of the naming mechanism in the dataset. Two features matter analytically. First, the harm is located "among their friends" stigma operates at peer level, in the very social space education is meant to provide. Second, the escalation from "Boko Haram children" to "bastard" shows the label sliding from political association to a denial of legitimacy, which the identity evidence below confirms is how children themselves experience it. A second survivor shows the same naming reaching into the displacement setting:

> *"The children also suffer because they are called children of Boko Haram; even those people in the IDP camp have been showing hatred towards us."— **Q1.3 · response #53***

The detail that the labelling occurs "even… in the IDP camp" is important: the camp, nominally a place of refuge, reproduces the stigma rather than relieving it. This triangulates with the displacement evidence in Section 6, where camp context and stigma co-occur in 15 responses. The implication is that anti-stigma work cannot be located only in home communities; it must extend into displacement and camp settings, where survivors and children are concentrated and where the label evidently follows them.

From naming to identity injury

Naming does not stay external. Survivors describe children internalising the label as confusion and worthlessness about their own origins.

> *"First they don't have a father and secondly they are not cared for, they don't know their status, it is as if they are useless."— Q1.3 · response #12*

This account traces the full arc from social naming to internalised identity injury from "no father" to "as if they are useless." It is the psychological counterpart of the labelling evidence above, and it is why the report treats stigma as a child-protection risk rather than a reputational inconvenience. A third survivor locates the same injury in the child's peer interactions:

> *"Children born of rape really feel unhappy and separated and uncomfortable all the time, and if they quarrel with other children, they are being insulted, and they will be telling them they don't have a father."— Q1.3 · response #9*

The mechanism is now fully visible: an ordinary childhood quarrel becomes an occasion for the absence of a father to be weaponised. The programming implication is that the child needs age-appropriate psychosocial support that addresses identity directly, and that school-based anti-bullying and acceptance work is not optional but central, because the school and peer group are where the injury is repeatedly inflicted.

Sensitive dimensions and a child-protection emergency

Two sensitive codes appear in small numbers: abortion considered or forced in connection with stigma (12 references) and maternal ambivalence or difficulty bonding (3 references). They are reported here only in aggregate. They are not failings of survivors; they are consequences of extreme stigma, trauma, social rejection and the absence of support, and they mark precisely where confidential, trauma-informed care is most needed. Read alongside the healthcare evidence in Section 4 births "in the bush… because there is no medical assistance," children lost for want of care these references sharpen the analysis from a description of social hardship into an immediate child-protection concern that warrants specialist response and careful human review before any external use.

The counter-theme: maternal protective agency

Against this cluster, the data record survivors who refuse the stigma on their children's behalf. Maternal protective agency (6 references) is among the most important assets the evidence reveals.

> *"They have to show them love, so that they will not feel that they were not born legally; secondly, to enrol them in school."— Q4.6FU · response #39*

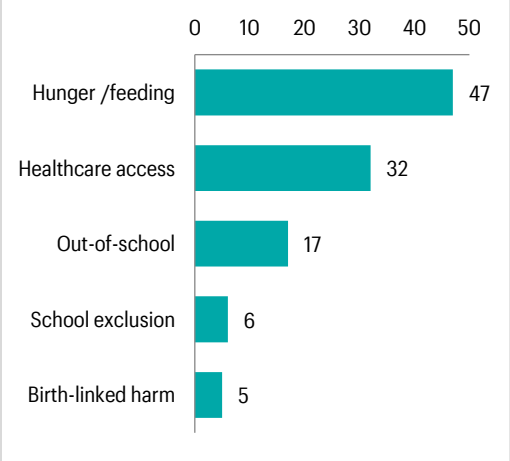
This account is doubly significant. It names the protective response to identity injury "show them love, so that they will not feel that they were not born legally" and then moves immediately to schooling, binding protection to education in a single sentence. It is the clearest evidence that survivors are not passive: they hold both the diagnosis and the remedy. The implication is that interventions should be built with survivors as partners, reinforcing the protective and aspirational capacity the data already document rather than positioning survivors solely as recipients of help.

