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FACULTY OF ARTS AND SOCIAL SCIENCES
DEPARTMENT OF SOCIAL SCIENCES AND DEVELOPMENT STUDIES

DE-INSTITUTIONALIZATION PROGRAM IMPLEMENTATION AND SOCIAL WELFARE OF VULNERABLE CHILDREN IN CARE INSTITUTIONS IN NAIROBI, KENYA

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DECLARATION

This thesis is my original work. It has not been presented in any other University or institution of higher learning for any academic credit. All work sourced from other scholars and sources have been duly cited and acknowledged in this document.

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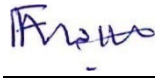
Signature:  Date: 25/05/2026

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I acknowledge my supervisors for their support and guidance throughout this journey! Their patience throughout has always given me strength and the desire to get to the finish line.

DEDICATION

This Thesis is dedicated to my late siblings, Lukas Odhiambo and Rita Eunice who left too soon and not being here to see this through despite their contribution and support at the beginning of my master's study. Their loss took me back a few steps but also gave me the energy and reason to see this through.

I also dedicate this to all the children out there, who do not have people to call family and a place to call home. To their caregivers and people who dedicate their lives to provide for these children. May God bless the work of their hands.

I dedicate this to my parents; their prayers and belief keep me going. I draw my strength from them always! They never fold no matter the circumstances.

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ACRONYM/ ABBREVIATIONS

CCIs: Charitable Children's Institutions

DI: Deinstitutionalization

EU: European Union

HIV: Human Immunodeficiency Virus

OVC: Orphans and Vulnerable Children

PBOs: Private Benefit Organizations

SDGs: Sustainable Development Goals

UNICEF: United Nations Children's Fund

ABSTRACT

Despite evidence the Children in care institutions (CCIs) have a negative effect on children's development, CCIs have continue to increase even with the implementation of de-institutionalization (DI) programs in Kenya. This study assessed the implementation of de-institutionalization programs and their influence on the social welfare of vulnerable children in care institutions in Nairobi, Kenya. The study was guided by four specific objectives: to analyse the influence of adherence to de-institutionalization program protocols on the welfare of vulnerable children; to examine the influence of the quality of program delivery on the welfare of vulnerable children; to examine the influence of participant engagement on the welfare of vulnerable children; and to assess the effect of the dosage of services on the welfare of vulnerable children in care institutions in Nairobi, Kenya. The theoretical foundation of the study is attachment theory and ecology systems theory. This research adopted an explanatory sequential mixed methods design, combining quantitative and qualitative approaches to provide a comprehensive understanding of the implementation of de-institutionalization programs. The target population was children in care institutions, public administrators, representatives of society's adoption agencies, adoptive parents, as well as social workers. The sample size was 380 calculated through Krejcie and Morgan, however, the response rate was 350 responses included in analysis. Participants in study were determined through a combination of stratified, as well as purposive sampling design. Data was collected through self-administered questionnaires and face to face interview with key informants. Descriptive and inferential statistics analysis was applied through SPSS version 24. Analyses of qualitative data was done through thematic analysis. Four program variables showed a high influence in determining children's well-being. The findings revealed that adherence to program protocols had a strong positive influence on children's welfare. Quality of program delivery demonstrated the highest positive relationship, while participant engagement showed a moderate influence. Dosage of services exhibited a highly significant positive relationship with children's well-being. Collectively, these variables showed a strong cumulative influence on children's welfare. Furthermore, implementation strategy was found to significantly mediate the relationship between program implementation and children's welfare.

The study concluded that adherence to program protocols, quality of program delivery, participant engagement, and dosage of services are key determinants of the welfare of vulnerable children in care institutions. The study recommends that program implementers strengthen staff training, increase stakeholder engagement, and ensure adequate and consistent service delivery to improve outcomes for vulnerable children in care institutions in Nairobi, Kenya.

CHAPTER ONE

INTRODUCTION

1.0. Introduction

Chapter one discusses "study background," presents "statement of the problem," highlights the "purpose of the study," lists research "specific objectives," questions and "null hypothesis" for testing, the importance of the study, the limitations, delimitations of the study and finally the assumptions been made while doing the research.

1.1 Background of the Study

Vulnerable children need alternative care; however, they face isolation from their families and communities (Aladegboyea et al., 2024). Because, they are deprived of parental care, face "physical, psychological, emotional, and social harm" (Ayuku, 2019, p 9). In addition, they experience violence, child abuse, neglect, and child labour (Beugre, 2019). Although Children in care institutions (CCI) emerge to address the plight (Ajinkya et al., 2021), residency in childcare institutions has been associated with negative effects (Huseynli, 2018; van IJzendoorn et al., 2020). Aladegboyea, et al. (2024) found that children in care institutions (CCIs) abuse leads to physical, psychosocial harm.

In addition, Aziz (2021) explained that absence of essential services such as education and healthcare makes the ICCs unsuitable for child development. Thus, de-institutionalization programmes, including family-based alternative care, community-based services, and assisted living are more ideal (Fulone et al., 2021). According to Beugre (2019) deinstitutionalization is the process of reintegrating orphans and vulnerable children (OVC) into families, aiming to transition them towards integrated family and community-based care services. However, the implementation of de-institutionalization faces challenges such as social stigma, human resources, little political good will, unstable budgetary support, and socio-cultural and legal obstacles especially in formal alternative care arrangements (Jones, 2019).

Despite these challenges, organizations like UNICEF have made significant progress. For instance, actively participating in deinstitutionalization of children with disabilities, advocating for informed decision-making among policymakers, and child welfare professionals (American Adoptions, 2020). In addition, they assist governments in understanding the necessity of

deinstitutionalization, aid in planning, and monitoring the process. In USA, the institutions has lobbied for political will, commitment, and vision for developing a childcare system addressing children's diverse needs (Shawar, 2023), including preventive measures to reduce the number of in CCI and promote alternative family-based care system.

Nevertheless, in spite of the gains that have been recorded in deinstitutionalization, research gaps continue to remain (Beugre, 2019; National Social Protection Council (NSPC), 2020; UNICEF, 2022). Very few studies have been done that examine in-depth the overall impacts of deinstitutionalization programs on children's welfare (CW) and how to improve their implementation. Moreover, further research is needed on the effectiveness of different deinstitutionalization strategies employed by the state and other non-government institutions (American Adoptions, 2020; Shawar, 2023), and on the experiences of deinstitutionalized individuals, especially in low and middle-income countries (Ayuku, 2019; Aziz, 2021). Consequently, the current study examines the "implementation of deinstitutionalization programs and their impact on vulnerable children's welfare." UNICEF (2022) defines "deinstitutionalization" as both returning children from institutional settings to the community and preventing their entry into institutions. It is crucial to prevent children, especially young ones, from entering institutions and facilitate their return to family and community settings.

Globally, approximately 2.7 million children under 18 live in institutional care, with 2.2 million in orphanages and the remainder in various institutions (UNICEF, 2022). Another report (UNICEF, 2023) estimates 105 per 100,000 children worldwide are in residential care. Many countries, including the United States, have endeavored to reduce institutionalized children and prevent institutionalization, or reunite children with families whenever feasible. Notably, over 150 million children worldwide have at least one parent, with more than 17 million having lost both parents. Children with disabilities are significantly more likely to be institutionalized than others, with 80-90% of institutionalized children having at least one living parent, though under-registration of orphanages globally likely underestimates these figures (Kwabena et al., 2023).

The welfare of children, whether in "alternative family care" or "care institutions," is a subject of inquiry. Child welfare concerns services and institutions ensuring children's physical, social, and psychological well-being, particularly relevant to children affected by poverty or lacking parental care and supervision (Aladegboyea, Adedeji, Komolafe, Olowokerec, & Irinoye,

2024). Child welfare also encompasses social work aimed at improving children's health, home conditions, and vocational training (Zaborskis, 2024), as well as services ensuring children's safety and supporting families in caring for them successfully. Aziz (2021) notes that lack of diverse care options, gatekeeping mechanisms, and family reintegration in CCIs provides reasons to implement deinstitutionalization programs to fill the void.

Moreover, large-scale orphanages and boarding schools institutionalizing children often fails to meet their needs or replicate a family environment (Stojanović et al., 2024; Perrigo et al., 2024). These institutions are characterized by institutional culture, including "depersonalization, rigid routines, block treatment, social distance, dependence, and lack of accountability," (Brodmann, et al., 2024.p 7). These negatively impact on children's health, development, and prospects, because children are deprived of basic care and subjected to inhuman treatment and unreasonable disciplinary (Ayuku, 2019; Brodmann et al., 2024), resulting in poor physical and mental health outcomes, poor nutrition, exposure to toxins and diseases, and limited cognitive development (Perrigo, et al., 2024).

Although, care institutions initially emerged as a means to cater to orphans and vulnerable children (OVCs) in society, its potential has not been fully realized (Aladegboyea et al., 2024; Brodmann *et al*., 2024). Poverty-stricken families often placed their children in orphanages to provide them with necessities. Moreover, institutions were seen as a way to address the needs of children living in absolute poverty, including those affected by natural disasters and chronic diseases like HIV (Mutenyo et al., 2019). However, Aladegboyea et al. (2024) observed that over the past six decades institutionalization has negatively impacted on child development and welfare. For instance, children raised in institutions commonly experience slow cognitive and physical development, behavioral problems, attachment disorders, poor life skills, and difficulties poor interpersonal skills (FuloneI, et al., 2021; Nsabimana et al., 2019). In addition, Browne (2017) notes the risks of abuse faced by children due to the lack of regulations and oversight within these institutions. In support, Hettiarachchi (2021) found that chronically physically ill children exhibited more behavioral and emotional issues than physically healthy children even prior to institutionalization and were at high risk of severe psychiatric disorder when placed in CCIs.

Similarly, in the USA, Goldman et al. (2020) meta-analysis on "the impact of institutionalization on children's development," revealing significant adverse effects. The study

found that physical costs, where children in institutions often lack adequate nutrition, exercise, and healthcare, resulted in "stunted growth, delayed motor development, and increased susceptibility to illness."(p. 134). In addition, there were high neurobiological costs, with institutionalization having a server imprint on brain development because of the absence of personal attention and stimulation, leading to low brain activity and slower cognitive development. In a different study Fulone et al. (2021) noted psychological costs, where children in institutions tend to suffer from emotional neglect, causing attachment disorders, lower social skills, and a higher risk of mental health disorders. Beugre (2019) unearthed the psychological costs, whereby a lack of constant, loving environment may culminate in high incidences of depression, anxiety, and post-traumatic stress disorder among institutional children.

Global movement towards de-institutionalization is tackling central problems (Aziz, 2021; Brodmann et al., 2024). Nations like the USA have moved away from childcare facilities and orphanages into foster care homes, where the government extends broad support (America Adoptions, 2020). Orphaned, rejected, and neglected children and children separated from parents, alternative care is possible. These are reunification, kinship care, foster care, guardianship, and adoption (Goldman et al., 2020). Nevertheless, the process of de-institutionalization does not come without issues. Fulone et al. (2021) cited a lack of formal mechanisms to monitor or follow up on children's wellbeing after de-institutionalization, resulting in possible child abuse and neglect. In addition, Koppes (2021) pointed out the lack of data on which particular strategies work best to assist children and parents in the process of reintegration and family reunification. Deinstitutionalization in Europe started in 2004 when ten nations, eight of which were from the former Eastern bloc, joined the EU as member states.

Initially lacking specific criteria for deinstitutionalization, these countries faced pressure to demonstrate progress in this area as part of their accession criteria, particularly in Bulgaria and Romania (America Adoptions, 2020). UNICEF (2023) reports that deinstitutionalization reforms in Europe and Central Asia over the past 15 years have shifted from large-scale institutional care to family and community-based care systems. UNICEF, the European Union (EU), and other partners have assisted in these reforms since 2000, bringing national legislation into compliance with international norms, designing closures of institutions, transferring staff to care services, enhancing family systems and community-based care, mobilizing donor funds to support transition expenses, and educating the public on the advantages of transforming into "family and community-

based care." The implementation of the afore mention saw Bulgaria experienced a dramatic decline in the number institutionalized children from more than 7,500 in 2010 to less than 1,000 in 2017 amidst continued challenges for most countries in the region. In Africa, some countries are implementing policies and programs aimed at decreasing the number of children in institutional care and scaling up family-based care (Aziz, 2021; Chege & Ucembe, 2020).

Furthermore, orphanages keep on increasing, weakening traditional customary family care systems and community-based care systems for children at risk. Africa has an estimate of 12 million orphans significantly attributed to HIV and AIDs (Mokaya, 2016). However, most orphanages are not registered, hence, making it is hard to determine their precise numbers (Mutenyo et al., 2019). In addition, accounts of exploitation, child rights violations, and mental health challenges within such CCIs point to the pressing necessity for deinstitutionalization (Child Foundation, 2018). According to Yiga (2023), Uganda and Rwanda host the highest number of CCIs in Eastern Africa. For instance, in Uganda, about 800 childcare institutions exist, but only 70 are licensed by the Ministry of Gender, Labour, and Social Development (MGLSD, 2012). This raises concerns about the welfare of children in unlicensed CCIs with the reports indicating they suffer from extreme poverty, high HIV and AIDS prevalence, and loss of stable home environments. This situation has led to increased institutionalization, necessitating more robust deinstitutionalization efforts in the region.

In Rwanda, deinstitutionalization efforts have shown limited significant impact on children welfare and slow adoption of alternative care systems. For instance, Nsabimana et al. (2019) observed externalizing behavioral problems among institutionalized children compared to non-institutionalized ones. The study found that non-orphans showed externalizing behavioral problems compared to orphans, regardless of institutionalization. In addition, there were no significant difference between internalizing problems, parental living status and its interaction with institutionalization affected self-esteem. The studies, however, relied on adult reports, leaving limited insight into how deinstitutionalization affects children welfare.

Care for children is an institutional issue in Kenya, with reports indicating that there is child abuse, misappropriation of funds from donors, businesses masquerading as charitable entities, and ineffective monitoring (UNICEF, 2023; Achieng, 2016). The welfare of the children within these institutions is highly compromised. For instance, Njoki (2019) reports that because of

the misappropriation of the funds, children in care institutions lack quality education, healthcare, shelter, and food, since these are compromised for the good of the owner of the institution, not to talk of the psychological and physical abuse. Government reports indicate that between 30-45% of the country's 2.4 million orphans and vulnerable children find their way into Charitable Children's Institutions (CCIs), estimated at about 1,200 of these institutions housing between 30,000 to 200,000 children (Ucembe, 2024). However, Saya (2021) postulates that up to 40,000 children live in 830 children's homes across Kenya, as some CCIs are not registered or regulated (Ayuku, 2019).

According to Risa (2018), notwithstanding concerted efforts at deinstitutionalization, several challenges persist, such as misuse of foreign aid meant for child protection, limited social workers, and a lack of support for children with special needs. Although there is plenty of literature highlighting the harm that institutional care exposes children to, there is a notable lack of discussion on enhancing the rollout of deinstitutionalization (Ayuku, 2019; Mokaya, 2016; Risa, 2018; Gayapersad et al., 2019). In addition, there is general ignorance regarding deinstitutionalization among the local communities (Ucembe, 2024), calling for empirical research to determine practitioner and public attitudes towards deinstitutionalization and the Guidelines for Alternative Family Care of Children in Kenya. More research is required to investigate the impact of governance and accountability mechanisms, legal frameworks, individualized services, and organizational dynamics on the process of deinstitutionalization (Njoki, 2019).

Deinstitutionalization is a fairly new phenomenon in Kenya and has only been adopted by a minority of society (Chege & Ucembe, 2020). This policy of shifting from institutional to family-based care is a central theme in Kenya's child protection agenda (Gayapersad et al., 2019; Murungi, 2019; Risa, 2018). Yet, in spite of legislative and regulatory measures for the protection of children, residential care facilities and the number of children in institutions keep increasing (Mokaya, 2016).

Following this, the government of Kenya placed a moratorium on new live-in childcare institutions in 2017 and launched a deinstitutionalization pilot project in Western Kenya in 2018, with the intention of expanding it nationwide (Miseki, 2018). Moreover, the Moratorium Kenya has achieved further milestones such as the care children act 2022 and the care reforms strategy

(Njoki, 2019). In the past, there has been an increasing acknowledgement of deinstitutionalization as a major strategy for improving child well-being (Aziz, 2021).

The harmful impact of institutionalization on child development and general health, together with heightened oversight of anomalies and abuse occurring in orphanages, have heralded demands for solutions based on family-based care. In spite of local initiatives aimed at deinstitutionalization, both implementation and sustainability difficulties, as well as cultural resistance, remain (Murungi, 2019). Moreover, there lacks empirical assessment of the process of deinstitutionalization and its effects on child welfare (Ayuku, 2019). Thus, the study investigates the implementation of deinstitutionalization programmes and its influence on the welfare of OVCs in care institutions. It offers a useful insight into the effectiveness of such programmes and guide future policy and practice in child protection.

1.2 Statement of Problem

When deinstitutionalization (DI) programs are effectively implemented, vulnerable children transition successfully from institutional care into family and community-based settings, resulting in improved physical, emotional, and social well-being (UNICEF, 2023). However, the implementation of DI programs in Nairobi, Kenya, remains a challenge as care institutions continue to increase despite policy reforms (Risa, 2018; Murungi, 2019).The number of children in institutions in Nairobi is unacceptably high. Currently, according to UNICEF (2019), approximately 45,000 children in Kenya are in institutional care, and a significant number of those children are in Nairobi. An estimate by Nairobi City County Government (2018) suggests that at least 30% of such children are in institutions within Nairobi. This is a result of poverty, abandonment, and death of parents attributable to diseases such as HIVand AIDS (UNICEF, 2019). In addition, about 30-45% of 2.4 million orphans and vulnerable children in Kenya are in Charitable Children's Institutions (CCIs) (Ucembe, 2024), with a significant CCIs not registered or unregulated, making it unfeasible to examine their conditions and therefore placing children at risk of endangerment (Saya, 2021; Ayuku, 2019).

The impact of institutionalization on children is acute and long-lasting. A study carried out by Better Care Network (2018) highlights that children institutionalized are at a higher risk of development delays, emotional issues, and issues of social integration than children in family care. Approximately 70% of children in institutions experience high stakes of psychological trauma and

lower academic achievements. In addition, a study carried out by Save the Children in 2020 found that 60% of children experience difficulties in reintegrating back into society after leaving care institutions, thus making them susceptible to greater risks of being exploited, becoming homeless, and being unemployed.

Though research has been done in relation to the effect of institutionalization and the benefits of deinstitutionalization (Saya, 2021; Chege & Ucembe, 2020), there is a substantial research gap in relation to concrete research studies involving the implementation of deinstitutionalization programs for vulnerable children, methods of implementation of various models of deinstitutionalization programs, as well as children of deinstitutionalization in Nairobi (Murungi, 2019). Most of the research done appears to generalize for Kenya as a whole, without considering Nairobi's unique urban setting (Ayuku, 2019).In addition, current studies often lack longitudinal data tracking the long-term outcomes of children post-deinstitutionalization (Shawar, 2023), and they fail to disaggregate data by specific vulnerable groups within the institutionalized child population, such as children with disabilities or those affected by HIV/AIDS (Aziz, 2021). There is a pressing need for studies that focus on urban-specific issues in deinstitutionalization to fully understand the impact of these programs (Chege & Ucembe, 2020). Therefore, this research explored the implementation of deinstitutionalization programs on the welfare of vulnerable children in care institutions in Nairobi, Kenya.

1.3 General Objective

Generally, the study investigated the implementation of de-institutionalization programs on the social welfare of vulnerable children in care institutions in Nairobi, Kenya.

1.3.1 Specific objective

The study will be guided by the following specific objectives;

1. To analyze the influence of adherence to de-institutionalization program protocols on the welfare of vulnerable children in care institutions in Nairobi, Kenya.
2. To examine the influence of the quality of program delivery on the welfare of vulnerable children in care institutions in Nairobi, Kenya.
3. To examine the influence of participant engagement on the welfare of vulnerable children in care institutions in Nairobi, Kenya.

4. To assess the effect of the dosage of services on the welfare of vulnerable children in care institutions in Nairobi, Kenya

1.3.2 Research Questions

This study the following questions.

1. How does staff adherence to de-institutionalization program protocols influence the welfare of vulnerable children in care institutions in Nairobi, Kenya?
2. What is the influence of the quality of program delivery on the welfare of vulnerable children in care institutions in Nairobi, Kenya?
3. How does participant engagement in de-institutionalization programs affect the welfare of vulnerable children in care institutions in Nairobi, Kenya?
4. What is the effect of the dosage of services on the welfare of vulnerable children in care institutions in Nairobi, Kenya?

1.4 Research Assumptions

The following are the research assumptions:

1. There is a direct influence of quality of program delivery and welfare of vulnerable children in care institutions. This assumption postulate that if a well-developed program when consistently implementation yields better outcomes for the children involved.

2. When stakeholders actively participate and engage in the effectiveness of de-institutionalization efforts. This assumes that the more the more stakeholders like children and staff are involved the programs, the more significant the positive impact on the children's welfare are experienced.

3. The service dosage supplied to vulnerable children has a direct influence on their well-being. This suggests that the frequency and intensity of the services and support offered determines welfare of a child.

1.5 Justification of the Study

The justification for this study was based on the rationale that it would assist in addressing crucial gaps in regard to existing understanding and implementation of de-institutionalization programs related to enhancing the well-being of at-risk children in care institutions in Nairobi,

Kenya. Even as it is clear in the study's literature that de-institutionalization is a crucial strategy, in fact, a clear body of proof is nevertheless lacking in regards to concrete findings concerning how various program components such as staff fidelity, program quality, engagement, and dosage influence and lead towards improvements in the well-being of children in care institutions (Pandey & Pandey, 2021).

This study also addresses the need for localized research that considers the unique socio-cultural and economic milieus in which Nairobi operates. While research has been conducted in diverse global milieus that have been affected by de-institutionalization, its challenges and opportunities in Nairobi's care institutions remain uncharted research territory. This study will aim to fill this vacuum through a detailed examination of best practices that might propel success in de-institutionalization initiatives in Nairobi.