SECTION 4: RQ3 AND RQ4 — HEALTH AND EDUCATION CHALLENGES

What are the children's daily survival and schooling burdens, and why do barriers appear less often than aspirations?

This section addresses the children's health challenges (RQ3, 84 references; peak 14/82) and education challenges (RQ4, 23 references; peak 6/82), and then draws out the aspiration–barrier gap that connects them to RQ1. Figure 6 sets out the burdens.

Figure 7: Health and education burdens — coded references by type.



Evidence note. *Bars show coded references (weight of evidence); red marks health burdens, orange marks education barriers. Big N = 82; health peak 14/82, education peak 6/82. Unit = coded reference. Reading limit: reference counts are not survivor counts.*

Figure 7 shows hunger and unmet feeding need as the dominant health burden, well ahead of any other concern, followed by lack of healthcare access. On the education side, the barriers named are children being out of school and exclusion within school. The sections below examine each, and then the gap between them and the aspiration of Section 2.

Hunger and healthcare as displacement-linked survival burdens

Survivors describe hunger not as a discrete problem but as the condition within which children are raised, and sometimes lost.

> *"Children born of rape are facing challenges from the womb; mostly the women that are giving birth in the bush are suffering because there is no medical assistance, with such kind of reason, I also lost my child."— **Q1.3 · response #6***

This account locates the healthcare burden at the very beginning of the child's life "from the womb" and ties child death directly to the absence of medical assistance during births in the bush. It triangulates with the sensitive-code evidence in Section 3: the same conditions that produce maternal trauma also produce preventable child mortality. A second survivor shows the burden persisting well beyond birth, and the failure of the services that do exist:

> *"My five-year-old child Habu has ear and stomach problem. I have visited several free health care services and several herbal medical treatments but did not work."— **Q1.3 · response #28***

This is an analytically valuable account because the survivor has actively sought care "several free health care services" and found it ineffective. The barrier here is not awareness or willingness but the quality and adequacy of available services. The implication is that health programming for these households must go beyond referral to ensure that the services referred to can actually treat the conditions presented; a referral to an ineffective service reproduces the very experience that erodes trust.

Education barriers: out of school, and excluded within it

The education barriers survivors name are being out of school and exclusion within it. One survivor's account shows how the disruption compounds across a life:

> *"This thing has badly affected me because, first of all, I have been taken to a bush which I have never known; secondly, I was forced to get married without my consent; and thirdly I had to drop out of school and I lost my home."— **Q1.1 · response #63***

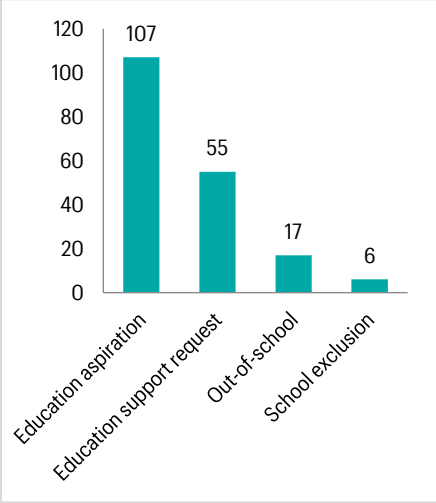
Education loss appears here as the third in a chain of dispossessions, which is precisely why it is often not volunteered as a discrete "barrier": it is experienced as

one facet of a larger catastrophe. This observation sets up the gap analysis below.

The aspiration–barrier gap

Here the analysis surfaces its central tension. Education is the thing survivors most want (107 references; peak 21/82) and most request (55 references; peak 29/82), yet they volunteer the education barriers far less often (out-of-school just 17 references; peak 5/82). Figure 7 shows the asymmetry.

Figure 8: The aspiration–barrier gap - demand-side codes against barrier-side codes.