1.6 Significance of the Study

Through an exploration of the effectiveness of de-institutionalization implementation, this research offers a valuable insight to the program managers of rehabilitation programs for street children, various stakeholders such as governments, donors, and non-profit organizations. The study findings can be helpful in making informed decisions regarding which techniques of de-institutionalization work best in improving the well-being of orphans and vulnerable children. Moreover, it may make it possible to analyze existing programs and open new avenues for improving in line with SDG objectives and Kenya vision 2030.

This study contributes to social work field. For instance, it holds several valuable lessons in effective ways of practice and emphasizes the important aspects of particular social work principles, thus improving social work as a whole. It emphasizes on the need for evidence-informed practice in social work and reiterate social workers' responsibility in ensuring social well-being of OVCs in Nairobi County. The findings may have social work practice implications, specifically about approaches that have been applied in DI. Social workers may be able to use findings of this research to make their work with OVCs more effective and of higher quality, thus offering greater benefits for such vulnerable populations. Based on real social work practices, conclusions of this research have a possible enhancing effect on social workers' professional practice, allowing social workers to work with clients effectively.

Moreover, this study is of immense value to social work practitioners in Nairobi and across countries engaging in child welfare programs. This research presents valuable recommendations on ways of ensuring that social work programs are effective. Based on the findings of this research, PBOs in Nairobi and emerging PBOs can be in a better position to become more effective in handling OVCs and make their best possible contribution to society. Outcomes of this research may result in greater well-being for OVCs in Nairobi County. Institutions offering valuable insights regarding effective de-institutionalization approaches may directly assist in improving the lives of vulnerable children in care institutions.

1.7 Delimitations and Scope of the Study

The conceptual delimitation of the study is its focus on the influence of De-Institutionalization program on the welfare of OVCs. The geographical delimitation is the study focus on CCIs in Nairobi area. The researcher recognizes that there are children's institutions across the country, but she opts to limit the study within Nairobi because of the timeline and the availability of the resources. The researcher is also aware of the many challenges she might have faced in the field, for instance, hostility when collecting data. Therefore, the researcher ensured she got permission from the authority to enable her to conduct research.

1.8 Limitations of the Study

This study examined the influence of the implementation of de-institutionalization programs on the well-being of orphans and vulnerable children (OVCs) in Nairobi, Kenya, and has the following limitation: 1) it is geographically constrained to the Nairobi region, therefore, not all the findings can be generalized, 2) the tools were based on self-reported that may be biased.

1.9 Conceptual Framework

The conceptual framework is a diagram showing the relationship between the variables (Pandey & Pandey, 2021). The independent variable is implementation of deinstitutionalization programs and dependent variable is Children Welfare. It is visualized as a model where the independent (implementation of the deinstitutionalization program) variables influence the dependent variable (Child Welfare), mediated by the implementation strategy.

Independent Variable (IV)
Implementation of Deinstitutionalization programs (DIP)

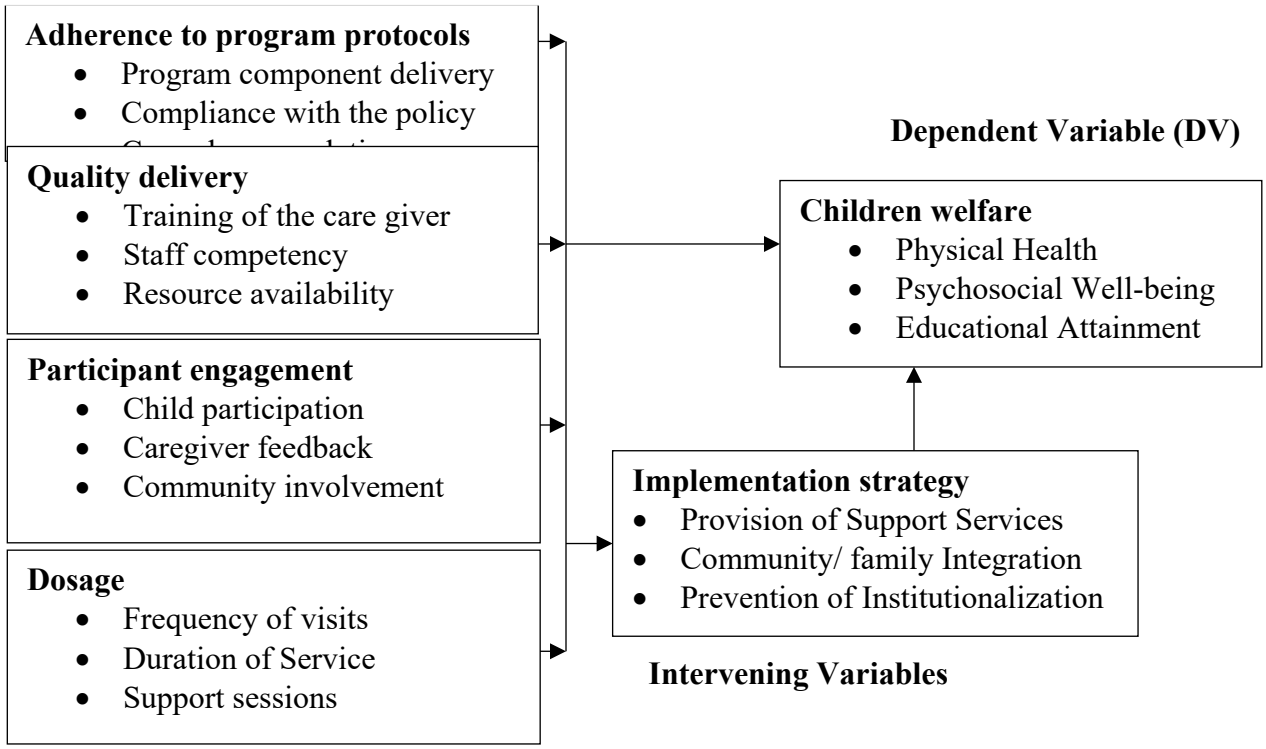

Figure 1.1: Conceptual Framework

The research explored the execution of de-institutionalization programs and their influence on the social welfare of vulnerable children in CCIs in Nairobi, Kenya. The conceptual framework illustrates how the three variables interact independently, variable, dependent variable and intervening variable. It shows that staff adherence to protocol, service quality in delivery, stakeholder participation or engagement, and service dosage provided serves as independent variable. For instance, staff compliance ensures the implementation do not violate the policy and guarantees that the interventions are implemented according to the blueprint. Njoki (2019) supports the adherence to program protocols, explaining that it aids in assessing using fidelity scales, besides, being a requirement for the attainment of anticipated results. Therefore, the study hypothesize due to its stringent way its adoption enhance the well-being of children.

Quality of program delivery concerns the effectiveness with which services are delivered. Competent staff, sufficient resources, and proper management are encompassed in quality delivery. Hunsley et al. (2022) emphasize the role of implementation quality in measuring de-institutionalization program success. Program effectiveness can be compromised by poor

implementation, while high-quality implementation has the potential to increase beneficial effects on child welfare. Participant engagement is also an important consideration. Participant engagement entails active involvement by the children and their caregivers in the program. For Schutt (2022), higher levels of engagement are linked to better outcomes since the individuals will be more receptive to gaining from the services. People who are actively engaged are demonstrated to be more sensitive to intervention, which can translate to higher social welfare.

The concept of dosage of the service is the number and frequency with which services are delivered to the children. Herschell et al. (2024) contend that effective dosage is a basic necessity in ensuring that intervention is effective. Insufficient dosage will be unable to bring about intended changes, and excessive dosage will be overwhelming to the participants. The right dosage is thus essential to get the most out of the program. Adherence by staff guarantees fidelity to the program, and delivery quality improves the effectiveness of interventions. Further, participant engagement enhances receptivity and outcomes, and the right dosage of services guarantees the provision of the correct level of intervention. All these variables play a significant role in influencing the well-being of vulnerable children within care institutions. Implementation strategy is the mediator of the conceptual framework and plays a significant role in ensuring that staff compliance, service delivery, and participant engagement are followed as appropriate, which has an effect on de-institutionalization programs and, by consequence, the well-being of susceptible children within care institutions.

1.10 Operational Definition of Terms

Children

Children is this study is an individual under the age of 18. They still in need adults for basic needs, emotional, social, and educational development**.**

Vulnerable Children

The vulnerable children are those children whose risk for negative life outcomes is increased due to factors like poverty, lack of family support, exposure to violence, or health problems. They may have parents or do not have parents as such they require special attention and interventions that assure their well-being and development.

Children Welfare

Children welfare in this study is defined as the overall positive aspects that makes children comfortable and entails inclusive of physical, emotional, social, and educational development. This, in context, is described as the "quality of life" for improved outcomes for vulnerable children who are beneficiaries of the de-institutionalization programs in the CCIs.

De-Institutionalization Programs

In this case, de-institutionalization programs are designed initiatives that aim at placing children from institutional care into either family or community care settings. De-institutionalization programs aim at providing an enabling environment that is supportive of children's development.

Care Institutions

Care institutions are places of residence for children who, for various reasons such as abandonment, abuse, or neglect, cannot live with their families. In addition to providing shelter, food, education, and healthcare, among other basic needs, these institutions look for permanent, family-based solutions. Implementation of Programs

Program implementation

This is the process of carrying out the planned interventions and activities that are foreseen for de-institutionalization programs. This includes resource mobilization, staff training, and actual program conduct in accordance with set guidelines and protocols. Effective implementation is important in realizing intended results for the vulnerable children; this is because through implementation, consistency and standardization of care are ensured**.**

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter two discusses "literature review," the review has two main sections; theoretical review which entails the two theories that informs the study. The second reviews is empirical reviews of literature that focus on secondary data from empirical research this has been

done in line with research objectives of the study. In addition, it discusses the research gaps identified in the literature and summation of the literature reviewed.

2.2. Critical Review of Relevant Theories

The two major theories that will guide the study on the implementation of DI programs on the social welfare of vulnerable children in care institutions in Nairobi, Kenya, are Attachment Theory and Ecological Systems Theory. Each of these theories offers different perspectives and insights that are important in the complete understanding of the variable.

2.2.1 Attachment Theory

Attachment Theory formulated Bowlby (1950s-1960s) places importance on the bond created between a child and the main carer as important in the emotional and psychological nurturing, and growth of a child. Bowlby (1969) proposed, experiences with caregivers in early life play a profound impact on the future social, emotional, and cognitive development of a child. The main ingredients that make up Attachment Theory include proximity-seeking behaviors, a concept of the caregiver as a secure base, internal working models of self and others, and attachment styles (Ainsworth, 1979)

In the context of this study, the implementation of DI programs (independent variable) and the welfare of vulnerable children (dependent variable) can be understood through the lens of Attachment Theory. This theory suggests that children benefit from stable, loving relationships. A plethora of evidence suggest that children in family-based care, as opposed to institutional care, develop better social and emotional skills (Ajinkya et al., 2021; Beugre, 2019). Therefore, the theory informs the study's objectives, it explains the parental role in stable and nurturing relationships that are crucial for children's development, hence, suggesting that family-based care is more effective in promoting welfare as compared to CCIs (Ainsworth, 1979). Programs that ensure stable placements and continuous caregiving support Attachment Theory. This leads to better psychological outcomes for children (Brodmann et al., 2024). When children have longer exposure to secure and stable environments, they can form stronger attachments. This improvement benefits their welfare over time (Child I Foundation, 2018). Intensive interventions that focus on building strong relationships between caregivers and children are essential for the child's development (Achieng, 2016).

Attachment Theory has several strengths. It shows predictive power, has empirical support, and takes a broad approach (Embleton et al., 2014). The model highlights and predicts outcomes based on early child-caregiver relationships. Many studies back up its main ideas, showing how early attachments affect later life outcomes. (Aziz, 2021; Cherry, 2023). However, Fulone, et al. (2021) identify that the theory has weaknesses, for instance, the study found that theory has cultural bias, a deterministic outlook, and an overemphasis on early childhood. In addition, being that the theory was developed in Western contexts, it may not fully apply to different cultural settings such as Africa where child socialization is diverse. In addition, it can be too rigid, overlooking later life experiences that can change developmental paths (Eriksson et al 2018). It also focuses heavily on early childhood, which may downplay the role of interventions later in life (Shawar, 2023). Despite these weaknesses, Attachment Theory remains significant. It highlights the crucial role of early relationships in child development and provides a valuable framework for understanding children's emotional needs in a family and CCI set ups. This understanding is essential when creating effective developmental intervention programs.

2.2.2 Ecological system Theory

Because of some shortcomings of Attachment Theory, particularly its culture bias and determinism, Ecological Systems Theory, proposed by Urie Bronfenbrenner in the 1970s, can give a more comprehensive view of this issue. According to this theory, many different systems of environments influence child development, including everything from close environments up to broader societal structures (Bronfenbrenner, 1979). Ecological Systems Theory has five basic elements, and these elements are microsystem, mesosystem, ecosystem, macrosystem, and chronosystem (Wirth & Kleve, 2023). Research permits an assessment of Developmental Interventions (DI) and the welfare of at-risk children based on these elements and their interrelations.

The study is expected to be consistent with Ecological Systems Theory, as it examines how environments influence DI program effectiveness. It examines ways through which diverse systems can impact or help facilitate a child's well-being (Neal & Neal, 2013). There is a focus on the advantages of experiencing healthy environments through diverse systems for a prolonged period of time for children (Mele, Pels, & Polese, 2012). Additionally, there is an emphasis on

intervening through diverse systems and environments for supportive surroundings for the child (Tudge et al., 2009).

There are many advantages of Ecological Systems Theory. It is comprehensive and flexible and addresses complex interactions between different systems across time (Hong & Espelage, 2012; Guyer & Nelson, 2016). But, like all other theories, this one has some disadvantages as well. Complexity, lack of emphasis on certain relationship details, and its resource-intensive nature might be considered some disadvantages (Beugre, 2019). The comprehensive nature of this theory might act as an impedance to its application and testing (Neal & Neal, 2013). Certain details of relationship, essential to Attachment Theory, might be neglected because of this comprehensive nature of this theory (Tudge et al., 2009). Applying this theory to some intervention may require many resources and may need interaction of many systems (Neal & Neal, 2013).

Despite its challenges, Ecological Systems Theory is essential as it provides an insightful explanation of all the varied elements of environment that have an effect on child development. It is helpful and assists in some way in bridging some of the flaws of Attachment Theory, especially regarding vast social systems that influence at-risk children. Even though Attachment Theory is essential for an insightful comprehension of child development, it often disregards all elements of environment. Ecological Systems Theory fills this loophole in that it considers the different levels of context that impact child welfare. With the integration of both theories, the study is in a better position to determine the impact of DI programs on vulnerable children in Nairobi, Kenya.

2.3. Review of Empirical Studies

This section focuses on empirical literature. The literature with primary data has been done from global perspective to national level.

2.3.1. Adherence to de-institutionalization program protocols

Wilke and Howard (2021) carried out a study in the United States on child transitioning using a mixed-methods design. The study had three main points of focus: (1) the causes of transition, (2) the critical elements of the transition process, and (3) the results of various models of transitional care. The study included 39 non-governmental organizations that had completely or partially transitioned to family-based care. Cumulatively, these organizations provided services to 12,325 children and 29,499 families per year in 22 countries (Wilke & Howard, 2021). The

findings revealed that, even though there was a consensus on the best place for children's well-being being in family settings, a significant percentage remains in institutional care. Additionally, the study pointed to the existence of resistance to deinstitutionalization among children, as well as their families. In addition, it was observed that most residential care facilities had redesigned their programs to utilize family-care, which was seen to benefit both families and children (Wilke & Howard, 2021). Furthermore, it was observed that organizations that supported more transitions showed a deeper understanding of the needs of children than those that transitioned fewer children. This implies that social workers who made constant follow-ups had an understanding of the problems children encountered in family settings, allowing them to come up with solutions that improved child well-being in care facilities (Aziz, 2021).

Empirical studies shows that foster care is the primary deinstitutionalization program in the USA (Darzi et al., 2023; Fulone, et al., 2021; UNICEF, 2022). According to USA Facts Team (2023) report an estimate of 606,031 children were in the US foster care system in 2021, with 391,098 children still in care as of September 30, 2021. This trend was concurrent with the deinstitutionalization policy in many countries. Fulone et al. (2021) and Huseynli (2018), reiterated this. Also, USA Facts Team (2023) described that the demographics for foster care have changed. Fewer Black children are in care, whereas more White and Hispanic children currently are. In 2021, 43% of the children in the foster care were White, whereas 22% were Black, and 22% were Hispanic. The other 13% came from children of all other races. According to Jones, 2019, the scale of deinstitutionalization programs is affected by the practice of discrimination, prejudice, and racism that could explain the plight in Western countries, which requires further understanding. Furthermore, the age of the children also affects the scale of implementation (Nsabimana, Rutembesa, Wilhel, & Soelch, 2019). In 2021, children aged 1–4 were the most represented age group in US foster care, making up 30% of all children in care. However, the representation of youth aged 15–20 has decreased to 19% (USA Facts Team, 2023). This trend suggests that it becomes more challenging to find alternative family care for older children. Further research is needed to understand why fewer older children are included in deinstitutionalization programs.

In another study, National Center for State Court (2022) revealed that crucial documentation issues in the USA hinder the transition of children to alternative family care placements and jeopardize the deinstitutionalization process. For example, out of 55,916 children in non-family placements, no documented clinical or behavioral need that might warrant their

adoption or alternative family placement existed for 41%, slowing down the deinstitutionalization process. The study also demonstrated that several organizations are working together to facilitate the deinstitutionalization process. Judges are leading reforms by shifting the culture towards fewer institutional placements. Court Improvement Programs are partnering with child welfare agencies to achieve better outcomes. Federal law and child welfare values advocate for placing children in the least restrictive settings with effective interventions and services. This alignment with the community has contributed to a reduction in institutional care placements through community-based prevention and intervention services (America Adoptions, 2020). Institutions like Specialized Intensive Foster Care (SIFC) are offering foster home settings for high-needs children. These findings highlight that the participation of numerous institutions in the deinstitutionalization program brings unique expertise that enhances the welfare of the children and scales up the implementation of deinstitutionalization (Beugre, 2019).

A study on deinstitutionalization in the Europe and Asia region was conducted, analyzing several case studies (UNICEF, 2022). The study found that as of 2021, there were 357,804 children in the ECA region living in some form of institutional care. This figure is five times the global average. Furthermore, almost half of the children living in institutional care are children with disabilities, and in some countries of the region, this figure reaches 60%-70%. Children with disabilities have a much greater chance up to 17 times more of being institutionalized than children without disabilities (Cherry, 2023). According to Cherry (2023), several factors contribute to the lower adoption rates of these children, including prevailing negative societal perceptions, insufficient community-based support services, and deeply rooted beliefs that institutional care remains the most suitable option for children with disabilities. However, a case study by UNICEF (2022) presents tangible examples of the transition process from institutional to family-based care in countries such as North Macedonia, Tajikistan, Ukraine, and Belarus. These countries have made efforts to replace institutional care with more family-centered support. The case study does not explicitly state how many organizations are involved in the programs or the strategies used to expand deinstitutionalization efforts. However, it highlights the need for a thorough approach to inclusion, ensuring that all children can access essential services and opportunities.

In Africa, evidence shows that strong family-based care systems, proper funding, and support from stakeholders are key to successful deinstitutionalization (DI) interventions in low- and middle-income countries (Zaborskis, 2024; Kwabena et al., 2023). Kwabena et al. (2023)

studied deinstitutionalization in Ghana, focusing on children in Residential Care Facilities. They found that issues in foster families, financial struggles among adoptive families, stigma, and abusive parents hinder progress. These challenges make Residential Homes for Children (RHCs) necessary (Achieng, 2016), limiting the number of children who transition to alternative family care. The research suggests a step-by-step DI process that starts with changing RHCs into temporary care centers and then developing alternative family-based care options.

Yiga (2023) conducted a similar study in Uganda on child protection systems, using a mix of research methods and involving 349 care institutions. This study found that poverty and orphanhood account for over 40% of admissions into Child Care Institutions (CCIs). It emphasizes the state's duty to provide suitable alternative care options. These options include “kinship care,” “foster care,” different types of “family-based” or “family-like care,” “residential care,” and “supervised independent living arrangements.” Such approaches ensure that children receive proper support and protection. The collaboration has led to an increase in the number of children placed in alternative family care homes. However, the study also mentions the “lack of suitable alternative family-based care, negative social attitudes, and limited community-based services” (p. 120). The Child I Foundation (2018) conducted another study in Uganda, identifying geographical factors as obstacles slowing the transition of children to family settings. The authors noted that care institutions often accept children from a wide area, which complicates finding families, working with them, and monitoring the well-being of children who return to their families.

In Rwanda, Nsabimana, Rutembesa, Wilhel, and Soelch (2019) identified social and cultural norms, along with legal frameworks, as barriers to establishing formal alternative care arrangements. Aladegboyea et al. (2024) noted that in Nigeria, profit motives sometimes drive support for residential facilities, leading some organizations to resist transitioning children to family-based care. The study also highlights that conflicting views among affected children, families, and the disability community slow progress.

However, non-governmental organizations in Africa are implementing various strategies to increase the number of children transitioning to alternative family care (Beugre, 2019). In Ghana, Chege and Ucembe (2020) observed that these organizations are helping families to prevent separation and improve child protection and welfare. They are reallocating resources and emphasizing family-based alternative care within communities (Wilke & Howard, 2021). They

also provide parenting skills training to vulnerable households (Aladegboyea et al., 2024) and offer cash support to these households, a practice noted in Uganda and Rwanda (Achieng, 2016). In Kenya, some institutions collaborate with local government personnel and para-social workers to form "Team Around the Child" groups. These groups consist of local governmental and non-governmental personnel who act as gatekeepers for admissions to institutions (Achieng, 2016; Ayuku, 2019; Saya, 2021).

Ayuku (2019) studied the design of a deinstitutionalization program in Kenya, which is based on a comprehensive guideline for alternative family care developed in 2014. This system focuses on three main areas: policy and legal frameworks for alternative family care, family support to prevent separation, and the implementation of alternative family care. Another study by Achieng (2016) in Homa Bay County, Kenya, revealed that extended families play a vital role in caring for orphans. The community feels it is responsible for supporting orphans, showing that culture influences the design of deinstitutionalization programs in Kenya.

A study by Stuckenbruck and Jini (2017) estimated that more than two million children are under kinship care in Kenya. However, this care is mostly informal, lacking regulation and state oversight. Since the state does not officially recognize kinship care arrangements, they receive little government support, with most funding directed to institutional care. In contrast, Ivanova and Bogdanov (2013) identified legal frameworks that recognize kinship care as a form of alternative care. For instance, legislation requires relatives to take custody of children without parental care.

Similarly, Stuckenbruck and Jini (2017) examined the adoption process in Kenya. They found that several steps are involved in adoption, which is managed by the Adoption Society of Kenya (ASK). Although kinship care has been common in Kenya, formal adoption is new and not very common. A study by Flagothier (2016) reported that the program aims to support children living in family and community-based care and foster care. In line with these findings, some institutions have developed outreach programs that offer financial assistance to extended families caring for orphaned children. However, according to Ayuku (2019), most communities in Kenya believed that children belonged to the society, and it is the responsibility of the community to take care of their children. This belief forms the basis for the design of de-institutionalization programs in Kenya.

2.3.2 Quality of program delivery on the welfare of vulnerable children

According to Fulone et al. (2021), in a study done in Brazil on the Enhancing care for deinstitutionalized individuals with mental disorders using knowledge translation tools. Found that several programs significantly enhance the implementation of deinstitutionalization, improving care for mentally ill patients. Psychoeducation programs, particularly those involving families, promoted treatment adherence, reduced relapse rates, and increased service satisfaction, although these benefits were not sustainable beyond a year. Anti-stigma programs effectively reduced internalized stigma and public prejudice, but these effects were not long-lasting. Intensive case management and community mental health teams improved patient satisfaction, reduced hospital admissions, and enhanced social functioning. In addition, the observe that assisted living provided stable housing for former psychiatric hospital patients, reducing hospitalizations and psychiatric symptoms. Moreover, interventions for acute psychiatric episodes resulted in greater treatment satisfaction and less family burden compared to standard hospital care. This suggest that the implantation of deinstitutionalization rely on numerous services that complement each other.

In another study conducted in the Eastern Europe and Central Asia Region by Jones (2019) on deinstitutionalization for children with disabilities, it was found that deinstitutionalization programs focus on promoting better decision-making among policymakers and child welfare professionals regarding the deinstitutionalization of children with disabilities and supporting governments in understanding the need for such work and planning, monitoring, and implementing effective strategies. The core elements of deinstitutionalization included a child-centered approach, prevention of institutionalization by identifying and addressing risk factors early, ensuring access to community-based services such as education, healthcare, and social support, strengthening families to care for their children with disabilities, measuring and improving the quality of care provided to vulnerable children, managing the transition from institutional care to community-based settings, and regularly assessing the effectiveness of deinstitutionalization efforts. Although deinstitutionalization is one of the most essential components of child and youth development, it is necessary that the progress of children be monitored, as many countries today lack any formal system for following up on post-deinstitutionalized children. Including children with disabilities as an essential part of any legislation or practice is integral for deinstitutionalization.

Along with this same direction, Ajinkya et al., (2021) examined comprehensive care provided by family practitioners in the UK. The research was based on interviews conducted with 20 family practitioners and showed that comprehensive care can help decrease or prevent referrals and other types of health care. By providing many varied aspects of care, practitioners can reduce instances of going outside of primary care for specialized care. Along this same direction, Killeen et al., (2022), explored the link between the practice environment and the comprehensive care relationship of practitioners and their effect on patient care as provided by family practitioners. It is evident that more comprehensive care, as indicated by more services provided, is reflected by low costs. If most of a patient's care can be provided by one comprehensive doctor, costs that would be considered unnecessary, due to many visits and many types of care, can be eliminated.

Accordingly, complementing this, research by Jones (2019) highlights that, within alternative family care, comprehensive standards are critical. Alternatively, there are diverse care provided through "alternative family care, such as kinship care, foster care, guardianship, and Supported Independent Living (SIL)." Simultaneously, its implementation all at once has improved deinstitutionalization within African nations collectively. To exemplify, as research undertaken within Uganda, case studies undertaken by Ddumba-Nyanzi and Li (2018)) concentrated on Alternative Care for Children). They focused on childcare institutions and guardians or families collectively. They used focused group discussions for generating data.) Research suggests that overall, Uganda has its formal care system based on residential care, mostly managed by non-government organizations as well.) Moreover, most of these Residential Care Facilities (RCFs) lack formal registrations, and lack of measures for implementation have been pronounced due to lack of resources and lack of capacity for assessment and inspections collectively.) Yet, basic standards have been identified as emerging by Mutenyo et al. (2019), indicating improvement of service quality within residential care, as well as families for reintegration and reunion, and some preventive care as well.) Yet, these standards remain neither comprehensive nor applied uniformly as guidelines regarding service delivery within care organizations, whether within or outside of governments collectively.) Thus, as such, the monitoring system has had its potential constrained for characteristic monitoring of high-quality delivery as well.

Another research was conducted by UNICEF for Every Child Rwanda (2019), and it showed that most of the services that are intended for alternative care have been endorsed by non-

state actors within the context of donor projects. These projects often incorporate services that target unwarranted separations of families and, at the same time, have improved family reunion and reunification processes as well. Services may include skills development for parenting, economic empowerment, case management, and psychosocial care that could cater to the welfare of children and their families as a whole.

In support of this, a study was conducted by Beugre (2019). It was based on Ghana, and it showed that services provided by social workers have helped uplift the number of children from 1,000 to 3,000 within two years only. According to this study, social workers have a complex role within the child welfare sector as well. They identify and meet the personalized needs of each child and create plans through cooperation and networking of other people accordingly. They continue to work on other goals such as improved reunion and maintenance of families, community development for deinstitutionalization, and development of their capacities through education and other means as well. They continue to influence and alter policies, aiming for more family-focused care plans and monitoring and reviewing continuously the progress of deinstitutionalization projects.

Studies undertaken by Murungi (2019) in Kenya have indicated some barriers and inequalities during the implementation of mental health policies. Among these, research stressed that plans and implementation of these plans should be based on characteristics of the strategy, context, internal setting, and characteristics of participants themselves. Moreover, studies undertaken by Ajinkya et al. (2021) have indicated that low political value, inefficient resource allocation, gap between values and actions regarding implementation of policies, and lack of integration of other sectors as the greatest problems that need addressing. In addition, other studies undertaken by Saya (2021) have indicated that policy dialogue and psychoeducation have been viewed as most generally endorsed through all participants. Additionally, studies undertaken by Murungi (2019) have indicated some challenges of implementation of policies, stressing especially stigma, lack of funds, and lack of political will. Moreover, studies undertaken by Yusefi et al., (2022) have shown these problems concerning more the complexity of deinstitutionalization program plans, requiring all resources, initiatives, and policies appropriate.

Consistent with these observations, Wagema (2018) observed that the Director of Children Welfare established an expert group to prepare an initial roadmap to deinstitutionalization. Browne

(2017), however, established that training of concerned staff, i.e., gatekeepers, is an essential part of any deinstitutionalization strategy. Different research conducted by Kuehr (2019) demonstrated that the insufficient availability of resources, both financial and human, especially at the local level, is a significant obstacle to efficient gatekeeping. According to Browne (2017), the lack of qualified gatekeepers limit decision making to a few leading to poor decision making or jeopardizing the quality of the policy process.

Wagema (2018) attests, the Kenyan Cash Transfer for Orphans and Vulnerable Children (CT-OVC) Program launched in 2004 is a central element of the nation's de-institutionalization plan. The program seeks to reduce poverty among economically poor families who are caring for orphans and vulnerable children. Embleton et al. (2014) reported that by June 2012, the initiative had expanded to all 47 counties, benefiting 145,590 households and approximately 509,565 children. The program provides a bi-monthly cash transfer of 4,000 Kenyan Shillings (around US$48) per household, utilizing both geographical and household-based targeting methods. Furthermore, the identification of eligible households is done by the Location OVC Committee (LOC), and child-headed and youth-headed households are prioritized when resources are scarce (Achieng, 2016).

2.4. Chapter Summary and Research Gap

The literature presents several research gaps in the study of the implementation of de-institutionalization programs on the welfare of vulnerable children in care institutions in Nairobi, Kenya. The study conducted by Save the Children (2015) titled “Kinship Care Research: Understanding Informal /Alternative Care Mechanisms for Protecting Children: Study of Kinship Care Practices in Busia County Kenya” revealed that kinship care is a common form of deinstitutionalization program in Kenya. However, it also showed that there is abuse and exploitation within this system. This represents an empirical gap as there is a lack of mechanisms to monitor or evaluate the kinship care program. Besides, little literature exists on the government regulation of kinship care in Kenya. This study, therefore, tries to fill these gaps by examining the effectiveness of monitoring mechanisms in kinship care programs and the role of government regulation.

One such study "Navigating uncharted terrain: Domestic adoptions in Kenya" by Stuckenbruck and Jini 2017, expressed the challenges experienced within the process of adoption

in Kenya-most especially the beliefs from the cultural perspective. This paper is more about the methodological gap since little research has been done to show how to overcome the cultural issues and stigmatization associated with adoption. The study postulates the need for awareness that will help correct the myth that adopted children have no right to inheritance. The current research tries to fill this gap by investigating ways of overcoming such cultural issues.

One such gap in knowledge is the study done by Usang and Sloth-Nielsen (2014) on the kafalah of Islam, an alternative family care based on religion. The study indicated that children born of the family have no right to inheritance and are at the mercy of charity. Nevertheless, there is scant empirical evidence that investigates these issues. The present research, therefore, seeks to fill this gap by analyzing the welfare of children under kafalah care. Lastly, a geographical gap is identified in the study of Kenya's alternative care guidelines, by Ayuku (2019) which are heavily influenced by several legal tools such as international conventions, the 2010 constitution, and the 2001 Children Act. However, some legal frameworks take too long to be domesticated and implemented, affecting the protection of children's rights and their welfare. This research aims to fill this gap by investigating the impact of delayed domestication on deinstitutionalization programs and policy formulation in Nairobi, Kenya.

Table 2 1: Table of Knowledge Gap

Variable	**Author**	**Title of the Study**	**Key findings**	**Knowledge Gaps**
Design of the deinstitutionalization program	(Embleton, et al., 2014)	*"Models of care for orphaned and separated children upholding children's rights: cross-sectional evidence from western Kenya"*	"Children in institutional care were far more likely, 95% compared to only 17% in family-based care, $p < 0.0001$, to have their basic material needs met; institutions were therefore better able to provide an adequate standard of living."	the study does not suggest better ways to regulate kinship care, or the process involved in kinship care
	(Otolo, et. al 2014)	*"Targeting of OVC Beneficiary Households in Kisumu County, Kenya,"*	The study points out that there are several programmes designed to support the deinstitutionalization. E.g.	The study does not suggest better ways to regulate the programs designed

			The Cash Transfer programme, and social welfare policy. "(71.4%) respondents indicating that community members were involved in targeting and validation of beneficiary households. the Non-government OVC programme did not involve community members in targeting and validating of beneficiary households with (88.3%)." Lack of proper stakeholders' involvement led to undeserving household to benefit worsening the condition of the deserving OVCs in family based care. The involvement of stakeholders such as NGOs enabled legal and policy reforms to both domestic and inter-country adoptions.	to support the deinstitutionalization process.
Planning of deinstitutionalization program.	*Damaris Wanjiku Njoki (2019)*	*"Evaluating the Implementation of The Policy of Deinstitutionalization in Charitable Children Institutions in Kiambu County*."	"Factors influencing implementation of deinstitutionalized program include Personalization of services, Lack of finances and resources, Difficulties of coordination across agencies and budgets, Legal framework, Lack of governance and accountability arrangements, Organizational complexity Budgetary allocations."	This study was limited to CCI and Government institution. There are societal factors relating to community and family that can be a hindrance to implementations of the programs. The study failed to articulate the issues.
	(Goldman, et al.,2020)	*"Institutionalization and deinstitutionalisation of children policy and practice recommendations for global, national, and local actors."*	"Kenya has strategies that include methods for tracking the progress made. The available strategies neither represent nor include a nationally agreed framework for either alternative care for	The study relied more on secondary data. In making such conclusion empirical evidence is significant.

			children or the linkages to child protection or strengthening families. Governments tend to collect and report administrative data, if they collect data at all, which are often largely quantitative in nature."	
Implementation of deinstitutionalization program	*Save the Children (2015)*	*"Kinship Care Research: Understanding Informal /Alternative Care Mechanisms for Protecting Children: Study of Kinship Care Practices in Busia County Kenya"*	Kinship care is the preferred deinstitutionalization. 75% of the OVCs are placed in Kinship care. 60% of children have basic needs. Due to lack of monitoring and regulation children under kinship care are at risk of child abuse and exploitation.	The study does not suggest better ways to regulate kinship care, or the process involved in kinship care.
	Denise Stuckenbruck & Jini L. Roby (2017).	*"Navigating uncharted terrain: Domestic adoptions in Kenya"*	Domestic adoption is faced by cultural beliefs and social stigma, Resistance to formalizing informal care, Freedom to terminate the relationship.	The gap in this research is, it does not answer whether domestic adoption is in the best interest of the child.

2.3.1 Summary of the Literature

Kenya has an estimate of 2.4 million orphans, of these 47% have lost their parents due to HIV and AIDS (Ayuku, 2019). However, orphanhood is not the only factor contributing to child vulnerability in the country. This has consequently rendered many more children vulnerable due to poverty and harmful cultural practices, family breakdown, abandonment, natural disasters, ethnic and political conflict, as well as the lack of proper care arrangements for them (Stuckenbruck, 2013). It is estimated that 30 - 45 percent of these orphans become absorbed into Charitable Children's Institutions. Furthermore, there are a projected 200,000 – 300,000 children residing and working in the streets as well as 349, 086 children living with disabilities. The children are exposed to different types of abused such as risks that include, "child trafficking, sexual exploitation-with 40% of the children involved in sex tourism on the coast being orphans-lack of

access to education and other basic services, disinheritance, child labor, and living outside of family care."

The literature reveals that Kenya has a deinstitutionalization policy, which is embedded in the 2010 constitution, the adoption policy, the Children Act of 2001, and many other legal frameworks (Achieng, 2016). This policy is a domestication of several international conventions ratified by the country to protect children's welfare. These policies are used as blueprints for deinstitutionalization programs, such as planning and implementation phases, monitoring, and evaluation. Research has, however, indicated that failure to commit to the implementation of these programs results in ongoing abuse of children (Browne, 2017). The majority of research has concluded that the government is not well prepared for deinstitutionalization programs, largely attributed to resource constraints such as financial support, human resource, and infrastructural capacity (Achieng, 2016; Ayuku, 2019; America Adoptions, 2020). Charitable care facilities play a primary role in deinstitutionalization, particularly in family tracing for adoption and short-term shelter. Kinship care is the most common deinstitutionalization program (Duca, 2011). It is, nevertheless, not regulated, and children are likely to be abused. Adoption in Kenya is highly developed, with policy, monitoring, and evaluation tools in place. Nonetheless, research has shown that the procedure is long and costly, deterring domestic adoption within the nation. In addition, because of cultural beliefs, adoption has been stigmatized, and few individuals are able to differentiate between adoption and kinship care (Ivanova & Bogdanov, 2013).

Other alternative family care arrangements like community-based care, kafalah, and guardianship are also recognized in Kenya. There is evidence to back the deinstitutionalization process in Kenya, as the government has come up with strategies to realize it, specifically through the cash transfer program. Community-based strategies are utilized in the program to reach Orphans and Vulnerable Children (OVC). Research has, however, indicated that some of those who have benefited from the program are not vulnerable. Community-Based Organizations (CBOs) and Non-Governmental Organizations (NGOs) also play a central role in ensuring the well-being of children.

2.3.3 Participant engagement on the welfare of vulnerable children

Implementation of program development and service delivery within the deinstitutionalization program has a significant effect on child welfare (Aziz, 2021; Brodmann et al., 2024). According to Fulone et al. (2021), implementing an adoption program from application through finalization, on average, takes nine months, just like a pregnancy period, as estimated in the USA. Based on a study on service intensity and program implementation performed by Pumariega et al. (2019), it was observed that about 70% of participants considered that adoption took too lengthy a time, thereby preventing them from adopting children through this program.

In a different study, Toros and Falch-Eriksen (2021) revealed that the adoption process can be divided into three phases, namely pre-placement, placement, and post-placement phases. They observed that, on average, "the pre-placement phase alone can take anything from six months up to one year or more, depending on 'the type of adoption, agency efficiency, and legal formalities.' On average, 'domestic adoptions can take one to two years, and international adoptions may take several years as well as other legal formalities.'" (Toros and Falch-Eriksen, 2021, p.120). Along this same line, Przeperski and Owusu (2021) examined meaningful changes occurring within social work practices intended for the promotion of children's welfare. They concluded that children may develop behavioral issues that would require them and their adoptive fathers and mothers, as well as other grown-ups, to undertake lengthy psychoeducation sessions.

Equally, studies that took place within countries on that continent concur that longer-term follow-up of children placed in alternative care brings a significant positive impact on child welfare (Achieng, 2016; Kuehr, 2019; Aladegboye et al., 2024). Research undertaken by Cooley and Krysik (2021), based on interviews of 240 carers in Abuja, Nigeria, showed that child removal is always improperly managed and that this often has traumatic effects on children and their parents as well. All this is quite concerning, especially taking into consideration that average stay duration of children under alternative care is 21 months, and median stay time was calculated at 14.6 months during the financial year of 2020.

Studies undertaken by Mutenyo et al. (2019) in Uganda reported that children placed under foster care and exposed to longer-term psychoeducation and parent training showed that they had improved parent and child relationship interactions on many occasions. In Kenya, there

are approved adoption agencies that are required to undertake all adoptions (Risa, 2018; Wagema, 2018). These agencies supervise, care, and monitor children involved in adoption procedures. They also supervise kinship adoption, modify rules concerning adoption by foreigners living in Kenya, supervise adoptions of foreigners living in Kenya, and further supervise international adoption procedures (United Nations Children's Fund (UNICEF), 2014). Accredited Adoption Society of Kenya undertakes these tasks, and they always act in the child's best interest (Achieng, 2016). But Njoki (2019) has indicated that these factors influence adoption and include agency factors, family, child, and legal considerations, as specified below. Specifically, Njoki (2019) has shown that these elements influence social interaction, and child elements, such as sudden separation, create uncertainty and problems of attachment, thus causing delays in this adoption process. Along with this inquiry, Ajinkya et al. (2021) have proposed that prolonged counseling and parental education are necessary before placing a child in adoption. Thus, this would logically cause delays during this process of adoption.

According to Risa (2018), the guidelines for alternative family care are mandated for civil society organizations that work with children. These organizations are responsible for conducting assessments, providing support to families and preventing separation, referring children and acting as gate keepers to children and their families in getting support services, supporting family reunion, overseeing integration of children into alternative care, monitoring each case, and training and supporting volunteers. All these efforts aim to ensure the welfare of children under alternative family care (Flagothier, 2016). In a separate study, Ayuku (2019) found that the duration and quality of alternative family care can significantly influence child welfare. For instance, the scholar revealed that services like education are long-term, and NGOs form a long-term relationship with the adoptive family by providing sponsorship to the children. Similarly, Gayapersad, Ombok, Kamanda, & Carren (2019) found that a long-term commitment in the provision of educational services by NGOs was associated with high education completion rates for orphan.

The most common alternative family care in Kenya is "traditional foster care of extended families. This program is better equipped to deal with the realities of the situation" (Chege & Ucembe, 2020). However, a study conducted by Save the Children (2015) in Busia, Kenya on Kinship care revealed that there is laxity by the government and external agency in regulating and monitoring traditional care systems specifically kinship care and traditional foster care. The study found that children in kinship care face some kind of abuse such as sexual exploitation and

infringement of their rights. Further, the study points out that some children were exploited. The study done by Achieng (2016) and Mokaya (2016) affirm that kinship care is not regulated or no monitoring and evaluation mechanism is in place to understand how they promote child welfare. However, in a study by Save the Children (2015) some children who were in kinship care were able to access education, food, and shelter. Although, some were deprived of love and attention and kins could not treat them as their own children, making them develop insecurity (Gayapersad, Ombok, Kamanda, & Carren, 2019).

Kinship care finds its roots in African traditional care systems of vulnerable individuals, such as orphans, widows, aged and the sick. Traditionally, a child belongs to a community that comprises of a large family, a clan. These systems played care role such as discipline of children and upbringing (Achieng, 2016). The role was based on prestige and there were no written rules for the clan to take care of the orphans and the vulnerable (Ayuku, 2019). However, urbanization has rode the values of kinship care creating a gap between families with the most affected being clan ties as well as extended families who have become strangers to one another. In addition, western culture and modernization has led to emergence of adoption care systems which are institutionalized (Stuckenbruck, 2013). Kenya has an adoption law and adoption society that regulate both domestic and inter-country adoption. Although, adoption has not been embraced in Kenya due to cultural reasons and beliefs. For instance, Stuckenbruck and Jini (2017) observed stigma associated with adoption as well as inheritance beliefs.

Among the Muslims, Kafaalah has emerged as an alternative care option for children deprived of parental care, However, there is still limited research on this area (Aziz, 2021). The kafaalah stems from the Muslim community and is recognized globally as alternative childcare (Usang & Sloth-Nielsen, 2014). The practice is guided by sheria law which is used to monitor and evaluate the process and the care given to children. Children under kafaalah are cared for and get all the basic needs from Manful (Ivanova & Bogdanov, 2013). In countries where kafaalah is highly practiced the local authority is tasked with the responsibility to monitor its process as the best interest of the child is considered in the process (Duca, 2011). However, there is no data on kafalah despite its recognition from the law.