Evidence note. *Bars show coded references (weight of evidence). Big N = 82; aspiration peak 21/82, support-request peak 29/82, out-of-school peak 5/82. Unit = coded reference. Reading limit: lower barrier counts do not mean barriers are minor.*

Figure 8 shows demand expressed far more frequently than explicit barriers. The interpretation is stated here precisely, because it is one of the report's most important analytical contributions:

> *The under-volunteering of education-barrier codes should not be read as the absence of barriers. Rather, it shows that survivors often translate hardship into aspiration: they speak first of what the child should become, and only second of the administrative, financial or social barriers that prevent this future.*

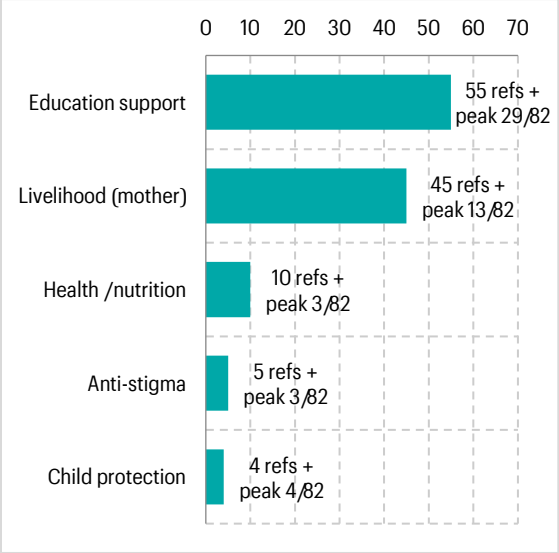
The evidence in this section supports the reading directly. The survivor who lost a child to the absence of medical assistance, and the survivor whose schooling was the third casualty of her abduction, do not present "barriers" as a category; they present a life in which the barriers are everywhere and therefore unremarkable. The programming implication is that need should be read from demand under conditions of poverty, displacement and stigma, rather than waiting for survivors to itemise obstacles. High, high-prevalence demand for schooling, set against near-universal hardship, already implies the barriers; a monitoring system that records only explicitly named barriers will badly understate them and should instead probe for them actively.

SECTION 5: RQ5 — WHAT WAY FORWARD DO SURVIVORS RECOMMEND?

What do survivors themselves prescribe, and what is the binding relationship between their requests?

RQ5 carries 119 coded references and reaches the highest prevalence in the dataset, 35 of 82 survivors at its peak in Q4.6FU. These are survivors' own prescriptions, and they form a coherent, priority-ranked agenda, set out in Figure 9.

Figure 9: Survivor-led recommendations — coded references with peak survivor figures.



Evidence note. *Bars show coded references (weight of evidence); peak figures show distinct survivors in a single question. Big N = 82; education-support peak 29/82, livelihood peak 13/82. Unit = coded reference.*

Figure 9 ranks the requests. Education support leads by a clear margin; livelihood support for the mother is second and, as this section shows, the enabling condition for the first. Health and nutrition, anti-stigma sensitisation and child protection appear less frequently but are not secondary: each protects the education pathway.

Livelihood is the condition, not a parallel ask

The defining feature of the recommendations is that survivors do not separate their child's education from their own income. They bind the two together in the same breath, repeatedly. The clearest statements come from the question on current needs:

> *"I am currently in need of capital to start a business, enrol my children in school like any other children to provide them with their needs, since they don't have anyone to support them other than me."— Q2.1 · response #10*

This single sentence contains the report's central argument in the survivor's own words. Capital, schooling "like any other children," and sole responsibility are stated as one indivisible need. The phrase "like any other children" again carries the dignity frame from Section 2: the livelihood is wanted not for its own sake but so that the child can be normal. A second survivor states the dependency even more economically:

> *"I need capital to start a business that will able me take care of my children and old parents also."— Q2.1 · response #14*

Here the livelihood is explicitly the instrument of care for the whole household children and "old parents" alike confirming the household lens of Section 1. A third survivor sequences the logic into a chain:

> *"My needs include a means of livelihood such as business, that will let me provide for my kids and send them to school, and also provide for my parents."— Q2.1 · response #66*

Across these three accounts the structure is identical and unmistakable: livelihood enables provision, provision enables schooling. This is not a coincidence of phrasing but a consistent causal model held by survivors, and it is confirmed quantitatively by the co-occurrence evidence in Section 6, where the schooling aspiration and the livelihood request appear together in 17 responses. The programming implication is the report's headline conclusion: funding a child's schooling without stabilising the mother's income risks the child dropping out, while supporting the mother's livelihood without an explicit schooling pathway risks income going to immediate survival first. The two must be designed as one.

SECTION 6: CROSS-CUTTING AND STRUCTURAL ANALYSIS

How do the themes connect, where do they surface, and what single pathway do they form?

6.1 Co-occurrence: the meanings survivors link

Response-level co-occurrence codes appearing together in the same response reveals the connections survivors themselves draw. The strongest links are summarised below; counts are response units in which both codes appear, not raw reference totals.

Linked codes	Co-occurring responses	What the link shows
Education aspiration × education support request	27	Survivors want schooling and ask for help to achieve it
Education aspiration × livelihood request	17	Schooling is made conditional on the mother's income
Displacement × hunger / feeding	15	Camp context drives unmet feeding need
Community ostracism × displacement	15	Stigma follows survivors into the camp
Provision × hunger / feeding	13	The wish to provide is voiced alongside hunger
Perpetrator label × child conceived through CRSV	9	Labelling attaches specifically to the child's origin

The table tells one story. The two strongest links in the entire dataset are between the education aspiration and the two requests that would make it achievable. This is the quantitative backbone of the qualitative argument built in Section 5: survivors' own answers connect schooling to support and to livelihood more tightly than they connect any other pair of ideas. Displacement, meanwhile, sits behind both hunger and stigma, confirming the camp setting as a driver of two distinct burdens. These are meanings co-stated by survivors, not artefacts of frequency, which is why they are read as pathways.

6.2 Question-flow and salience

Where a theme peaks in the interview is informative. Because complete coding-visibility denominators (eligible responses per question) are not available in the supplied register, this report does not present visibility percentages; it provides instead a traceable map of distinct survivors raising each code in each question.

Table 1: Question-flow evidence map — distinct survivors per code, by question

Each cell is the number of distinct survivors raising that code in that question. Big N = 82.

Code / Question	Q1.1	Q1.1a	Q1.2	Q1.3	Q2.1	Q2.2	Q2.3	Q3.1	Q3.2	Q4.6	Q4.6FU	Q5.2	Q5.3	Q5.4	Q8.2c	Q8.3h	Q9.9
Education aspiration	1	1	2	8	12	9	13	1	2	2	21	2	20	2	2	5	2
Provision / basic needs	5	6	4	0	6	3	2	1	2	0	2	0	3	2	1	3	0
Perpetrator labels	1	1	1	14	0	0	0	0	0	0	0	0	0	0	0	0	0
Community ostracism	9	9	6	8	0	0	0	0	0	0	1	0	0	0	0	0	0
Identity confusion	0	0	1	7	0	0	0	0	0	0	1	0	0	0	0	0	0
Hunger / feeding	5	6	3	5	6	0	1	1	1	1	2	0	3	2	1	1	0
Healthcare access	1	2	3	8	2	1	2	0	1	0	2	2	5	1	0	0	0
Out-of-school	2	2	1	2	1	0	1	1	0	0	5	0	1	0	0	0	0
Education support requested	0	0	2	0	2	0	1	1	0	0	29	0	15	2	0	0	0
Livelihood support requested	0	0	0	1	13	6	5	0	2	1	2	2	1	2	0	5	3
Health / nutrition support	1	1	0	0	0	0	1	0	1	0	3	1	1	1	0	0	0
Anti-stigma sensitisation	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0
Household / wider child lens	2	2	0	29	0	0	0	0	0	0	10	0	14	0	6	0	7