2.3.3 The dosage of services on the welfare of vulnerable children in care institutions

Studies have revealed that the intensity of the implementation of deinstitutionalization programs, especially service frequency, provider ratio, and service individualization, has a significant effect on child welfare (Ajinkya, Petterson, Westfall, & Jabbarpour, 2021; Beugre, 2019; Cooley & Krysik, 2021). According to Montenegro, Dominguez, Moller, Thomas, and Ortiz (2023), an examination of the degree of psychiatric deinstitutionalization (PDI) in the USA found that obstacles to PDI consist of a lack of proper planning, financing, and leadership, insufficient knowledge, conflicting interests, a lack of community-based alternatives, and opposition from the workforce, community, and family/caregivers. In contrast, Cooley and Krysik (2021) found that institutions implementing deinstitutionalization programs engage facilitators like social workers and government institutions to ensure that the programs not only succeed but also promote the welfare of the children. In another study conducted in Ohio, Shawar (2023) found that careful planning, financing and coordination, available research and evidence, strong and sustained advocacy, comprehensive community services, and a well-trained workforce were significant to the welfare of the children.

In many Asian nations, family-based alternative care services, such as foster care, supported kinship care, and successful domestic adoption, are still in short supply for children in need of long-term care outside their biological families (Flagothier, 2016). This shortage largely impedes critical processes like gatekeeping, deinstitutionalization, and care system reforms on a larger scale (Ivanova & Bogdanov, 2013). Moreover, negative attitudes, especially prevalent within residential care facility staff and social welfare age ncy staff, still hamper gatekeeping activities effectively (Ajinkya et al., 2021). Not only do these attitudes derail deinstitutionalization, but they also lead to the ongoing intake of children into institutions (Beugre, 2019). A study conducted in China by Lobanov-Rostovsky et al. (2023) investigated the transition from institutionalization to the development of family informal care resources. The study piloted 49 “alternative long-term care insurance systems” and found a gap between the social service providers and the demanding needs for child welfare protection services, with disparities between urban and rural areas. The study recommended an increase in the ratio of service providers to adopted children.

In Egypt, Aziz (2021) carried out research on deinstitutionalization and alternative family care. The research entailed meta-analysis of literature on alternative care for children, participant observation, and the use of qualitative methodological approaches founded on purposive and snowball sampling strategies. The research identified insufficient diversity in care options, gatekeeping practices, and family reintegration. The research prescribed a comprehensive alternative care approach under the banner of deinstitutionalization and advocated that there should not be an exclusive emphasis on alternative families' programs as the primary system strengthening intervention.

In yet another research, Milligan et al. (2017) explored "*alternative childcare and deinstitutionalization in Sub-Saharan Africa*." Their combined 3 continental review and 6 empirical study. The research stated that the prevalence of Child-Headed Households (CHH) was at a rate of 30 in every 1,000 families in Uganda's Rakai district, 4 in every 1,000 in Zimbabwe, and 0.3 in every 1,000 in Tanzania. When multifaceted interventions were provided, including community-based education, parent education, cash transfer programs, and case management by social workers, a reduction in child-headed households occurred by 0.3%. This implies that such services often work towards the welfare of the child (Aziz, 2021). Milligan, Withington, Connelly, and Gale (2017) suggest that governments develop sustainable action plans and strategies towards a shift from an arrangement of long-stay residential institutions to an arrangement of community-based services.

In addition, Gayapersad et al. (2019) looked at whether and how alternative kinship forms were reproduced within Charitable Children's Institutions (CCIs) in Kenya. The research was qualitative in nature, and data were gathered "from 22 caregivers and 30 orphaned and separated children and adolescents (OSCAs) through participant observation and in-depth interviews." The data were interpreted based on a symbolic interactionist theoretical framework. The research concluded that social interaction with caregivers helped define family in certain CCIs, specifically those structured as a village and/or a single family. Having more than one caregiver alleviated economic difficulty. Despite several drawbacks, the research concluded that family-like CCIs can be a caring last resort for children who lack kin to provide care for them.

Njoki (2019) carried out a study assessing factors influencing the implementation of de-institutionalization programs in Kiambu. The research identified non-existent governance and

accountability mechanisms on deinstitutionalization, coordination challenges between agencies, and finances, resource, and budgetary allocation shortages influencing the implementation of deinstitutionalization. The research, however, indicated that the legal framework has a moderate influence on the implementation of deinstitutionalization. Other factors influencing the implementation are personalization of services, organizational complexity, and staff turnover.

Here, neither the government nor CCIs has mechanisms for accountability that would make the CCIs comply with the policy (Njoki, 2019). Moreover, Zaborskis (2024) adds that CCIs do not have guidelines that regulate decision-making processes regarding the duration of residence and responsibility for the adverse effects that result from children not being reunited with their families. A research by Risa (2018) established that the issues arising in the process of applying Direct Instruction (DI) can be classified into three main categories: having insufficient funds, inadequate social workers, and systemic problems with respect to children with special needs. Ayuku (2019) corroborated that such challenges lead to what termed abuses within the child protection system may be. The child protection system, designed to safeguard children, is undermined by the institutionalization of children.

A study done by Saya (2021) with CCI uncovered that various factor hindered deinstitutionalization among CCIs. Some of the factors are insufficient mapping of families willing to adopt, inadequate foster care systems, abuse of children by guardians when they take them to visit their homes, and guardians and parents' failure to cooperate (Chege & Ucembe, 2020). Additional factors were oversighted, a workforce with no skills, and irresponsibility of caregivers (Browne, 2017). The researcher observed that children declined to leave CCIs due to abuse by parents and guardians, violation of rights outside CCI, hunger, poverty, and domestic violence. Managers interviewed reported that children remained in their CCIs longer than anticipated due to stigma, unaccepting family members, communities rejecting children, truant children, failure by the government to enforce, and the incapability of guardians to manage irresponsible children.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

Chapter three describes the "study methodology" giving step by step account of how the research was conducted in a more logical way. It describes the research design, other designs like sampling and data collection methods; "validity and reliability" of research and ethical issues in research in the proposed study and how data was analyzed are discussed.

3.1 Research Design

The "research design" is an important component of a study. According to De Vaus and de Vaus (2001) it provides an overall plan for data collection, measurement, and analysis, ensuring that the research problem is addressed effectively and logically. This study has adopted "a mixed-methods approach." This study adopted a convergent mixed-methods research design, which integrates both quantitative and qualitative approaches within a single phase of data collection.

The convergent design involves the simultaneous collection of quantitative and qualitative data, followed by separate analysis of each dataset and subsequent integration during interpretation (Creswell & Plano Clark, 2018). In this study, quantitative data were collected through structured questionnaires to generate measurable and generalizable findings on the implementation of de-institutionalization programs. At the same time, qualitative data were collected through interviews to provide deeper insights into stakeholders' experiences, perceptions, and contextual realities surrounding program implementation.

The choice of a convergent mixed-methods design was informed by the complex nature of deinstitutionalization programs, which require both statistical analysis of implementation outcomes and an in-depth understanding of social processes influencing children's welfare. Quantitative findings provided objective evidence on relationships between variables such as adherence, quality of service delivery, participant engagement, and dosage of services, while qualitative findings enriched the analysis by explaining the underlying factors influencing these relationships.

Furthermore, the convergent design enhances the validity of the study through triangulation, whereby findings from both data strands are compared and corroborated to provide a more comprehensive understanding of the research problem (Creswell & Plano Clark, 2018). This approach ensured that the weaknesses inherent in one method were compensated by the strengths of the other, leading to more robust and reliable conclusions.

In addition, the study incorporated elements of cross-sectional design, allowing data to be collected from respondents at a single point in time. This facilitated the assessment of the current status of de-institutionalization program implementation and its influence on the welfare of vulnerable children in care institutions (Pandey & Pandey, 2021). The exploratory aspect of the design also enabled the researcher to capture diverse perspectives from multiple stakeholders involved in child welfare systems, thereby enriching the overall analysis.

Overall, the convergent mixed-methods design was considered most appropriate for this study as it provided a comprehensive, flexible, and holistic approach to examining the implementation of de-institutionalization programs and their implications for children's welfare in Nairobi, Kenya.

3.2 Site description

Research will be conducted at "Nairobi, the capital of Kenya located south-central Kenya, at an elevation of approximately 5,500 feet (1,680 meters), and some 300 miles (480km) northwest of Mombasa, Kenya's major port on the Indian Ocean." Nairobi is a diverse and thriving city, and as such, many institutions offering care services for needy children. These institutions have played critical roles in childcare and, thereby, child protection in Kenya. Of late, however, there has been de-institutionalization, and emphasis has been on providing care services for children within families. Consequently, this region is of great significance to this research, as findings will help

shape future policies on child welfare and child and parent protection within Kenya and other parts of the world.

The capital and centrally located, Nairobi is an ideal location since most governmental and non-governmental organizations concerned with the welfare of the child are located here. This means a wide variety of stakeholders and resources for research. Previous studies have already highlighted the over-reliance on institutionalization in Kenya, along with ongoing efforts toward de-institutionalization. This gives a good background on which the study is based. This means that Nairobi is the best location to conduct the study on how the implementation of de-institutionalization programs has affected the welfare of children within care institutions because of its unique geographical setting, diverse population, and currently unfolding policy shift towards de-institutionalization.

3.2.1 Target population

Christensen, Johnson, and Turner (2015) define the target population as the entire group of individuals or objects that researchers aim to generalize their conclusions to. This group stands out from the general population due to certain distinguishing attributes. The research took place in children's homes, also known as CCIs or orphanages, and government-run institutions in Nairobi, Kenya. Saya (2021) approximates that Nairobi houses around 40,000 children across approximately 830 children's homes. Murungi (2019) adds that over 845 private charitable children's institutions exist, with an additional 1,700 children living in government-run institutions. Consequently, this research's study population encompassed all vulnerable children in Nairobi, Kenya's care institutions. This includes the estimated 40,000 children in 830 children's homes across Nairobi, and the 1,700 children in government-run institutions.

3.2.2 Study population

According to Pandey and Pandey (2021), the study population, otherwise referred to as the accessible population, is a subset of the target population from which the researchers choose. This definition is broader compared to a sample frame. The study population in this research involved 41,645 OVCs (Saya 2021; Murungi, 2019), who are the primary subjects of the DI Programmes, Government Officials affluential in the implementation and regulation of DI Programmes, directors of Children Care Institutions/Children in care institutions participating and directly

involved in the implementation of DI Programmes thus providing practical insight and valuable responses.

3.2.3 Sample size and sampling procedure

The sample size for the study will be calculated using Krejcie and Morgan (1970):

$n= \frac{NS^2}{((N-1)se^2+s^2)}$

Where $s= (Z\frac{\alpha}{2})\sigma$ and se= margin of error

Therefore, $n= \frac{41645 \times(1.96\times\sqrt{0.25})^2}{((41645 \times0.05^2)+(1.96\times\sqrt{0.25})^2)}$ $n= \frac{41645 \times0.9604}{18.3675+0.9604}$ $n= \frac{7056.0588}{19.3279}$ n= 380

3.2.4 Sampling Procedure

The study adopted a mixed sampling approach, combining stratified random sampling, purposive sampling, and convenience sampling to ensure both representativeness and inclusion of participants with specialized knowledge relevant to the study objectives.

For the primary respondents, namely Orphans and Vulnerable Children (OVCs), stratified random sampling was used. According to Busetto, Wick, and Gumbinger (2020), stratified sampling involves dividing a population into homogeneous subgroups (strata) and selecting samples randomly from each stratum to enhance representativeness. In this study, stratification was based on children's residence within selected care institutions in Nairobi. From these strata, a sample of 320 OVCs was randomly selected. This approach minimized sampling bias and ensured that the views of children from different institutional settings were adequately captured (Kothari, 2014).

For participants with specialized knowledge and direct involvement in the implementation of de-institutionalization programs, specifically directors of Charitable Children's Institutions (CCIs) and social workers (gatekeepers), the study employed purposive sampling. Purposive sampling allows the researcher to intentionally select individuals who possess specific characteristics and are knowledgeable about the phenomenon under investigation (Palinkas et al., 2015). In this case, directors and social workers were selected based on their active roles in program implementation, decision-making, and child welfare service delivery. A total of 7 directors and 7 social workers were included in the study. The relatively small number of

participants in these categories is justified by the need for in-depth, context-specific insights, which is consistent with qualitative research principles emphasizing information richness over sample size (Creswell & Plano Clark, 2018).

For other stakeholder groups, including government officials, officers from the Adoption Society of Kenya, and adoptive parents and guardians, convenience sampling was utilized. According to Orodho (2008), convenience sampling is appropriate where participants are readily accessible and possess relevant information needed for the study. A total of 10 government officials, 5 Adoption Society officers, and 30 adoptive parents and guardians were selected based on their availability and willingness to participate, as well as their involvement in child protection and alternative care systems.

The use of these combined sampling techniques ensured a balance between statistical representativeness and depth of information. Stratified random sampling enhanced the generalizability of findings among OVCs, while purposive and convenience sampling ensured the inclusion of key informants with critical expertise in de-institutionalization programs. This approach is consistent with mixed-methods research designs, which require the integration of both breadth and depth in data collection to achieve comprehensive analysis (Creswell & Plano Clark, 2018).

3.2.5 Sample frame

Table 3.1: Sample frame

Study Population	Population Size	Sampling Method	Sample
OVCs	40,000	Stratified Random Sampling	320
Government Official	10	Convenience Sampling	10
Children care institution/children in care institutions directors	830	Purposive Sampling	7
Adoption Society of Kenya officials	5	Convenience Sampling	5
Adoption Parents and Guardians	40	Convenience Sampling	30
Gate Keepers e.g., Social Workers	800	Purposive Sampling	7
Total	**41645**		**380**

3.3 Methods and Instruments of Data Collection

The researcher collected primary data from the respondents using two tools: a structured survey questionnaire and an interview guide. The questionnaire was employed to gather the

respondents' opinions. According to Kombo and Tromp (2006), interviews in social science provide in-depth information that can clarify data that might have been captured by the structured questionnaire. While the majority were the OVC, the few social worker were included for the interview, the research considered this due to the data saturation for qualitative research.

3.3.1. Questionnaire

The study employed a questionnaire to collect quantitative data. This questionnaire, composed of closed-ended questions, is divided into several sections. Section a focus on gathering demographic characteristics of the participants, including gender, age, years of service, highest professional qualification, and employment status. Sections B through E are developed to collect data on indicators related to DI Programmes, including their "Adherence to program protocols, Quality of Program Delivery, Participant Engagement, and Dosage of Services." Before data collection, permission was sought from the CCI. Following this, an appointment was be made with the respondents.

The questionnaire was self-administered to the respondents themselves. For the OVC the researcher sought permission from the parents, and the guardians and children were then given assent forms, children between the age of 10-18 who have lived in care institution or have been placed in alternative family care were included in the study. The purpose of the study was then elaborated to the children create a conducive environment and then self-administered the questions.

The questionnaire was chosen because of its ability to gather data from many of many participants in a structured manner, making it easier to analyses and draw conclusions. To address the research questions, Likert items based on modified implementation fidelity Scales that have been used in implementation of programs and projects. Respondents were asked to rate these statements on a Likert scale of 1-5, ranging from "1= strongly disagree to 5 = strongly agree." This allowed for the measurement of attitudes or feelings in a quantifiable manner, hence contributing to ease in data analysis and saving time. This method was chosen because it has proven to be effective in capturing nuanced data and is widely accepted in social science research.

3.3.2 Interview Guide

The use of interview guide in data collection involves the presentation of oral-verbal spurs and responses in the form of oral replies. The researcher developed an interview guide for various stakeholders including Orphans and Vulnerable Children (OVCs), gatekeepers, project managers, government officials, and directors of Child Care Institutions (CCI). This guide complemented the structured questions that require verification. Upon receiving approval from the CCI institutions and respondents were asked to sign a consent to participate in the interview scheduled, the researcher agreed upon a suitable and flexible time for the interview with each respondent. Subsequently, the researcher will schedule and conduct face-to-face interviews with the respondents.

3.4 Piloting of Instruments

A preliminary investigation within a charitable care institution in Nairobi County, Kenya. According to Kombo and Tromp (2006), ten percent of 380, which equates to 38 respondents, for pilot test. This assisted the researcher in identifying areas that were not captured in the data collection tools. The intention of this pilot test is to collect data in preparation for a larger and more definitive study. Additionally, it aided in testing the relevance and internal consistency of the data collection instrument.

3.4.1 Validity of Instruments

Validity is the extent to which a study measures the idea it is intended to measure (Christensen, Johnson, & Turner, 2015). Validity is a cornerstone of research as it ascertains that the tools correctly measure the variables. Exploratory factor analysis was used to test for construct validity and content validity. Construct validity was tasted using factor analysis, a statistical method employed in detecting associations between observed variables and the latent constructs (Young, 2016). Factor loadings, which have values between -1 and 1, express the extent of relationship between each variable and a particular factor. Larger absolute values (i.e., close to -1 or 1) imply stronger relationships, while values close to 0 convey weaker relations. A standard rule of thumb is that an item must have a rotated factor loading of 0.4 ($\geq +0.4$ or ≤ -0.4) to be significant. Some researchers suggest a stricter cutoff value of 0.7, however, which was used in this research (Christensen et al., 2015; Pandey & Pandey, 2021). All the items had a factor loading of.76 to 80 suggesting high construction validity.

Content validity, on the other hand, assessed using expert consultation. Content validity was determined by experts' evaluation in the respective field as to whether the measurement instrument fully represents all aspects of the construct. Content validity ensures that the tool fully addresses all the critical elements of what is supposed to be measured. A quantitative method, Content Validity Index (CVI) was used to determine the proportion of experts who judge each item as relevant or representative of the construction. A CVI value closer to 1 indicates greater content validity, and any item below .6 would have been removed. However, all the items scored .96 and above.

According to Pandey and Pandey (2021), reliability is an aspect that measures consistency in a study or factor. Internal consistency is a form of reliability that is applied in determining the measures of data through a test of multiple study variables that aim at measuring a similar variable or aspect. The study utilized a statistical procedure known as Cranach's Alpha, which is a widely utilized statistical procedure in determining internal reliability. This procedure measures the average relationship of a study that entails all its multiple study variables on a predetermined scale. This statistical procedure measures its value between 0 and 1, whereby a high value indicates high internal reliability. In essence, a value of 0.7 or higher is acceptable in most social studies (Christensen et al., 2015) This study's items were highly reliable with a value of 0.93 to 0.96.

3.5 Data analysis Techniques

Data analysis involved triangulation of qualitative and quantitative techniques. For example, qualitative data was analyzed using thematic analysis, data collected from the interview schedule was transcribed and codes developed. Themes and patterns were identified and analyzed to understand the influence of De-Institutionalization (DI) Programs on the welfare of vulnerable children. Conversely, the data obtained from the questionnaire were analyzed using SPSS version 26. "Descriptive statistics" were employed to provide a summation of the gathered data, such as mean, and standard deviation. Inferential statistics was utilized to determine the relationship of the variable. Specifically, a regression model was developed to analyze the association between the implementation of DI Programs (independent variables) and the welfare of vulnerable children (dependent variable). The model was considering the scale, "Adherence to program protocols," "Quality of Program Delivery," "Participant Engagement," and "Dosage of Services." An intervening variable, the 'Implementation Strategy', was also be incorporated into the model to

understand its effect on the relationship between the DI Programs and the welfare of vulnerable children.

The regression model can be represented as:

"$Y = B_0 + B_1X_1 + B_2X_2 + B_3X_3 + B_4X_4 + B_5M + \epsilon$"

Where:

- Y represents the welfare of vulnerable children,
- X_1 represents the scale of "Adherence to program protocols,"
- X_2 represents the "Quality of Program Delivery,"
- X_3 represents the "Participant Engagement,"
- X_4 represents the Dosage of Services,
- M represents the intervening variable 'Implementation Strategy',
- "β_0, β_1, β_2, β_3, β_4, β_5 are the parameters to be estimated,"
- ϵ is the error term.

The parameters were estimated using a suitable method such as "Ordinary Least Squares (OLS)." The significance of the parameters was tested to determine if the independent variables have a significant impact on the dependent variable. The model's fitness was assessed using measures such as R-squared and Adjusted R-squared. After conducting diagnostic tests.

3.6 Ethical Considerations

The researcher is assured that the research process does not cause harm to respondents and research assistants (non-maleficence). This meant that the researcher gets all the relevant permits and recommendations from the University and elsewhere that allows her to conduct the research. It involved the researcher informing the respondents about every aspect of the research so that they are well informed to make a choice on whether to participate. This according to McLeod (2003) is the principle of autonomy, allowing free participation without manipulation or coercion. The researcher explained that despite the signed consent, the respondents are free to drop from participating at any time during the research process. It ensures the rights of the respondents are respected. The research team ensured that they treat respondents equally. This is the principle of justice which according to McLeod (2003) mean being fair to all regardless of gender, race, ethnicity or age.

For children, the researcher sought the guardian consent and the institutional approval, a conducive environment was then created to ensure the children feel safe, this was followed by explanation of the purpose of the study, the children were assured of privacy and confidentiality. In addition, the researcher identified a child counsellor owing to the sensitivity of the study and counselling services which did not occur.

CHAPTER FOUR

DATA PRESENTATION, INTERPRETATION AND DISCUSSION

4.1 Introduction

This chapter presents return response rate based on distributed questionnaire and interview schedule. In addition, it highlights respondent's demographic representations. Further, the chapter presents data, interpretation and discussions. The presentation of data is based on the study objectives: the influence of adherence to de-institutionalization program protocols on the welfare of vulnerable children in care institutions, the influence of the quality of program delivery on the welfare of vulnerable children in care institutions, the influence of participant engagement on the welfare of vulnerable children in care institutions and the effect of the dosage of services on the welfare of vulnerable children in care institutions.

4.2 Return Response Rate

Table 4.1:Return Response Rate

Response Category	Count	Percentage (%)
Distributed Questionnaires	380	100.00
Returned (Total)	375	98.68
Incomplete (Excluded)	20	5.26
Not Filled (No Reason)	5	1.32
Not Returned	5	1.32
Valid Responses	350	92.11

The study achieved a valid response rate of 92.11%, derived from 350 valid questionnaires out of 380 distributed, with only 5 not returned, 5 returned unfilled, and 20 excluded due to incompleteness. According to Mugenda and Mugenda (2003), a response rate of 50% or more is considered adequate for analysis, while 70% and above is rated as very good. The response rate in

this study therefore far exceeds the recommended "very good" threshold, indicating exceptional participant engagement and minimal non-response bias. Such a high rate strengthens the representativeness of the data, enhances reliability, and increases the generalizability of the findings to the broader population of care institutions in Nairobi.

4.3 Respondents Demographic Representation

Table 4.2: Demographic Representation

Age Representation		
	N	%
12-17	10	2.9%
18-24	52	14.9%
25-34	78	22.3%
35-44	88	25.1%
45-54	75	21.4%
55-64	41	11.7%
65+	6	1.7%
Gender Representation		
	N	%
Male	165	47.1%
Female	185	52.9%
Employment status		
	N	%
Employed full-time	199	56.9%
Employed part-time	55	15.7%
Self-employed	22	6.3%
Unemployed	40	11.4%
Student/pupil	28	8.0%
Retired	6	1.7%

(Source Field Data, 2025)

Table 4.2 presents demographics data of the respondents, the result shows that there is a relatively equal spread of ages, with most of them falling within the productive and working age groups. Also, more participants belonged to the age groups of 35-44 (25.1%), followed by those belonging to 25-34 (22.3%), and then participants belonging to 45-54 (21.4%). Young participants belonging to the age group of 18-24 accounted for only 14.9%, followed by the number of adolescents belonging to the age group of 12-17, who accounted for only 2.9%. Moreover, people belonging to the older age group of 65+ are least represented (only 1.7%). Additionally, people belonging to the older age group of 55-64 accounted for 11.7%. Moreover, there is a relatively equal number of men and women, and most of them belong to female (51.7%), followed by men (45.7%).

Moreover, a small number of people belong outside these two classifications (2.6%). Employment statistics indicated that most of them, i.e., (56.9%), belong to people who have been fully employed, followed by (15.7%) people who have been part-time employed, and then (6.3%) people who belong to people who have been self-employed, followed by (11.4%) people who have not been unemployed, then.

4.4 Diagnostic Tests

The diagnostic test was conducted to verify that data meet key statistical assumptions, ensuring validity, reliability, and accuracy of regression or inferential results.

4.4.1 Normality test

Table 4.3 Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	Df	Sig.
Children Welfare	.141	350	.000	.951	350	.000
Staff Adherence to Program Protocols	.112	350	.000	.983	350	.000
Quality of Program Delivery	.109	350	.000	.981	350	.000
Participant Engagement	.099	350	.000	.985	350	.001
Implementation Strategy	.097	350	.000	.984	350	.001
Dosage of Services	.079	350	.000	.986	350	.001

a. Lilliefors Significance Correction

The normality test aimed to “check if the study variables were normally distributed, this is a key assumption in regression analysis.” Results from the Kolmogorov-Smirnov test with Lilliefors correction showed that all variables deviated significantly from normality. The test statistics ranged from .079 for Dosage of Services ($p = .000$) to .141 for Children Welfare ($p = .000$), all below the 0.05 threshold. This result suggests a breach of the normality assumption for the study variables. However, regression analysis needs normality of residuals instead of raw variables. Given the “large sample size ($n = 350$),” the “Central Limit Theorem” confirms that parametric methods still work well. Therefore, regression analysis can be performed.

4.4.2 Linearity Test

The linearity test is conducted to “determine the relationship between independent variables and the dependent variable.” It is the key assumption for regression analysis and necessary for validating data for regression analysis. However, if nonlinearity is observed the estimates from a

regression may be misleading or biased, this is because the model specification would not correctly reflect the real relationship.

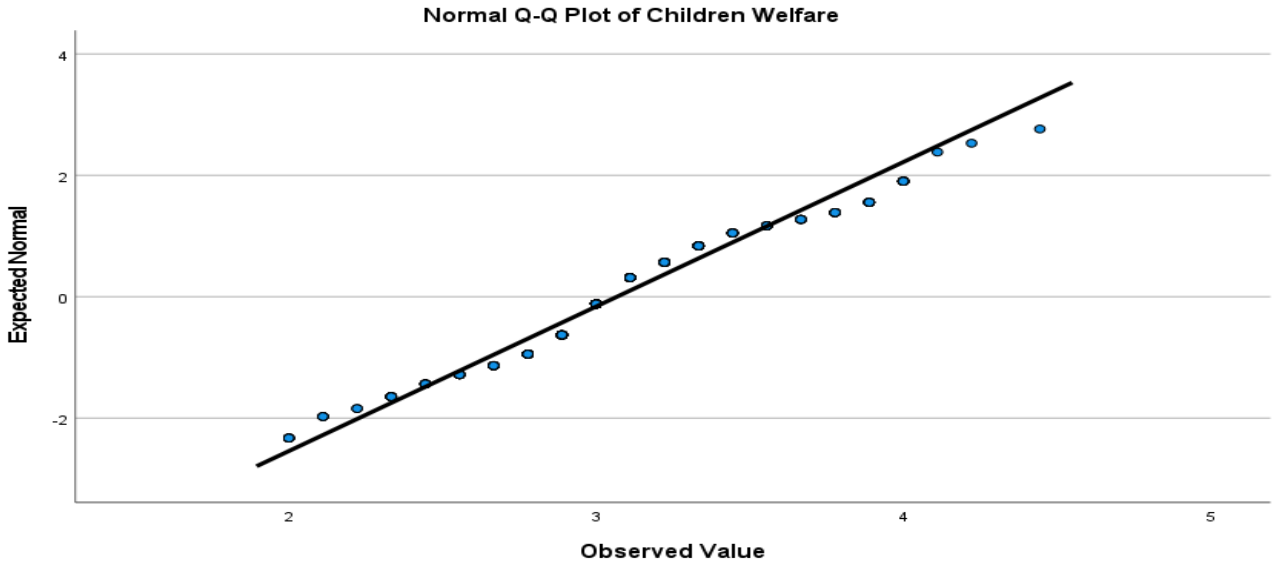

Figure 4.1: Normal Q-Q Plot of Child Welfare

The figure 4.1 presents the Q-Q plot of child welfare the result demonstrates that it has not violated the normality test assumptions for regression analysis with an indication of data pointing closely following the diagonal reference line. However, there are minor deviations in the upper tail suggest slight positive skewness, indicating higher welfare scores occur more frequently than normal distribution predicts.

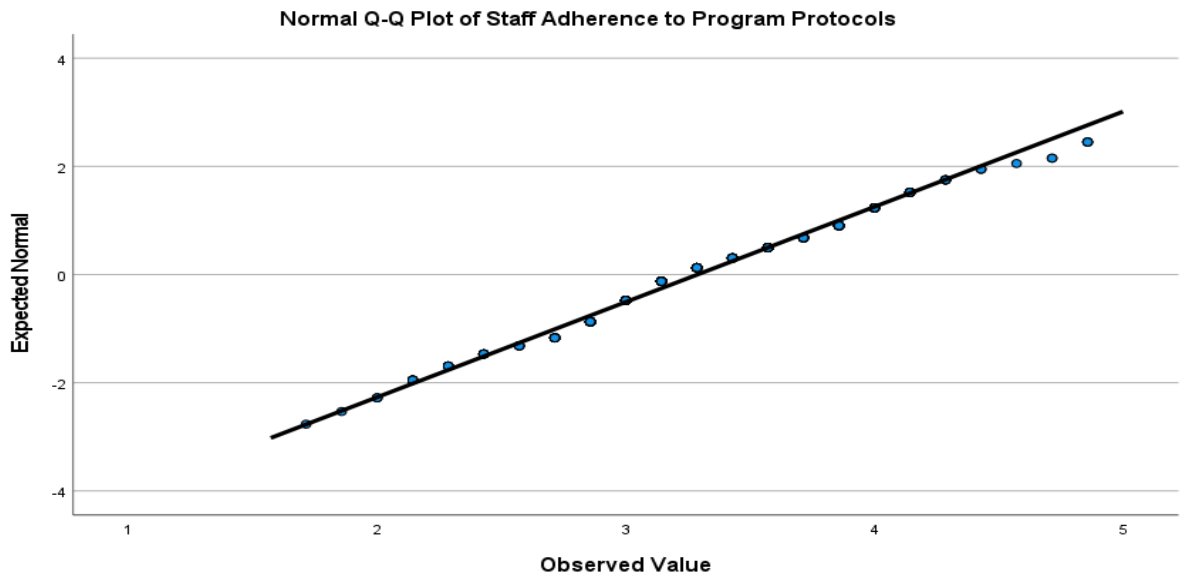

Figure 4.2: Normal Q-Q Plot of Staff Adherence to Program Protocols

As shown in Fig 4.2 the "normal Q-Q Plot" of Staff Adherence to Program Protocols shows strong adherence to normality assumptions with data points demonstrating strong linear alignment along the diagonal reference line. Although, there is a slight deviation across all quantiles indicate staff adherence scores follow normal distribution patterns consistently. This strong linear relationship affirms parametric statistical use approaches and confidence on non-biased result in relationship prediction.

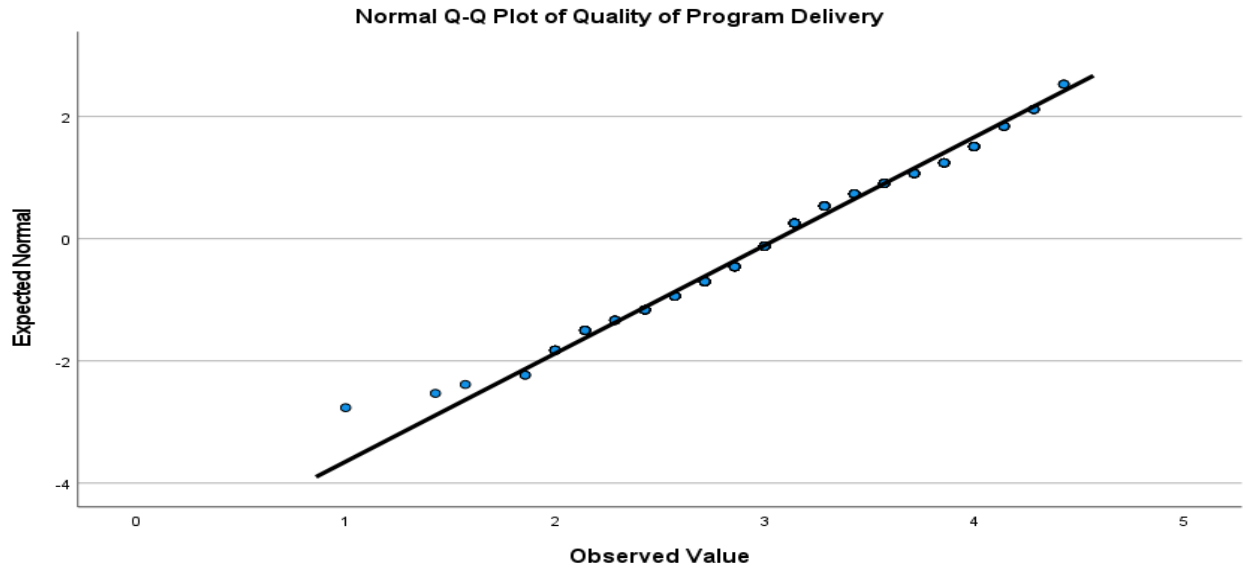

Figure 4.3: Normal Q-Q Plot of Quality of Program Delivery

Figure 4.3 shows the "normal Q-Q Plot" of Program Delivery. The result indicates no violation to normality with data points closely following a straight-line reference line throughout most quantiles. Slight deviation is however observed the lower tail where one-point falls substantially below the straight line, suggesting small outlier or extreme low-quality delivery score but it has no effect on the overall assumption.

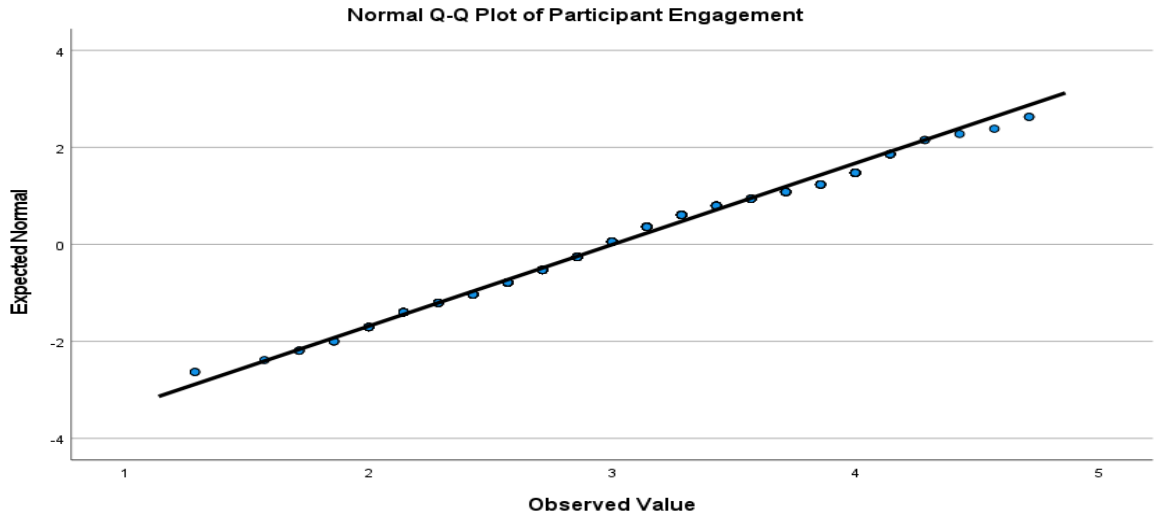

Figure 4.4: Normal Q-Q Plot of Participant Engagement

As shown in Figure 4.4 the "normal Q-Q Plot" of Participant Engagement indicate perfect alignment to normal regression assumptions with data demonstrating near-perfect linear alignment along the diagonal reference line across all quantiles. There are, however, minimal systematic deviations, suggesting that participant engagement is normally distributed in a consistent pattern. The perfect distribution validates parametric statistical procedures and supports the application of standard inferential methods for analysis.

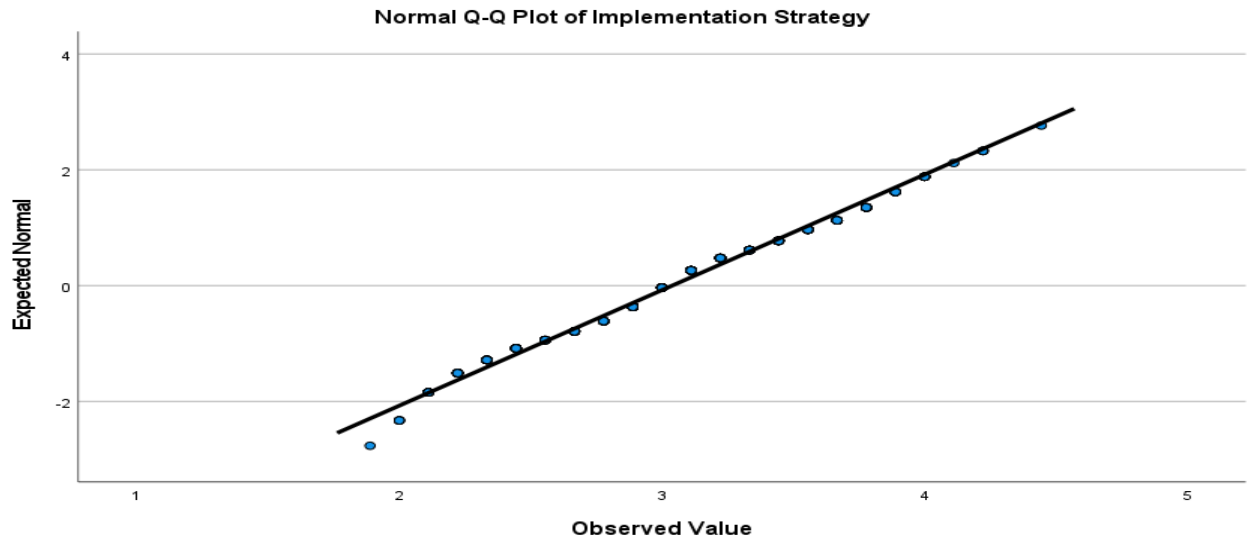

Figure 4.5:Normal Q-Q Plot for Implementation strategy

As shown in Figure 4.5: "normal Q-Q Plot" for Implementation strategy indicates perfect alignment on the straight line supporting normal regression assumptions with data demonstrating near-perfect linear alignment along the diagonal reference line across all quantiles. There are, however, minimal outliers suggesting that participant engagement is normally distributed in a consistent pattern. The perfect distribution validates parametric statistical procedures and supports the application of standard inferential methods for analysis.

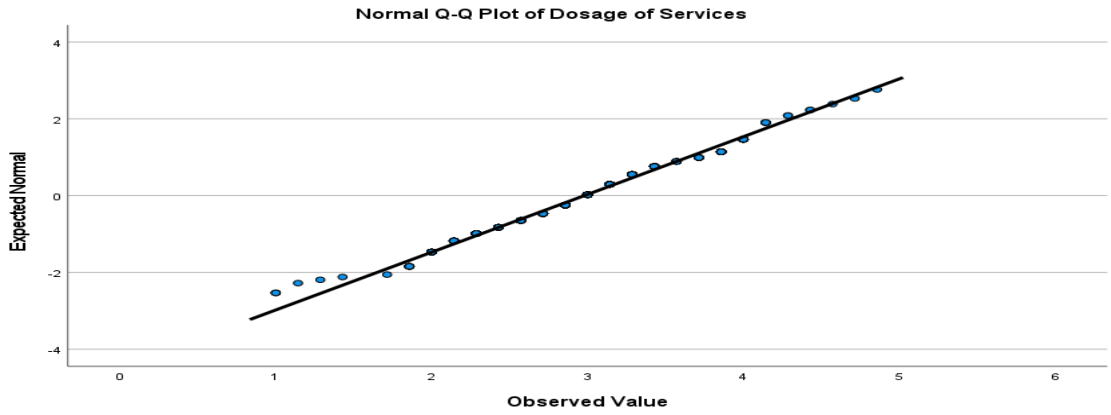

Figure 4.6: Normal Q-Q Plot for Dosage of Services

As shown in Figure 4.6: "normal Q-Q Plot" for Dosage of Services indicates perfect normality assumption supporting normal regression assumptions with data demonstrating near-perfect linear alignment along the diagonal reference line across all quantiles. There are, however, minimal outliers suggesting that participant engagement is normally distributed in a consistent pattern. The

perfect distribution validates parametric statistical procedures and supports the application of standard inferential methods for analysis.

4.4.3 Multicollinearity Test

The "multicollinearity" test is conducted to assess the correlations between "independent variables." The result shows that all the variables were highly correlated with each other. This is a key to diagnostic in regression analysis. The high multicollinearity inflates the standard errors of coefficients; this makes it difficult to determine the unique contribution of each predictor to the dependent variable which can distort the analysis leading to unstable or misleading results.

Table 4.4: Multicollinearity Test

Model		Condition Index	Collinearity Statistics	
			Tolerance	VIF
1	Staff Adherence to Program Protocols	1.000	.768	1.302
	Quality of Program Delivery	10.563	.725	1.380
	Participant Engagement	15.091	.989	1.011
	Dosage of Services	15.979	.678	1.475

a. Dependent Variable: Children Welfare

The table 4.4 presents multicollinearity test results, all tolerance values fall well above the critical cutoff of 0.1, ranging from .678 for Dosage of Services to .989 for Participant Engagement. Similarly, all "Variance Inflation Factor (VIF)" values were found to be below threshold of 10 commonly accepted, with the lowest being 1.011 for Participant Engagement and the highest 1.475 for Dosage of Services. These results indicate that the predictors do not exhibit problematic multicollinearity. The condition index values, which ranged from 1.000 to 15.979, remain below the threshold of 30, further confirming absence of multicollinearity concerns. Collectively, these findings suggest that each predictor variable contributes uniquely to explaining Children Welfare, and regression coefficients can therefore be interpreted with confidence.

4.6 Adherence to de-institutionalization program protocols and the welfare of VC.

4.6.1 Quantitative Analysis Adherence to de-institutionalization program protocols

To understand the "staff adherence to de-institutionalization program protocols" and the "welfare of vulnerable children." The participants rated the items on a scale of 1-5, where "1=strongly disagree, 2=Disagree, 3= Neutral, 4 =Agree and 5=Strongly Agree." This was applied across all variable. The result for mean and standard deviation is presented in table 4.5.

Table 4 5: Descriptive Statistics on Children Welfare

Items	Mean	Std. Deviation
Children in the program have access to adequate healthcare services.	3.03	.540
The program promotes healthy lifestyles and habits among children.	3.03	.642
The physical health needs of children are effectively addressed by the program.	3.05	.530
Children's emotional and social needs are supported by the program.	3.11	.554
The program fosters a supportive and nurturing environment for children's mental well-being.	3.07	.562
Children in the program experience a sense of belonging and security.	3.04	.562
The program supports children's educational goals and aspirations.	3.06	.526
Educational resources and opportunities provided by the program contribute to children's academic success.	3.06	.532
Children in the program demonstrate improvements in educational outcomes.	3.08	.588

The table 4.5 shows the perceptions of the program's contribution to children's welfare. The findings were slightly positive, with mean scores ranging from 3.03 to 3.11 and standard deviations between 0.526 and 0.642, indicating relatively consistent views. The highest-rated area was support for children's emotional and social needs (M = 3.11, SD = 0.554), highlighting perceived strengths in psychosocial care. Support for mental well-being (M = 3.07) and educational outcomes (M = 3.08) were also rated positively. Access to healthcare services (M = 3.03, SD = 0.540) and promotion of healthy lifestyles (M = 3.03, SD = 0.642) received the lowest ratings, though still above neutral. Generally, the program implementation is viewed as moderately effective in promoting children's welfare health, such as psychosocial, and education though further enhancement in health promotion could strengthen its positive impact.

The overall rating on child welfare, though moderate, suggests that while psychosocial and educational needs are relatively addressed by CCIs, there is a gap in promoting child health. Embleton et al. (2014), findings that institutional care often prioritizes basic needs but neglects health. In support, Nsabimana et al. (2019) reported that psychosocial support mitigates internalizing problems, this affirms the observed high rating in emotional care. However, Hettiarachchi (2021) contrasts this by showing that unmet health needs in Sri Lankan institutions significantly undermine children's well-being revealing a health challenge in program implementation. Bronfenbrenner's ecological model (Cherry, 2023), provides a theoretical frame: neglect in one domain (health) can weaken outcomes across interconnected systems.