Evidence note. *Each cell is the number of distinct survivors raising that code in that question. Big N = 82; unit = survivor × question. This is a distinct-survivor salience map (a coding-visibility proxy), not coding-visibility percentages; eligible per-question denominators are not supplied and an NVivo matrix export is required for percentages.*

Table 1 makes the salience structure visible. The stigma codes perpetrator labels, ostracism, identity confusion concentrate sharply in Q1.3, the question about challenges children face, which is why the theme's peak prevalence is so high there. Education support and the wider-household lens peak in the forward-looking questions Q4.6FU and Q5.3. The education aspiration, by contrast, is distributed across many questions, confirming the observation in Section 2 that survivors reach for the language of schooling throughout the interview. Hunger and healthcare recur across experience, support and future-oriented questions, reflecting their status as persistent daily burdens rather than answers to a single prompt.

6.3 The aspiration–barrier gap as a structural finding

Developed in Section 4, the aspiration–barrier gap is restated here as a structural property of the evidence: hardship is expressed as aspiration. Its practical force is that demand is a reliable signal of need even where the barrier is unstated, and that monitoring must probe barriers actively rather than expect them to be volunteered.

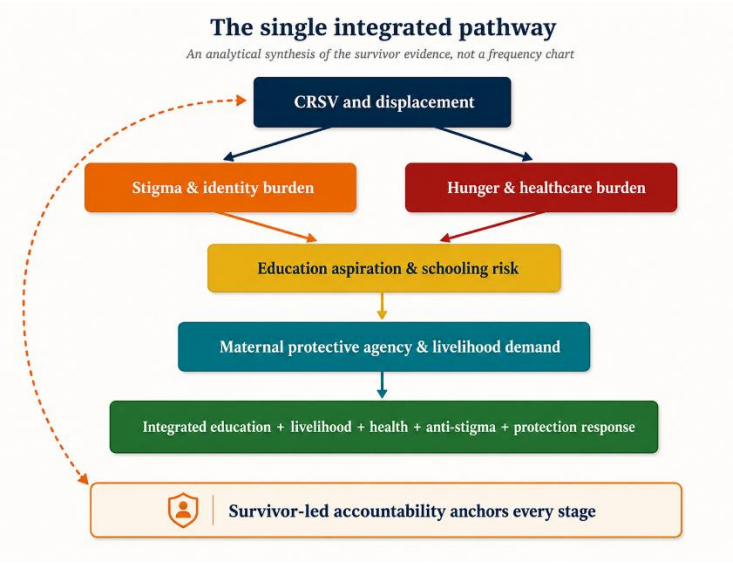
6.4 The household lens

As established in Section 1, 267 of 671 references (39.8%) concern siblings or wider dependants. The lens corrects a common design error targeting a single identified child by recognising that stigma, hunger and schooling needs are shared across the survivor's young dependants. Support that reaches the whole child household is more equitable, reduces the risk of sibling tension, and matches the way survivors describe their responsibilities.

6.5 The single integrated pathway

The findings integrate into one pathway, presented as Figure 1. It runs from CRSV and displacement, through the compounding burdens of stigma and material deprivation, to the maternal agency and education aspiration survivors bring, and onward to the integrated response they call for, with survivor-led accountability anchoring every stage.

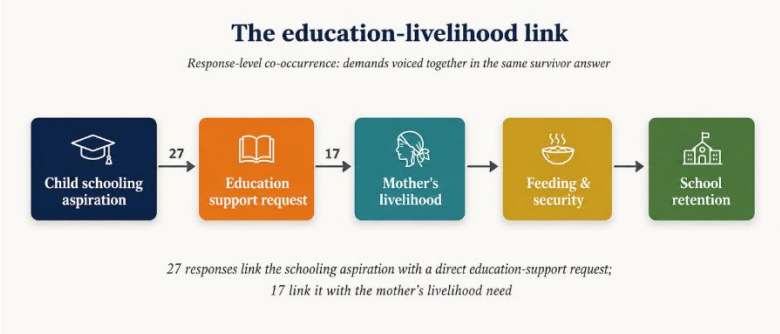
Figure 10: The single integrated pathway - an analytical synthesis of the survivor evidence.



Evidence note. *This figure is a qualitative synthesis, not a frequency measure; stage prominence is not proportional to references. Big N = 82 (underlying evidence).*

Figure 10 shows two engines driving the child's disadvantage conception through CRSV, which drives stigma and identity injury, and displacement, which drives hunger and healthcare deprivation converging on the child's schooling, simultaneously the survivor's highest aspiration and the point of greatest risk. The pathway then turns on maternal agency and the livelihood demand, resolving into an integrated response in which education, livelihood, health, anti-stigma and protection are woven together. The feedback loop signals that survivor-led accountability should inform every stage.

Figure 11: The education–livelihood link response-level co-occurrence of linked demands.



Evidence note. *Links show response-level co-occurrence (codes in the same response), not raw reference counts. Big N = 82; 27 and 17 co-occurring responses. Unit = response. Reading limit: indicates linked meaning, not statistical causation.*

Figure 11 isolates the decisive link. The schooling aspiration connects, in survivors' own answers, first to a request for education support (27 responses) and then to the mother's livelihood need (17 responses), which underwrites feeding, security and school retention. This is the empirical backbone of the report's central recommendation, and it is visible across all three measures the report uses weight (107 and 45 references), prevalence (peak 21/82 and 13/82) and co-occurrence (17 responses) a convergence that no single statistic could establish.

DISCUSSION

The findings describe survivors who are not only asking for relief but articulating a future-facing child-protection agenda. Four threads deserve drawing out.

Education as protection

Education emerges as the master aspiration because it carries a dense set of meanings dignity, a normal childhood, future security and, for children marked by stigma, re-inclusion. The recurring phrase "like any other children" shows education functioning as social repair. This reframes education programming from service delivery to a form of child protection, and it means education and anti-stigma work are interdependent: enrolment without acceptance leaves a child exposed within the school, while acceptance work without enrolment leaves the aspiration unmet.

Stigma as the binding social constraint

Stigma is the most prevalent challenge and the clearest protection risk. Because it operates through naming and follows survivors into displacement settings, it threatens precisely the school inclusion survivors most want. The evidence that the label reaches "even… in the IDP camp" means anti-stigma work cannot be confined to home communities. And because the injury is repeatedly inflicted in peer interactions, the school is both the site of harm and the necessary site of remedy.

Livelihood as the bridge

The single most important structural finding is that survivors make their child's schooling conditional on their own income. Livelihood support is the bridge between the maternal protective agency the data document and the child outcomes survivors seek: it converts willingness to provide into the capacity to provide. This is why the report's central recommendation is integration rather than sequencing.

Why multiple measures matter

The report's confidence rests on triangulating measures rather than relying on any one. Figure 4 shows why this is not a technicality: hunger and perpetrator labelling have opposite weight-and-prevalence profiles, and a programme that read only references would over-weight hunger while one that read only prevalence would over-weight labelling. Weight reveals what survivors dwell on; prevalence reveals how widely a concern is shared; salience reveals where it surfaces; and co-occurrence reveals how meanings connect. The education–livelihood link is robust precisely because it is visible on all four.

RECOMMENDATIONS

The recommendations below are practical and implementation-focused. Each links back to the coded evidence and states the measure on which it rests.

1. Design child education and maternal livelihood as one integrated package

Element	Detail
Evidence basis	Education aspiration 107 refs (peak 21/82) and support 55 refs (peak 29/82); livelihood 45 refs (peak 13/82); 17 co-occurring responses. Measures: weight, peak prevalence, co-occurrence.
Programme action	Combine school fees, materials, uniforms and transport for the child with the mother's livelihood capital, skills, predictable cash support and case management, in a single case plan.
Responsible actors	Civil societies/NGOs and education partners; livelihoods/economic-recovery actors; case-management teams.
Expected outcome	Children enrolled and retained; mothers able to sustain provision; reduced drop-out from economic shock.