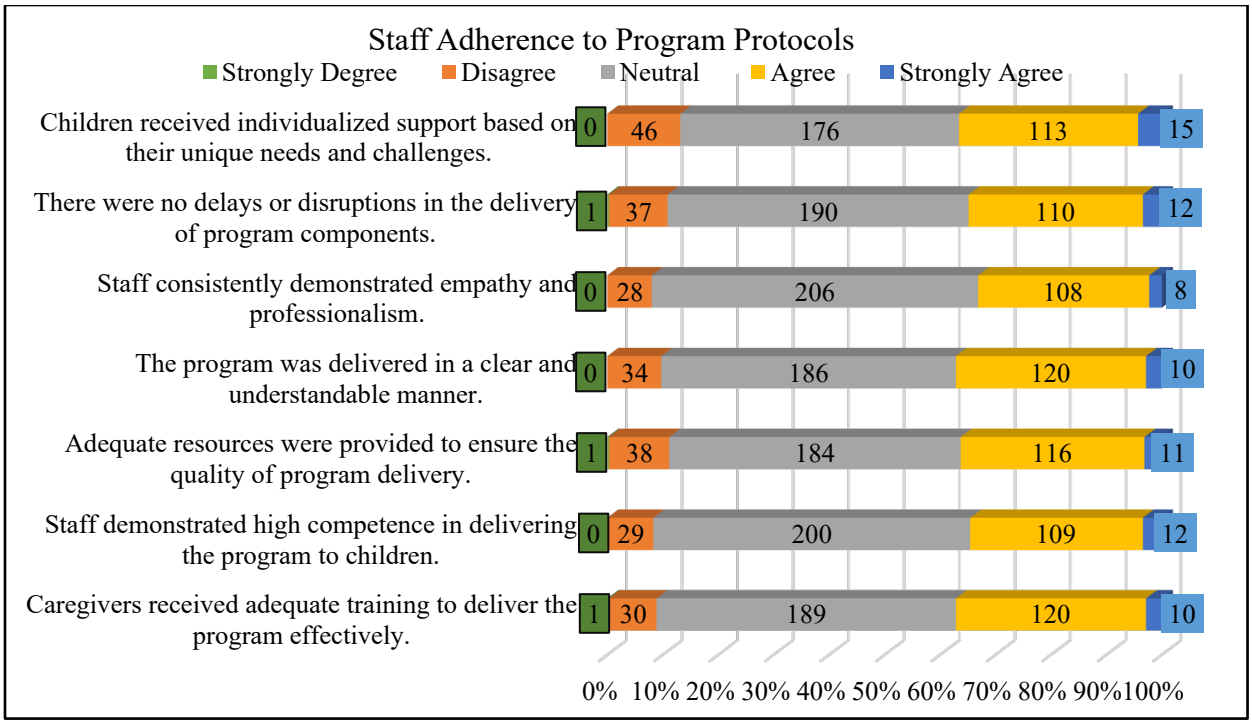

Figure 4.7: Frequency distribution of staff adherence to program protocols

Findings from figure 4.7 indicate that adherence to de-institutionalization program guidelines and protocols within care facilities is neutral, indicating a certain lack of certainty on this matter. To successfully adhere to core components, a total of 189 (54.0%) adopted a neutral stance, while 120 (34.3%) fully agreed, indicating that despite lack of compliance, there was a certain sense of programmatic alignment on this matter. To strictly adhere to guidelines without any flexibility, a total of 200 (57.1%) adopted a neutral stance, while 109 (31.1%) fully agreed, indicating some monitoring challenges on this matter. Both fulfillment of case plans and compliance with policies showed a neutral stance (52.6% and 53.1% respectively), with about a third of all respondents fully agreeing, indicating some form of compliance on this matter of program implementation and child welfare outcomes.

Table 4.6: Descriptive statistics on staff adherence to program protocols

Items	Mean	Std. Deviation
The delivery of services adhered to the prescribed timelines and sequence.	3.27	.704
Program documentation and reporting were completed on time and accurately.	3.27	.637
Staff regularly reviewed program procedures to ensure ongoing compliance.	3.28	.742

Case plans for children were completed as per the protocol.	3.28	.707
Staff followed the program guidelines without deviation.	3.30	.667
Staff members complied with organizational and governmental policies.	3.30	.681
All core components of the de-institutionalization program were consistently implemented in accordance with laid policy.	3.31	.679
Overall	3.29	.688

As shown in table 4.6, descriptive statistics on staff adherence to program protocols were moderate with a "mean of 3.29 and a standard deviation of .688" high consensus among the response. On the statement, adherence to the timeline was neutral with a "mean of 3.27 and standard deviation of .707" indicating low variability among the respondent. Program documentation and reporting was neutral with a "mean of 3.27 and standard deviation .637" high consensus, regular procedure review was neutral with a "mean of 3.28 and standard deviation .742" showing low variability among the response, case plans was neutral with a "mean of 3.28 and standard deviation .707" high consensus, following program guidelines "mean of 3.30 and standard deviation of .667, and adherence to organization policy was neutral with mean of 3.30 and standard deviation of .667" respectively showing high consensus and implementation of core components of DI was the highest with a "mean of 3.31 and standard deviation of .679" indicating low variability. This suggests CCI moderately adhered to DI programs.

The moderate trends observed for compliance with protocols indicate uncertainty or potential superficial compliance on the part of the personnel. This finding aligns with Njoki (2019) who observed corresponding trends in Kiambu, where compliance was indicated but monitoring was irregular. It corresponds with Risa (2018), who indicated corresponding tensions during Kenya's deinstitutionalization transitional from institutional care to family alternative care systems. In contrast, UNICEF (2022) indicates in Eastern Europe that enforced compliance for timelines and monitoring yielded positive impacts, indicating that strong accountability structures can counter neutrality. These findings can be understood through systems theory that conjectures that noncompliance is due to weak feedback loops that consistently need monitoring, personnel compliance tends hence, moderate compliance may seem stable but insufficient affecting children welfare (Wilkinson, 2011; Wirth & Kleve, 2023).

Relation between adherence and Children welfare

Table 4.1: Model Summary on Staff Adherence to Program Protocols

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.606[a]	.367	.366	.33450

a. Predictors: (Constant), Staff Adherence to Program Protocols

(Source Field Data, 2025)

As presented table 4.7 the model summary adherence and Children welfare. The correlation coefficient, R, is 0.606, showing a strong positive relationship between Staff Adherence to Program Protocols and Children Welfare. From this analysis, the R^2 0.367 shows that 36.7% of the positive Children Welfare is explained by the predictor variable. The adjusted R Square is 0.366, thus indicating a minimal shrinkage, which implies stability in the population. The standard error of estimate is 0.33450 relatively good in precision. Thus, the model explained a significant amount of variance, suggesting that the better the adherence to program protocols by staff, the better the children's welfare outcome.

Table 4.2: Analysis of Variance of Adherence

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	22.611	1	22.611	202.084	.000[b]
	Residual	38.937	348	.112		
	Total	61.548	349			

a. Dependent Variable: Children Welfare

b. Predictors: (Constant), Staff Adherence to Program Protocols

The ANOVA results are significant: the F-statistic for the regression model is F (1,348) = 202.084, p <.000, indicating that Staff Adherence to Program Protocols was a "statistically significant" predictor of Children Welfare. The comparison of the sums of squares from the regression, 22.611, and the residual, 38.937, suggests that the model explains the variability in Children Welfare well. The high F-value confirms a strong overall fit between Staff Adherence to Program Protocols and the Children Welfare. With the significance value below the threshold of 0.05, thus, rejecting the null hypothesis that the adherence to protocols has no effect.

Table 4. 3: Coefficient table

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	1.595	.105		15.170	.000
	Staff Adherence to Program Protocols	.448	.032	.606	14.216	.000

a. Dependent Variable: Children Welfare

Table 4.9 presents the regression coefficient results. The unstandardized coefficient (B) for Staff Adherence to Program Protocols was 0.448, which means that a one-unit increase in adherence to the protocol enhanced Children Welfare positively by 0.448 units, when all factors are constant. The strong standardized beta coefficient 0.606 explained significant positive effect, showing that with increasing adherence, a better welfare outcome for children is supported. The constant value, 1.595, sets the level of Children Welfare when staff adherence is zero. The ($p < 001$) for both the constant and the staff adherence demonstrate that the relationship is unlikely due to chance. Affirming the significant influence of staff adherence on program protocols improving children's welfare.

4.6.2 Qualitative Findings on Staff Adherence to Program Protocols

To complement statistical evidence the interview with key participant were conducted. The result showed there exist disparities between intended program protocols and actual implementation practices across participating institutions. The findings showed that most stakeholders understand the theoretical framework of implementation of de-institutionalization guidelines. However, they face challenge in practical application. The reason being there is inadequate supervision and unclear procedural guidance. In addition, there are uncertainty about correct implementation methods despite training, indicating gaps in ongoing professional development and mentorship.

Implementation Gaps Between Policy and Practice

The project managers have shown awareness of programmatic achievements, acknowledging that systemic methods of compliance and their responses reflected an institutional effort to integrate follows practices as per defined guidelines through case planning and case review Mechanisms. This approach called attention to organizational dedication to protocol compliance despite implementation issues. The focus on timeline completion and policy compliance, reflected an institutionalized awareness of external accountability obligations. These responses disclosed the administrative view on success concerning implementation, emphasizing that compliance indicators, rather than qualitative measures of implementation success. These responses contextualized the ratings of moderate levels of adherence by indicating awareness of was expected alongside implementation considerations.

> "We have made considerable progress on adhering to the essential elements of deinstitutionalization program. Our case plans are currently finished based on the

prescribed timelines, and we undertake periodic checks on compliance with both organizational and policies of the government." (PM001,2025)

Professional uncertainty was experienced by social workers concerning accuracy of implementation despite receiving basic training. Their responses indicated that there was a gap between capacity development and continued support required for consistent implementation quality on this matter. This view stressed that continuous observation and guidance played an essential role in following protocol fidelity over time. The admission of lack of complete confidence indicated that training alone was not adequate for facilitating consistent implementation techniques. These responses shed light on Front-Line Worker Experience of Implementation Challenges, Emphasizing the Need for Ongoing Support Professional development and supervisory support. These findings explained why neutrality was quite high trends in adherence ratings, as staff uncertainty translated into inconsistent implementation.

practices.

"While we attempt to adhere to guidelines, sometimes we may not be entirely sure whether we're implementing everything correctly. The training was helpful, but we could have used more of it, or more of it on different supervision…to feel confident about our adherence to protocols." (SW002, 2025)

Government monitoring officers showed they had systematically observed the relationship between protocol compliance and child welfare outcomes. However, these responses indicated that external validation of implementation quality via periodic evaluations of institutions and outcome measurement. Thus, the perspective that emerged stressed that these links between compliance and outcomes had a predictable several institutional settings. The emphasis on patterns that are consistent reflected evidence-based Understanding of implementation effectiveness based on systematic monitoring. These responses provided external validation for the statistical relationship between adherence and welfare outcomes by indicating independent observation of this relationship. Officials' acknowledgment of clear patterns indicated policy-level awareness of the significance of compliance while supporting quantitative findings through systematic institutional monitoring and evaluation.

"In institutions, in which we notice high compliance with protocols during our inspection visits, we have always observed improved child welfare outcomes. There is no doubt that

improved compliance is equal to improved child outcomes. Far from coincidence." (GOV002, 2025)

Statistical model demonstrating that compliance significantly predicts welfare is consistent with research by Goldman et al. (2020) and IJzendoorn et al. (2020), who associated program fidelity with improved developmental outcomes. The amount of variance explained of 36.7% indicates a large, though not complete, influence, as reflected by Montenegro et al. (2023), who stressed that external factors such as community integration also influence these outcomes. Beta value of 0.606 supports that the point made by Wilke and Howard (2021) that consistent program implementation helps hasten transition from institutional care to family-based care. What this means is that education and supervision of staff, as UNICEF Rwanda (2019) suggests, could enhance compliance and translate into measurable welfare gains.

There are contradictions, especially when some literature questions whether following protocol is adequate alone. According to Gayapersad et al. (2019), kinship interactions may be sustaining welfare despite only partly following it, emphasizing alternative means of buffering through culture. However, Chege and Ucembe (2020) point out that Kenya's over-reliance on indicating that levels of compliance, possibly high, may never attain maximum welfare outcomes relative to familial approaches as a solution. Systems thinking Mobus (2022) protocol fidelity enhances internal processes, whereas systemwide changes are required for maximum outcomes.

4.7 The quality of program delivery on the welfare of VC in care institutions

4.7.1 Quantitative Analysis of quality of program delivery

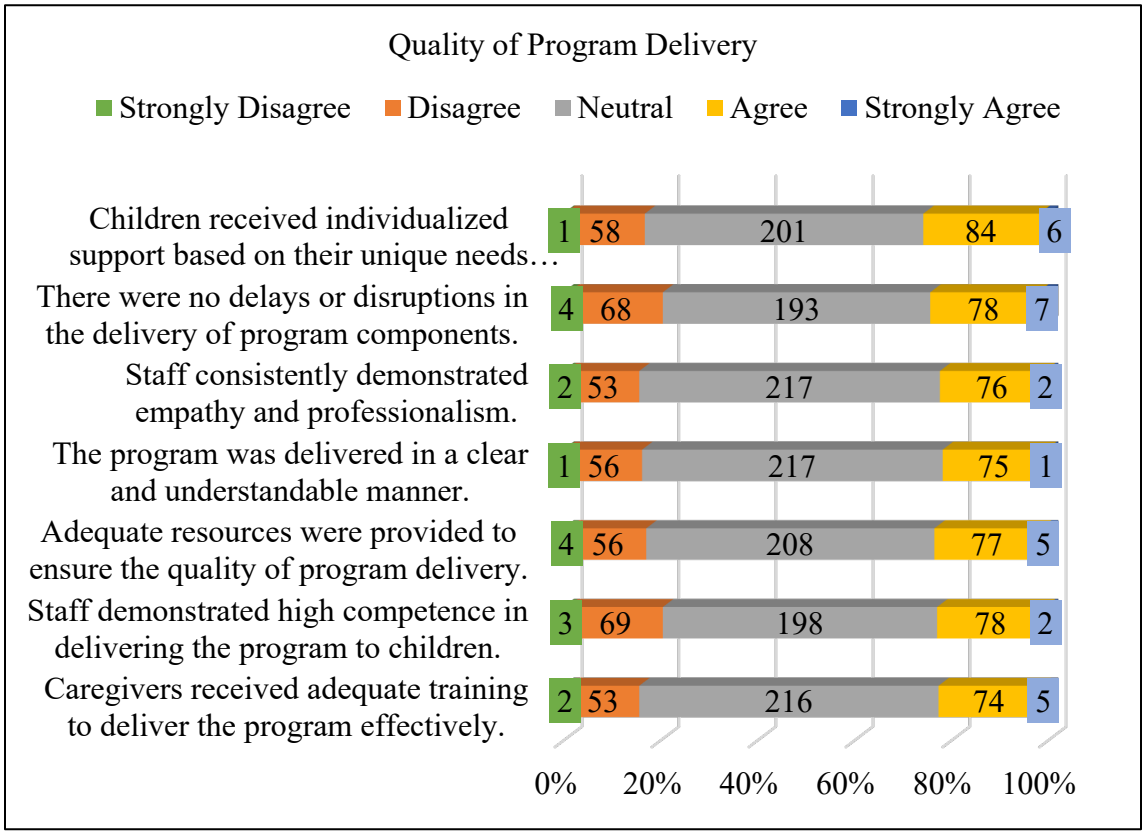

Figure 4.8: frequency distribution for service quality

The figure 4.8 presents the frequency distribution for service quality. The indicated is largely neutral perceptions across all the items. On the statement adequate training, 216 respondents (61.7%) were neutral, 74 (21.1%) agreed, and 53 (15.1%) disagreed. Regarding staff competency, 198 (56.6%) were neutral, 78 (22.3%) agreed, while 69 (19.7%) disagreed. On the statement of resource adequacy, 208 (59.4%) were neutral, 77 (22.0%) agreed, and 56 (16.0%) disagreed. Clarity of delivery saw 217 (62.0%) neutral, 75 (21.4%) agree, and 56 (16.0%) disagree. Empathy and professionalism had 217 (62.0%) neutral, 76 (21.7%) agree, and 53 (15.1%) disagree. Timeliness recorded 193 (55.1%) neutral, 78 (22.3%) agree, and 68 (19.4%) disagree. Individualized support saw 201 (57.4%) neutral, 84 (24.0%) agree, and 58 (16.6%) disagree. Overall, there is moderate service quality delivery with a modest consensus explaining moderate influence on children's welfare.

Table 4.4: Descriptive statistics on service quality

Items	Mean	Std. Deviation
Caregivers received adequate training to deliver the program effectively.	3.08	.662
Staff demonstrated high competence in delivering the program to children.	3.02	.691
Adequate resources were provided to ensure the quality of program delivery.	3.07	.693
The program was delivered in a clear and understandable manner.	3.05	.629
Staff consistently demonstrated empathy and professionalism.	3.07	.641
There were no delays or disruptions in the delivery of program components.	3.05	.736
Children receive individual support based on their unique needs and challenges.	3.10	.690
Overall	3.06	.677

As shown in table 4.10, descriptive statistics on service quality were moderate with a "mean of 3.06 and a standard deviation of .697" high consensus among the response. On the statement, for "Caregivers received adequate training" was neutral with a "mean of 3.08 and standard deviation of .662" indicating low variability among the respondent. Staff demonstration of competence was neutral with a "mean of 3.02 and standard deviation .691" high consensus, resource adequacy was neutral with a "mean of 3.07 and standard deviation .693" showing low variability among the response, clear service delivery and comprehendible was neutral with a "mean of 3.05 and standard deviation .629" high consensus, empathy and professionalism was neutral with a "mean of 3.07 and standard deviation of .641" showing high consensus and delay or disruption was neutral with a "mean of 3.05 and standard deviation of .736" indicating moderate variability. This suggests CCI moderately deliver services to DI programs.

The neutrality responses suggest a moderate uncertainty or inconsistency in program delivery quality. This aligns with Njenga (2019), who found that Kenyan CCIs staff often lack clarity and face sufficient resources to deliver services, resulting to moderate service delivery. The study is consistent with Boothby and Stark (2020). Findings that CCIs acknowledge of children individualized support but do not fully offer it, the study recommended that CCIs needs tailor care to children's specific needs in institutional settings. In construct, the relatively low ratings on staff competency highlight concerns also raised by Williamson and Greenberg (2010), who postulate that inadequate training undermines the implementation of deinstitutionalization programs. This can be understood through the lens of social learning theory that explains that modeling is necessary for best practices and structured training can aid in inconsistent support.

Table 4.5: Model Summary on Quality of Program Delivery

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.688[a]	.473	.472	.30520

a. Predictors: (Constant), Quality of Program Delivery

Table 4.11 presents the model summary on quality of program delivery. The correlation coefficient (R) of 0.688 demonstrated a strong positive relationship between predictor variable and children welfare. The (R^2)0.473 showed that 47.3% of the variation in Children Welfare is explained by implementing quality of program delivery to the children. On the other hand, the adjusted R Square (0.472) indicates a small reduction, indicating that the model's fit for generalizability. The standard error of the estimate (0.30520) demonstrated that predicted values deviate from actual observations by an average of 0.31 units, which is relatively low. Thus, highlighting quality of program delivery is significant in enhancing children welfare in CCIs.

The strong positive correlation (R = 0.688) between the quality of program delivery and welfare is consistent with Dozier et al.'s (2014) study that found that caregiver sensitivity and quality of delivery predicted child socioemotional outcomes. The 47.3% variance explained reflects strong levels of influence, similar to those reported by Berens & Nelson (2015), who discovered that quality caregiving environments are vital in improving child subjective wellbeing within both CCIs and alternative care systems. However, Gayapersad et al.'s (2019) contradicts this by highlights how the quality of child program outcomes is, on its own, unable to compensate for the inherent challenges of care within an institution, set against the flexibility of familial care structures, explained through system theory of interconnection of services.

Table 4.6: Analysis of Variance on Quality of Program Delivery

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	29.133	1	29.133	312.772	.000[b]
	Residual	32.415	348	.093		
	Total	61.548	349			

a. Dependent Variable: Children Welfare

b. Predictors: (Constant), Quality of Program Delivery

Table 4.12 shows the ANOVA results. It confirmed that the regression model was statistically significant ($F(1,348) = 312.772$, $p < .001$), this underscore that Quality of Program Delivery positively predicts of Children Welfare. Moreover, sum of squares (29.133) compared to the

residual sum of squares (32.415) suggest that almost half of the variation in children's welfare is accounted in the model. The high F-value shows a strong model fit, and the low significance level rules out the likelihood of the relationship occurring by chance. Therefore, supporting the conclusion that improvements in program delivery quality could substantially influence children's welfare outcomes.

Table4.7: Coefficient on Quality of Program Delivery

Coefficients[a]

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
1(Constant)	1.502	.090		16.694	.000
Quality of Program Delivery	.511	.029	.688	17.685	.000

a. Dependent Variable: Children Welfare

Table 4.13 presents the regression coefficient results. The unstandardized coefficient (B) for Quality of Program Delivery was 0.511, which means that a one-unit increase in Quality of Program Delivery proves Children Welfare positively by 0.511 units, when all factors are constant. The strong standardized beta coefficient 0.688 explained significant positive effect, showing that with increasing quality of program delivery, a better welfare outcome for children is supported. The constant value, 1.502, sets the level of Children Welfare when quality of program delivery is zero. The ($p < 000$) for both the constant and the quality of program delivery demonstrate that the relationship is unlikely due to chance. Affirming the significant influence of quality of program delivery improving children's welfare.

The strong correlation (0.688) explains that program delivery quality is a substantial predictor of children welfare, consenting to Lumos (2017), who found that structured staff training improved psychosocial and educational of children in CCIs. It also supports Goldman et al. (2020), findings that empathy in delivery directly influences resilience in vulnerable children. However, Chege and Ucembe (2020) descent that quality interventions enhance child welfare temporarily, but risk entrenching institutional models instead of facilitating reintegration into families. Thus, these findings suggest that while quality delivery should be strengthened through training, they need enough resource allocation, and monitoring for sustainability.