2. Adopt a household-based child support model

Element	Detail
Evidence basis	267 of 671 references (39.8%) concern siblings or wider dependants. Measure: coded-reference share.
Programme action	Define eligibility around the survivor's child household so that all young children in her care are covered, not a single identified child.
Responsible actors	Civil societies/NGOs programme design; child protection actors; community case workers.
Expected outcome	More equitable coverage; reduced sibling tension; protection of all dependants.

3. Make community anti-stigma and acceptance work a standing component, including in displacement settings

Element	Detail
Evidence basis	Stigma is the most prevalent challenge (34/82); labels reach into IDP camps (ostracism × displacement, 15 co-occurring responses). Measures: peak prevalence, co-occurrence.
Programme action	Engage community and religious leaders, teachers, women's groups and protection actors to counter labelling and promote acceptance, extending the work into camps, paired with material support.
Responsible actors	Community and faith leaders; schools; women's groups; Civil societies/NGOs and protection actors.
Expected outcome	Reduced labelling and exclusion; safer school inclusion; improved child belonging.

4. Provide food, nutrition and quality-assured healthcare in parallel, not in sequence

Element	Detail
Evidence basis	Hunger 47 refs and healthcare 32 refs dominate RQ3; survivors report ineffective free services. Measure: weight of evidence.
Programme action	Provide feeding support, nutrition screening and referral to services audited for effectiveness, delivered alongside education and livelihood support, not after.
Responsible actors	Health and nutrition partners; primary healthcare facilities; Civil societies/NGOs referral teams.
Expected outcome	Children fed and well enough to attend and learn; acute needs met early; trust maintained.

5. Strengthen child protection and trauma-informed psychosocial referral

Element	Detail
Evidence basis	Identity confusion (peak 7/82), distress, and sensitive disclosures (abortion-linked 12 refs; ambivalence 3 refs). Measures: peak prevalence, weight, sensitive codes.
Programme action	Provide confidential case management, age-appropriate psychosocial support addressing identity, school-based anti-bullying work, family-acceptance support and protection monitoring.

Element	Detail
Responsible actors	Child protection actors; psychosocial support providers; Civil societies/NGOs case management.
Expected outcome	Children and mothers supported; risks identified and referred; sensitive needs handled safely.

6. Adopt survivor-led monitoring indicators and probe for barriers actively

Element	Detail
Evidence basis	Recommendations peak at 35/82 (42.7%); the aspiration–barrier gap shows barriers are under-volunteered. Measures: peak prevalence, weight.
Programme action	Track enrolment, retention, feeding security, healthcare access, stigma incidents, livelihood stability and child wellbeing, defined with survivors; actively probe for barriers rather than await them.
Responsible actors	Civil societies/NGOs MEAL function; survivors as monitoring partners; protection actors.
Expected outcome	Accountability to survivor priorities; early detection of drop-out and stigma.

CONCLUSION

The report's main contribution is to show that survivors connect child education, maternal livelihood, stigma reduction and household survival into one integrated pathway. Children's futures cannot be secured by education alone unless mothers' economic and social conditions are strengthened at the same time.

Survivors have articulated, in their own words and across their own answers, a coherent child-protection agenda: educate the child, enable the mother to provide, protect the child from stigma in the community and the camp alike, meet immediate health and feeding needs, and reach every young child in the household. The evidence for this agenda is consistent across weight of evidence, peak prevalence, question-flow salience and response-level co-occurrence. The clearest implication for dRPC and its partners is to design child education support and maternal livelihood support as a single, integrated intervention, underpinned by anti-stigma work, health and nutrition support, child protection and survivor-led monitoring.

> *Survivors are not only asking for relief. They are describing the conditions under which their children can have a different future and asking to be enabled to provide those conditions themselves.*