4.7.2 Qualitative Findings on Quality of Program Delivery

The interviews uncovered that quality of program service is an overarching catalyst with pervasive rippling benefits across several spheres of the welfare state yet operates under the constraints of pervasive resource challenges. The quality of training, availability of resources, and professional competency provided harmonious benefits, but the lack of resources hampered the best possible service provision.

Resource Constraints as Universal Barriers

The directors also recognized the limitations of their training to effectively address children with complex needs who call for specialized interventions. In their responses, the institutional directors revealed their recognition of the existing competency gap between the staff capabilities within the institution and the required needs of the children presented with different complexity levels. The view brought to the fore the difficulty of matching the capabilities of the workforce with the child welfare needs that are complex in nature but required specialized interventions that the current workforce within the organization cannot provide, yet with devotion to quality improvements, the organization aimed to improve these inadequacies.

> "The type of training we've done with caregivers has equipped them with the basics, but we always feel the need for specialized training. The children we work with are complex, requiring higher levels of skill than we are currently equipped with." (DIR002, 2025)

Quality as Catalyst for Comprehensive Impact

The project managers indicated commitment to the provision of quality service, with an appreciation of the barriers created by resources in the process of implementation. The answers provided indicated the imperfections between the service ideals and the challenges of offering the best services due to resource limitation impacts on various aspects of the programs. The focus was on the children-staff ratio, material sufficiency, among other aspects, which indicated appreciation for the requirements for quality service provision. The answers provided context about the ratings received on the quality of service, with indications from the managers about the appreciation of the requirements for quality service provision, but with resources creating barriers within the organizational quest for excellence.

> “We would also like to offer quality services, but we are sometimes hampered by the lack of resources available to us. We lack materials, and we do not have the ideal child-staff ratio.” (PM003, 2025)

The senior caregivers demonstrated their understanding of the quality-welfare linkage between resources, competency, and child well-being outcomes. The answers provided by the senior caregivers indicated the front-line worker's recognition of the quality prerequisites that facilitated successful interventions and substantial behavioural change occurrences. The response, with its focus on appropriate training, resources, and time allocations necessary for the best service delivery, indicated the caregivers' recognition of the quality prerequisites necessary for successful service interventions. The response demonstrated the caregivers' recognition of the quality prerequisites necessary for successful service interventions, with their acknowledgment of significant changes linked to quality service delivery evidencing professional competency in relation to the interventions’ prerequisites, taking into consideration the importance of system support for quality in achieving significant child well-being outcomes.

> “When we have the proper training, resources, and time to give each child, we observe tremendous changes in their behaviors and well-being. The quality of delivery is more than just the process, because quality is the ability to deliver the right things.” (CG001, 2025)

The child participants evidenced the ability to distinguish between quality service delivery and poor service delivery based on experiences. The answers provided clear experiential insights into how caregiver competency/ability and resource availability contributed to feelings of support and well-being among the child participants. It is important to note that the service quality considerations, caregiver competency/ability, and lack of rushed interactions are reflective of child recognition of the dimensions of quality service provision. The child answers provided clear proof of the quality-welfare association based on child experiences with enhanced well-being from competent service provision. The recognition of greater feelings of support with quality service provision validated the service quality-welfare connection based on emotional processes underlying the efficacy of quality service contributions toward improved child well-being, offering confirmation from the child participant perspective on the statistically validated connection between service quality and child well-being outcomes.

"The difference is obvious if the caregivers understand what they are doing and have everything they need to help us. When the caregivers are well-trained, when they're not in a hurry, we feel supported, and everything turns out well for us." (OVC001, 2025).

4.8 Participant engagement on the welfare of VC in care institutions.

4.8.1: Quantitative Analysais of Participant engagement

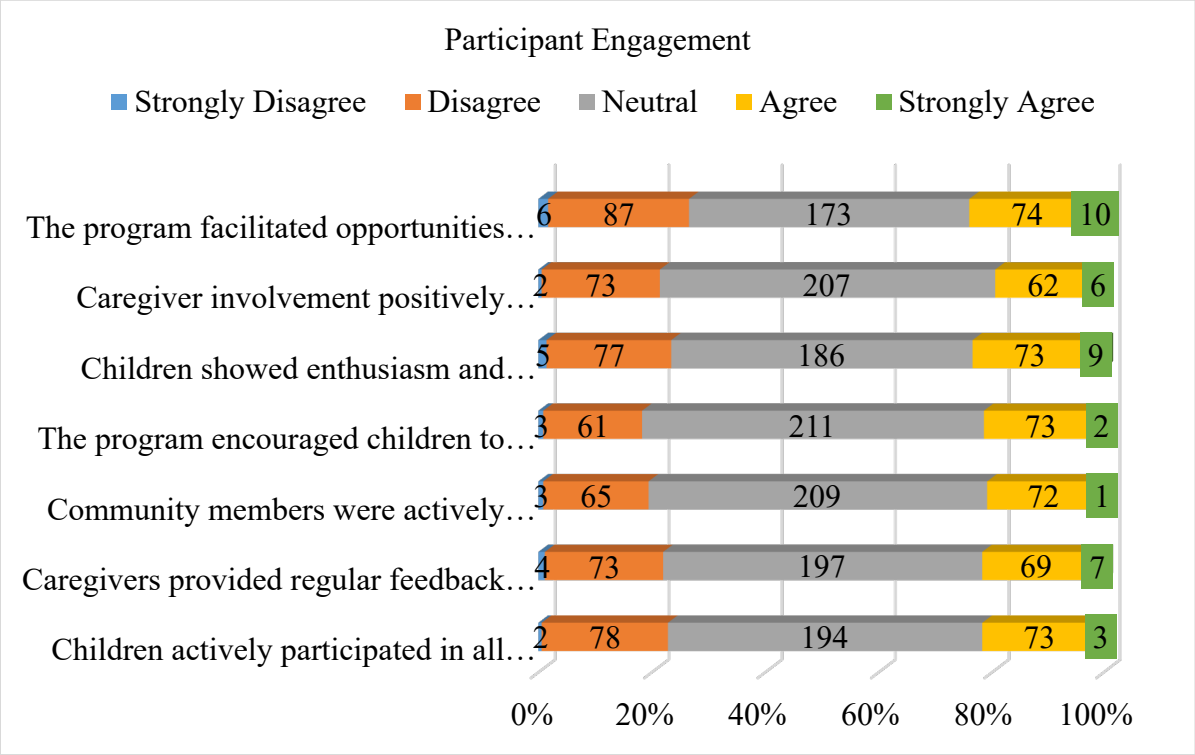

Figure 4.9: Frequency distribution of Participant Engagement

The results indicate that perceptions of participant engagement in program activities were largely neutral across all items. For active participation, 194 respondents (55.4%) were neutral, 73 (20.9%) agreed, and 78 (22.3%) disagreed. On caregiver feedback, 197 (56.3%) were neutral, 69 (19.7%) agreed, and 73 (20.9%) disagreed. Community involvement recorded 209 (59.7%) neutral, 72 (20.6%) agree, and 65 (18.6%) disagree. Encouraging children's expression had 211 (60.3%) neutral, 73 (20.9%) agreed, and 61 (17.4%) disagreed. Enthusiasm during sessions was noted by 73 (20.9%) agree, while 186 (53.1%) were neutral and 77 (22.0%) disagreed. Caregiver influence was seen positively by 62 (17.7%), but 207 (59.1%) were neutral. Opportunities for interaction had the lowest agreement (21.1%) and highest disagreement (24.9%). Overall, engagement

indicators show moderate agreement, high neutrality, and notable disagreement, suggesting mixed participation experience.

Table 4.8: Descriptive statistics of participant engagement

Items	Mean	Std. Deviation
Children actively participated in all program activities.	2.99	.700
Caregivers provided regular feedback on the program's impact on children.	3.01	.730
Community members were actively involved in supporting the program.	3.01	.662
The program encouraged children to express their opinions and feelings.	3.03	.664
Children showed enthusiasm and interest during the program sessions.	3.01	.768
Caregiver involvement positively influenced children's participation.	2.99	.692
The program facilitated opportunities for children to interact with peers and caregivers.	2.99	.803
Overall	3.00	.717

Table 4.14 indicates that participant engagement in the program was generally neutral to slightly positive across all measured items, with mean scores ranging from 2.99 to 3.03 on a 5-point scale. Children's active participation (M = 2.99, SD = 0.700) and caregiver influence on participation (M = 2.99, SD = 0.692) reflected moderate agreement and consistent perceptions. Caregiver feedback (M = 3.01, SD = 0.730) and community involvement (M = 3.01, SD = 0.662) also showed moderate engagement with low variability variation. The highest-rated item was the program's encouragement for children to express feelings (M = 3.03, SD = 0.664), while interaction opportunities had a mixed perception (M = 2.99, SD = 0.803) with low consensus. Overall (M = 3.00, SD = 0.717), engagement was present but not strongly impactful on children's welfare, suggesting room for deeper involvement.

Table 4.9: Model Summary on Participant engagement

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.418[a]	.175	.172	.38203

a. Predictors : (Constant), Participant Engagement

Table 4.15 presents the model summary on participant engagement. The correlation coefficient (R) of 0.418 demonstrated a moderate positive relationship between predictor variable and children welfare. The (R^2)0.175 showed that 17.5% of the variation in Children Welfare is explained by on Participant engagement to the children. On the other hand, the adjusted R Square (0.172) indicates a small reduction, indicating that the model's fit for generalizability. The standard error of the estimate (0.38203) demonstrated moderate deviation from actual observations by an average of

0.38 units, which moderate. Thus, highlighting participant engagement is significant in enhancing children's welfare in CCIs.

Table 4.10: Analysis of Variance of Participant engagement

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	10.759	1	10.759	73.716	.000[b]
	Residual	50.789	348	.146		
	Total	61.548	349			

a. Dependent Variable: Children Welfare
b. Predictors : (Constant), Participant Engagement

Table 4.16 shows the ANOVA of Participant engagement. The findings indicate that the model is statistically significant. The sum of squares (10.759) compared to the residual sum of squares (50.789) shows that the model explains a notable portion of the total variance in children's welfare. The F-statistics (1,348) = 50.789, $p < .001$), meaning the relationship between participant engagement and welfare is not due to chance. The findings affirms that participant engagement is a statistically significant predictor of children's welfare. However, the variance explained is moderate with remaining variance that are likely explained by factors such as institutional resources or caregiver training should be included to enhance explanatory power. Though it remains significant.

Table 4.11: Coefficient of participant engagement

Coefficients[a]

	Unstandardized Coefficients		Standardized Coefficients		
Model	B	Std. Error	Beta	t	Sig.
1(Constant)	2.182	.105		20.759	.000
Participant Engagement	.295	.034	.418	8.586	.000

a. Dependent Variable: Children Welfare

Table 4.17 presents regression coefficient results. The unstandardized coefficient (B) for participant engagement was 0.295, which means that a one-unit increase in participant engagement positively improves children's welfare by 0.299 units, when all factors are constant. The strong standardized beta coefficient 0.418 explained significant positive effect, showing that with increasing of participant engagement, a better welfare outcome for children is supported. The constant value, 2.182, sets the level of children welfare when participant engagement is zero. The ($p <000$) for both the constant and the participant engagement demonstrate that the relationship is

unlikely due to chance. Affirming the significant influence of participant engagement improving children's welfare.

The correlation coefficient indicates a moderate level of relationship between engagement and welfare, though much weaker than delivery quality. This supports Kirby and Bryson (2002), which indicated that participative approaches to children's services have a positive impact on well-being, though only as a long-term strategy. The percentage variance explained, 17.5%, supports the findings of Hart (1992), which indicated the importance of engagement, though insufficient on its own to affect outcomes, suggesting a need for structural support. The significance of ANOVA validates the model's construct, supporting Lansdown' (2011), suggesting a positive relationship between participation as a predictor of resilience, though insufficient on its own for transforming outcomes within the context of welfare.

4.8.2 Qualitative Findings on Participant Engagement

To further understand the dynamic in participant engagement the interview with key participants was conducted. The interviews findings revealed a complex tension between tokenistic consultation and genuine child participation in program activities and decision-making processes. The findings indicate that children although consulted their views are not genuinely integrated into program planning or service delivery modifications.

Child Agency and Participation Paradox

The child participants had mixed feelings about the availability of participation yet doubted the genuine process of the consultation activities. The answers provided by the child participants revealed their consciousness about the superficial participation practices, which did not contribute to the real effect of influencing the activities of the programs. The children seemed to be able to differentiate between authentic participation and the superficial process of the consultation activities, which highlighted their capabilities in making distinctions between the two aspects. The child participants' answers about participation, pointing out the limitations of participation yet identifying their preferences, indicated the children's capabilities in analysing the practices of the institution with which they are involved. One child noted that:

> “Sometimes, they also ask for our opinions about the activities, but I’m not sure if they hear us out on the ideas we have. We go there because we must, but it would be nice if we had some input about which activities we attend.” (CHP003, 2025)

The community leaders indicated their readiness to be involved with the children, but with the recognition of the challenges that limit their involvement with the institution fully. The community leaders’ answers brought into focus the readiness of the community to participate, but the limitations within the institution for the successful involvement of the community members. The focus on the lack of clear involvement channels indicated the system's limitations in involving the communities beyond the need to be involved. The community leaders’ recognition of feelings of exclusion indicated the involvement difficulty the institution faces in creating channels for involvement while pointing out the communities’ unexplored potential in childcare programs. A community leader expressed that:

> “We want to help these children, but we're not always sure how we can get involved. The program doesn’t have clear ways for us to get involved, and sometimes we feel like we are outsiders looking in." (CL004, 2025).

The child participants validated the direct positive link between authentic participation and their outcomes in the study. The children demonstrated an experiential level of understanding about the impact of authentic participation on their emotional well-being, adaptation, and feelings of happiness and settlement in the care institution. The child-focused view revealed the link between authentic participation and their feelings of happiness and settlement in care yet also brought meaning to the lack of strong explanatory power because meaningful participation achieved an optimistic outcome with their participatory involvement. The children are in the best position to validate the importance of their participation effectiveness in care because children’s acknowledgment about the positive emotional mechanism of authentic participation leading to their happiness illustrated the fluctuating level of meaningful participation opportunity availability within the care context.

> “When they actually hear what we are saying and let us be part of deciding things, we feel happier and more settled. It doesn’t happen all the time, but when it does, it makes a big difference in how we feel about being here.” (CHP003, 2025)

The social workers evidenced professional insight regarding the benefits of participation, with admission of the limitations in its implementation, being practical about its expectations. The answers revealed the workers' appreciation of the value but inadequacy of participation in the entire provision of welfare benefits. The outlook on the complexity of participation, beyond the consultation or involvement, was brought out by the social workers' answers, which portrayed the need for involvement and positivity, mixed with the admission of limitations, depicting their well-rounded appreciation of the effectiveness of participation. The answers from the social workers placed the moderate efficacy of participation into context with their admission of regional complexity, in relation to the influence on child welfare, aside from the consideration of participation itself.

> "Involvement of children definitely benefits child welfare but is no magic solution. When children are involved in the activities of the programs, their voices are counted, and children appear to be more engaged or positive, but there is only so much that involvement can do." (SW003, 2025).

4.9 The dosage of services on the welfare VC in care institutions

4.9.1 Quantitative Analysis of Dosage of Service

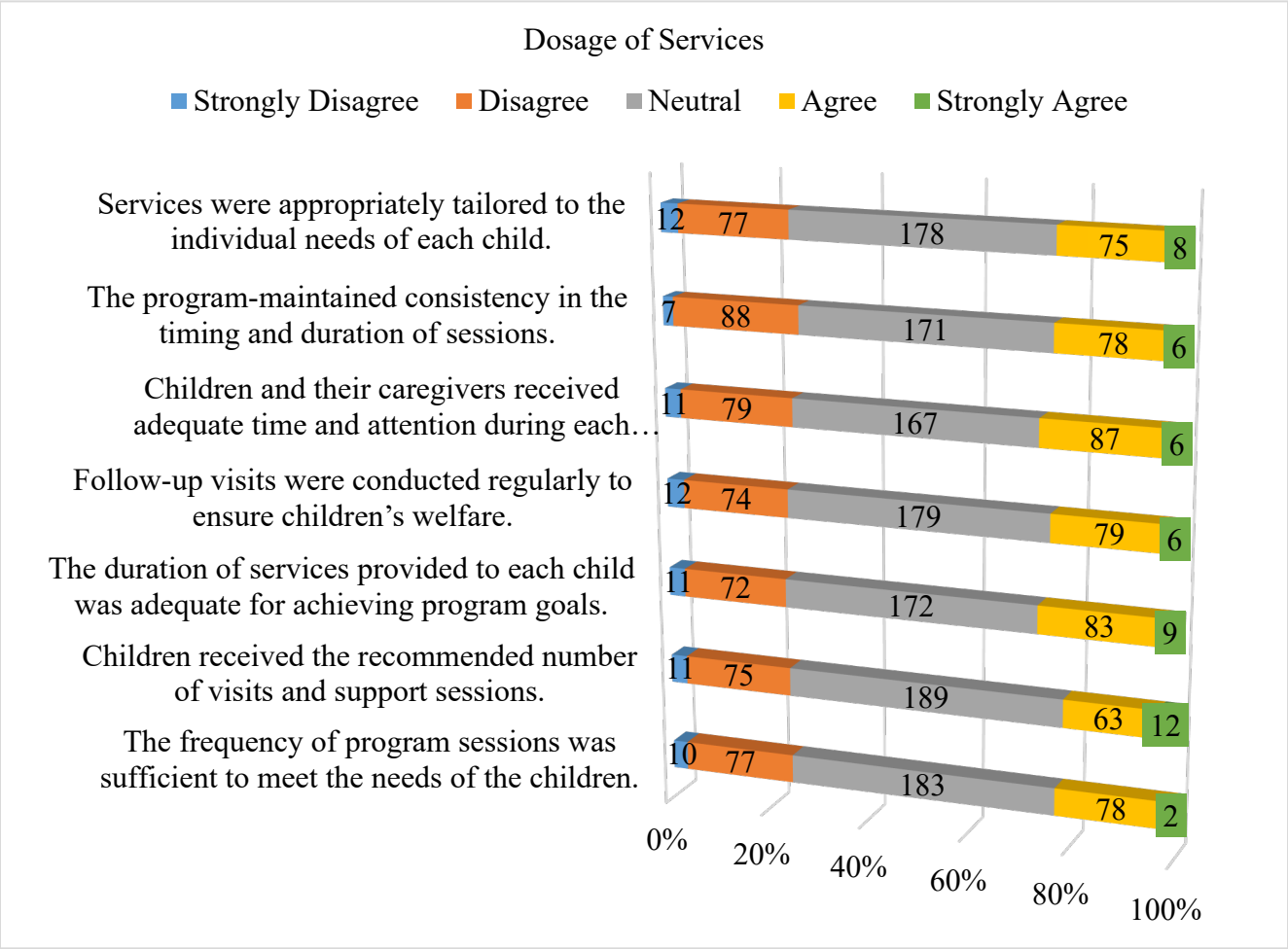

Figure 4.10: Frequency distribution of Dosage of service

The figure 4.10 presents analysis of service dosage. The overall result is *Neutral* (47.7%–54.0%), indicating a mixed feeling on service adequacy. The levels of agreement (Agree + Strongly Agree) varied between 20.6% for the provision of tailoring services to the needs of the beneficiaries to 27.5% for the provision of sufficient time, with modestly positive responses. Disagreement levels (Disagree + Strongly Disagree) also varied between 23.1% and 27.1%, indicating the presence of a considerable number of people who are dissatisfied with the inadequacy of the services provided. The greatest strength observed is the sufficiency of the service duration with 26.3% agreement, followed by the number of sessions with 23% agreement, followed by the provision of tailored services with 23.7% agreement.

Table 4.12: Descriptive statistics of Dosage of Service

Items	Mean	Std. Deviation
The frequency of program sessions was sufficient to meet the needs of the children.	2.96	.761
Children received the recommended number of visits and support sessions.	2.97	.811
The duration of services provided to each child was adequate for achieving program goals.	3.01	.826
Follow-up visits were conducted regularly to ensure children's welfare.	2.98	.803
Children and their caregivers received adequate time and attention during each session.	2.99	.819
The program maintained consistency in the timing and duration of sessions.	2.97	.790
Services were appropriately tailored to the individual needs of each child.	2.97	.815
Valid N (listwise)		

Table 4.18 shows results from the descriptive statistics of dosage of service the mean values for individual items measuring perceptions of service dosage, including frequency, duration, follow-up, attention, consistency, and tailoring, were slightly positive, ranging from 2.96 to 3.01. The highest mean value was for the attentional component of services, which referred to the duration of services, while the lowest mean value was associated with the frequency of services. The standard deviations, ranging from 0.761 to 0.826, were moderate, implying variability in the responses. The results indicate a possible need to improve on services related to tailoring, frequency, as well as follow-up services for children.

The lack of item convergence shows a weak practice of participation in care setting organizations. This supports the findings of Munene (2020), which suggested tokenistic participation levels in children within organizations. The slightly higher recognition level of children's expression is consistent with the views proposed by Shier (2001), as the 'Pathways to Participation' model recognizes children's expression as a starting point for participation. The very low recognition level of interaction opportunity supports the views proposed by Tisdall (2017), who suggested institutional power structures prevent dialogue between children and practitioners. In respect to children's rights, it could be suggested the development of children's participation levels is poor, as it does not comply with Article 12 UNCRC, which focuses on children having a voice being heard.

Table 4.13: Model Summary of dosage of service

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate

1	.734[a]	.538	.537	.28579

a. Predictors: (Constant), Dosage of Services

(Source Field Data, 2025)

Table 4.19 presents the model summary on quality of dosage of service. The correlation coefficient (R) of 0.734 demonstrated a strong positive relationship between predictor variable and children welfare. The (R Square)0.53 showed that 53.8% of the variation in Children Welfare is explained by of dosage of service. On the other hand, the adjusted R Square (0.53.7) indicates a small reduction, indicating that the model's fit for generalizability. The standard error of the estimate (0.28579) demonstrated that predicted values deviate from actual observations by an average of 0.27 units, which is relatively low. This high explanatory power signifies that the adequacy, frequency, and tailoring of services is significant in determining welfare outcomes. However, the remaining 46.2% of variance suggests that other variables such as quality of interaction, program resources, or caregiver engagement also contribute significantly.

Table 4.14: ANOVA of Dosage of service

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	33.124	1	33.124	405.545	.000[b]
	Residual	28.424	348	.082		
	Total	61.548	349			

a. Dependent Variable: Children Welfare

b. Predictors: (Constant), Dosage of Services

Table 4.20 shows the ANOVA results. It confirmed that the regression model was statistically significant ($F(1,348) = 405.545$, $p < .000$), this underscore underscores that dosage of service positively predicts of Children Welfare. Moreover, sum of squares (28.424) compared to the residual sum of squares (33.124) suggest more than half of the variation in children's welfare is accounted in the model. The high F-value shows a strong model fit, and the low significance level rules out the likelihood of the relationship occurring by chance. Therefore, supporting the conclusion that improvements in dosage of service could substantially influence children's welfare outcomes.

Table 4.15: Coefficient of Dosage of Service

Coefficients[a]

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
1(Constant)	1.687	.070		24.020	.000
Dosage of Services	.463	.023	.734	20.138	.000

a. Dependent Variable: Children Welfare

Table 4.21 presents regression coefficient results of dosage of service. The unstandardized coefficient (B) for participant engagement was 0.463, which means that a one-unit increase in dosage of service positively improves children's welfare by 0.463 units, when all factors are constant. The strong standardized beta coefficient 0.734 explained significant positive effect, showing that with increasing of dosage of service, a better welfare outcome for children is supported. The constant value, 1.687, sets the level of children welfare when participant dosage of service is zero. The ($p < 000$) for both the constant and the dosage of service demonstrate that the relationship is unlikely due to chance. Affirming the significant influence of dosage of service improving children's welfare. The large t-value (20.138) confirms the robustness of this relationship. These results imply that enhancing the dosage through more frequent, consistent, and individualized sessions can substantially improve welfare outcomes. The strength of this effect underscores dosage as a critical program factor, warranting prioritization in intervention design.

4.9.1 Qualitative Findings on Dosage of Services

The interviews indicated that the service rate, duration, and consistency represented basic prerequisites for the formation of the therapeutic relationships, successful welfare outcomes, but also had service limitations due to resource constraints pervasive in the system. The interviewees highlighted the importance of service interactions facilitating trust, consistency, and effectiveness, but with the limitation in the resources available.

Dosage as Foundation for Relationship Building

The child participants revealed clear links between service consistency and their emotional well-being, meaning their emotional experiences highlighted the impact of consistent quality service on their feelings of safety and care. The service context, grounded in the children's experiences, indicated their recognition of good, compared to poor, service patterns, which was important given the children's own experiences with service provision or lack of it. Acknowledgments about the children's experiences of greater care with consistent service provision revealed the emotional

processes involved with the beneficial impact of good service dosage, with the recognition of poor service experiences informing the outcomes with inconsistent service provision.

> "'If the social workers are coming to see us on a regular basis, spending quality time with us, if they are following through on things that they said they would do, then we feel taken care of, then things got better for us.' But if things are just rushed, irregular, then nothing much changes.'" (CHP004, 2025)

The government officials validated the importance of dosage on a systematic basis by making comprehensive observations in their respective institutions. They justified the importance of service dosage on the policy level by identifying it as one of the crucial predictive variables for the effectiveness of the institution, irrespective of the differences among them. The validation on the part of the officials supported the importance of data-driven facts with respect to the requirements of service delivery for achieving optimum outcomes. The officials' recognition of the importance of service dosage with its immense predictive value validated the prerequisites of service delivery on the policy level while confirming the quantitative validation on the basis of independent observation and analysis.

> "Our own data has repeatedly revealed that service dosage, whether in terms of frequency, duration, or consistency, is one of the strongest predictors of child welfare outcomes. Those organizations offering the effective dosage of services always produce the better outcomes." (GV003, 2025))

4.10 The Mediating Role of Implementation Strategy

Implementation strategy

Table 4.16: Implementation strategy

Items	Mean	Std. Deviation
The support services provided by the program adequately meet the needs of vulnerable children.	2.96	.741
The availability of support services positively impacts the welfare of children.	3.01	.677
The program effectively connects children with essential support services.	2.98	.694
The program facilitates meaningful integration of children into their communities and families.	2.97	.683
Community involvement enhances the well-being of children in care institutions.	3.03	.664
The program promotes family engagement and support for children in care.	2.97	.735
The program helps prevent unnecessary institutionalization of vulnerable children.	3.06	.662

Efforts to keep children out of institutions contribute to their overall welfare.	3.07	.709
The program provides alternatives to institutional care that are beneficial for children.	3.06	.732

The table 4.22 presents the opinions on the implementation strategy that were slightly positive, as indicated by mean values between 2.96 and 3.07, while the standard deviations were between 0.662 and 0.741. The lowest mean value, implying areas for improvement, was observed to support the needs of susceptible children, which scored a mean of 2.96, with a standard deviation of 0.741. The highest mean values, implying success, were obtained on supporting the goal of keeping children out of institutional care, scoring a mean of 3.07, with a standard deviation of 0.709. Another high mean value of 3.06, with a standard deviation of 0.662, was attained on supporting the goal of preventing unnecessary institutionalization. Involvement of the community scored a mean of 3.03, while support services scored a mean of 3.01. The implementation strategy can be considered moderately successful, but areas for improvement were identified in direct delivery service**.**

Multiple Regression Analysis

Table 4.17: Correlation of all Variable

Correlations

		SA	QD	PE	DS	IS	CW
Staff Adherence to Program Protocols	Pearson Correlation	1					
	Sig. (2-tailed)						
	N	350					
Quality of Program Delivery	Pearson Correlation	.374**	1				
	Sig. (2-tailed)	.000					
	N	350	350				
Participant Engagement	Pearson Correlation	.046	.105*	1			
	Sig. (2-tailed)	.390	.050				
	N	350	350	350			
Dosage of Services	Pearson Correlation	.448**	.490**	.059	1		
	Sig. (2-tailed)	.000	.000	.272			
	N	350	350	350	350		
Implementation Strategy	Pearson Correlation	.375**	.521**	.340**	.758**	1	
	Sig. (2-tailed)	.000	.000	.000	.000		
	N	350	350	350	350	350	
Children Welfare	Pearson Correlation	.606**	.688**	.418**	.734**	.795**	1
	Sig. (2-tailed)	.000	.000	.000	.000	.000	
	N	350	350	350	350	350	350

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

The correlation analysis outcome indicates strong positive associations between all the program implementation predictors and children's welfare. Implementation strategy had a stronger correlation with children's welfare than any other predictor, as indicated by a correlation coefficient of .795 ($p < .001$), followed by the dosage of services, which correlated to .734 ($p < .001$), while program quality implementation correlated to .688 ($p < .001$). Staff compliance with protocols, as well as participants' level of engagement, were also positively correlated, though to a lower degree, having correlation coefficients of .606 ($p < .001$) and .418 ($p < .001$), respectively. It is worth noting that a high level of correlation, .758, also exists between the dosage of services and implementation strategy, implying a close relationship. A high correlation coefficient indicates that quality programs implemented in a strategic and adequate dosage contribute greatly to the improvement of children's welfares residing in care institutions.

4.10.1 Multiple Linear Regression

Table 4.18: Overall Model summary

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.925[a]	.855	.854	.16057

a. Predictors: (Constant), Dosage of Services, Participant Engagement, Staff Adherence to Program Protocols, Quality of Program Delivery

From the table 2.4 the model summary, it can be observed that the adherence of personnel to the protocol, quality of program implementation, level of participant engagement, as well as the dosage level, has a strong relationship with the well-being of children, as indicated by the value of $R = .925$. The value of the coefficient of determination, $R^2 = .855$, indicates that 85.5% of the variance in children's well-being is accounted for by the four predictors, while the Adjusted R^2 value of .854 indicates a strong model without shrinkage. The standard error of the estimate is .16057, which is small; hence, the difference between the observed values and the values of well-being as predicted is very small. This indicates a strong explanatory model, which shows a significant impact on children's well-being within care Institutions in Nairobi.

Table 4.19: Overall ANOVA

ANOVA[a]					
Model	Sum of Squares	df	Mean Square	F	Sig.
1 Regression	52.652	4	13.163	510.523	.000[b]
Residual	8.895	345	.026		

Total	61.548	349

a. Dependent Variable: Children Welfare

b. Predictors: (Constant), Dosage of Services, Participant Engagement, Staff Adherence to Program Protocols, Quality of Program Delivery

The results of the ANOVA table 4.25 indicate significance on the measure of how well the model predicts children's well-being, as indicated by $F(4, 345) = 510.523$, $p < .001$). The sum of squares for the model (52.652) is significantly higher than the sum of squares for the residuals (8.895), suggesting that the predictors account for the vast majority of variation on well-being as opposed to the residuals. The mean square value of the model (13.163) being significantly higher than the mean square value of the residuals (.026) supports a good model fit. This indicates the significance of the combined impact of adherence, delivery quality, participant factors, and service delivery on well-being, as opposed to it being a chance occurrence. Programmatic changes based on these factors can therefore be expected to facilitate a vast improvement in well-being among children in care organizations.

Table 4.20: Overall Coefficient

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	.100	.071		1.411	.159
	Staff Adherence to Program Protocols	.202	.017	.273	11.675	.000
	Quality of Program Delivery	.254	.018	.342	14.242	.000
	Participant Engagement	.243	.015	.345	16.748	.000
	Dosage of Services	.267	.016	.423	17.027	.000

a. Dependent Variable: Children Welfare

The coefficients table reveals that all four predictors have significant positive effects on children's welfare ($p < .001$). Dosage of services emerged as the strongest predictor ($\beta = .423$, $B = .267$), followed by participant engagement ($\beta = .345$, $B = .243$), quality of program delivery ($\beta = .342$, $B = .254$), and staff adherence to protocols ($\beta = .273$, $B = .202$). This suggests that increasing service dosage yields the largest potential welfare improvement, but enhancing engagement, delivery quality, and adherence also contribute substantially. The constant term (.100) was not significant ($p = .159$), implying welfare outcomes depend strongly on these program factors rather than baseline conditions. Overall, the results emphasize a multi-dimensional approach strengthening all

four predictors to maximize children's welfare outcomes. Based on the coefficients table, the multiple regression model predicting children's welfare can be expressed as:

$$Y = B_0 + B_1X_1 + B_2X_2 + B_3X_3 + B_4X_4 + \epsilon$$

Where:

- Y represents the welfare of vulnerable children,
- X_1 represents the scale of Adherence to program protocols,
- X_2 represents the Quality of Program Delivery,
- X_3 represents the Participant Engagement,
- X_4 represents the Dosage of Services,

Children's Welfare= 0.100 + 0.202 (Staff Adherence) +0.254 (Quality of Delivery) + 0.243 (Participant Engagement) +0.267 (Dosage of Services) +ε

Where:

- **0.100** = constant (intercept), the predicted welfare score when all predictors are zero.
- **0.202** = increase in welfare for each one-unit increase in staff adherence to program protocols, holding other factors constant.
- **0.254** = increase in welfare for each one-unit increase in quality of program delivery.
- **0.243** = increase in welfare for each one-unit increase in participant engagement.
- **0.267** = increase in welfare for each one-unit increase in dosage of services.
- **ε** = error term.

4.10.2 Mediated Linear Regression

Table 4.21Mediated Model Summary

Model Summary[c]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.925[a]	.855	.854	.16057	.855	510.523	4	345	.000	
2	.935[b]	.874	.872	.15018	.018	50.410	1	344	.000	2.093

a. Predictors: (Constant), Dosage of Services, Participant Engagement, Staff Adherence to Program Protocols, Quality of Program Delivery

b. Predictors: (Constant), Dosage of Services, Participant Engagement, Staff Adherence to Program Protocols, Quality of Program Delivery, Implementation Strategy
c. Dependent Variable: Children Welfare

The regression model summary demonstrates the incremental value of introducing the mediator variable, implementation strategy. In the initial model, which included dosage of services, participant engagement, staff adherence to program protocols, and quality of program delivery, the predictors explained 85.5% of the variance in children's welfare ($R^2 = .855$, *Adjusted* $R^2 = .854$). Upon the addition of implementation strategy in the second model, the explained variance increased to 87.4% ($R^2 = .874$, Adjusted $R^2 = .872$). This represents a 1.8% improvement ($\Delta R^2 = .018$, $p < .001$), indicating that implementation strategy contributes significantly to explaining variations in children's welfare beyond the direct effects of the other program-related predictors. The Durbin Watson statistic of 2.093 confirmed the independence of residuals, suggesting that autocorrelation was not a concern.

Table 4.22: Mediated ANOVA

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	52.652	4	13.163	510.523	.000[b]
	Residual	8.895	345	.026		
	Total	61.548	349			
2	Regression	53.789	5	10.758	476.993	.000[c]
	Residual	7.758	344	.023		
	Total	61.548	349			

a. Dependent Variable: Children Welfare
b. Predictors: (Constant), Dosage of Services, Participant Engagement, Staff Adherence to Program Protocols, Quality of Program Delivery
c. Predictors: (Constant), Dosage of Services, Participant Engagement, Staff Adherence to Program Protocols, Quality of Program Delivery, Implementation Strategy

In step 1, dosage, engagement, staff adherence, and quality of delivery jointly predicted children's welfare at a very significant level: $F(4, 345) = 510.523$, $p < .001$. When implementation strategy was added as a mediator in the second model, regression remained significant, $F(5, 344) = 476.993$, $p < .001$, while residual variance was reduced and fit was generally improved. The shift from Model 1 to Model 2 underlines that implementation strategy makes a significant contribution to the predictive power of the model and, therefore, plays an important mediating role in shaping the association between program delivery factors and children's welfare.

Table 4.23: Mediated Coefficient

Coefficients[a]							
	Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
Model	B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1(Constant)	.100	.071		1.411	.159		
Staff Adherence to Program Protocols	.202	.017	.273	11.675	.000	.768	1.302
Quality of Program Delivery	.254	.018	.342	14.242	.000	.725	1.380
Participant Engagement	.243	.015	.345	16.748	.000	.989	1.011
Dosage of Services	.267	.016	.423	17.027	.000	.678	1.475
2(Constant)	.023	.067		.344	.731		
Staff Adherence to Program Protocols	.201	.016	.271	12.427	.000	.768	1.302
Quality of Program Delivery	.224	.017	.302	13.015	.000	.681	1.469
Participant Engagement	.195	.015	.276	12.836	.000	.791	1.265
Dosage of Services	.167	.020	.265	8.213	.000	.353	2.835
Implementation Strategy	.202	.028	.241	7.100	.000	.317	3.155

a. Dependent Variable: Children Welfare

When implementation strategy was introduced in Model 2, its effect was itself significant: a one-unit increase in implementation strategy was associated with a .202 unit increase in children's welfare. At the same time, reductions were observed in the coefficients of other predictors. The effect of dosage of services declined substantially, from .267 units to .167 units per one-unit increase, indicating that part of its effect on children's welfare is transmitted indirectly through implementation strategy. Likewise, participant engagement declined from .243 to .195 units, and quality of delivery from .254 to .224 units, suggesting that these variables also partly operate through implementation strategy. Staff adherence, however, remained stable, moving only slightly from .202 to .201 units per one-unit increase, suggesting a predominantly direct influence. Multicollinearity diagnostics (VIF < 3.2) confirmed that these effects were independent and reliable. These coefficient shifts clearly support the mediating role of implementation strategy.

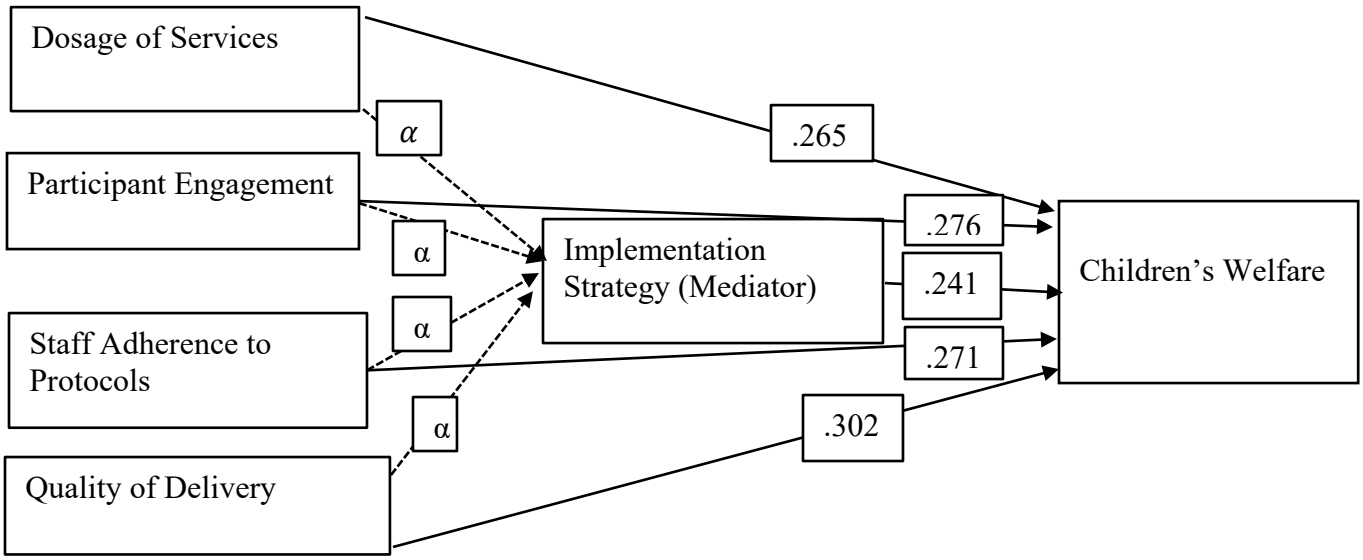

Figure 4.11: Mediated Model Representation

When mediator variable is included

$$Y = B_0 + B_1X_1 + B_2X_2 + B_3X_3 + B_4X_4 + B_5M + \epsilon$$

Where:

- Y represents the welfare of vulnerable children,
- X_1 represents the scale of Adherence to program protocols,
- X_2 represents the Quality of Program Delivery,
- X_3 represents the Participant Engagement,
- X_4 represents the Dosage of Services,
- M represents the intervening variable 'Implementation Strategy',
- β_0, β_1, β_2, β_3, β_4, β_5 are the parameters to be estimated,
- ϵ is the error term.

Children's Welfare= 0.023 + 0.167 (Dosage of Services) + 0.195 (Participant Engagement) + 0.201(Staff Adherence) + 0.224 (Quality of Delivery) +0.202 (Implementation Strategy) +ε.

Table 4.24 Bootstrap for Coefficients:

Bootstrap for Coefficients

Model		Bootstrap[a]					
						95% Confidence Interval	
		B	Bias	Std. Error	Sig. (2-tailed)	Lower	Upper
1	(Constant)	.100	-.006	.079	.203	-.049	.263
	Staff Adherence to Protocols	Program.202	.001	.017	.001	.171	.236

Quality of Program Delivery	.254	-.001	.020	.001	.212	.292
Participant Engagement	.243	.001	.015	.001	.215	.274
Dosage of Services	.267	.001	.023	.001	.225	.316
2(Constant)	.023	-.005	.071	.731	-.115	.170
Staff Adherence to Program Protocols	.201	.000	.015	.001	.171	.232
Quality of Program Delivery	.224	.000	.019	.001	.189	.263
Participant Engagement	.195	.002	.017	.001	.166	.230
Dosage of Services	.167	.003	.028	.001	.119	.232
Implementation Strategy	.202	-.004	.035	.001	.128	.265

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

(Source Field Data, 2025)

The bootstrap analysis, conducted with 1,000 samples, provided further robustness checks for the mediation model. For Model 2, all predictors, including the mediator, displayed 95% confidence intervals that did not cross zero, thereby confirming the statistical reliability of the effects. Most importantly, the mediator retained significance, with a one-unit increase in implementation strategy corresponding to a .202 unit increase in children's welfare (95% CI [.128, .265], $p < .001$). The bootstrap results also reinforced the observed reduction in coefficients for dosage, engagement, and quality once the mediator was added, strengthening the conclusion that implementation strategy acts as a partial mediator.

4.10.3 Direct and indirect effect of Mediator Variable

To further understand the indirect and direct effect of meditator variable the Hayes' PROCESS macro (Model 4) was used. The analysis confirmed that Implementation Strategy (IM) acts as a significant mediator between program implementation factors and Children's Welfare (CW).

Table 4.25: Path Coefficients for Individual Mediation Models

Predictor Variable	Path a (X → M)			Path b (M → Y)			Path c' (X → Y)		
	Coeff	SE	P	Coeff	SE	p	Coeff	SE	p
Staff Adherence to Program Protocols	.3306	.0438	<.001	.5538	.0246	<.001	.2649	.0217	<.001
Quality of Program Delivery	.4622	.0406	<.001	.5023	.0271	<.001	.2791	.0241	<.001
Participant Engagement	.2858	.0424	<.001	.6187	.0280	<.001	.1179	.0236	<.001

Predictor Variable	Path a (X → M)			Path b (M → Y)			Path c' (X → Y)		
	Coeff	SE	P	Coeff	SE	p	Coeff	SE	p
Dosage of Services	.5712	.0264	<.001	.4708	.0395	<.001	.1946	.0297	<.001

Note. N = 350. Path a = predictor to mediator; Path b = mediator to outcome controlling for predictor; Path c' = direct effect of predictor on outcome controlling for mediator. M = Implementation Strategy; Y = Children's Welfare.

Table 4.31 presents regression coefficients for each mediation pathway. Results show that all predictors significantly influenced Implementation Strategy (Path a, $p < .001$). Staff Adherence ($\beta = .331$), Quality of Delivery ($\beta = .462$), Participant Engagement ($\beta = .286$), and Dosage of Services ($\beta = .571$) all positively predicted IM. In turn, IM strongly predicted Children's Welfare (Path b), with coefficients ranging from .471 to .619 (all $p < .001$). Direct effects of predictors on CW (Path c′) also remained significant, though reduced, ranging from $\beta = .118$ (PE) to $\beta = .279$ (QS). This pattern confirms partial mediation across all variables. Notably, PE had the weakest direct effect, suggesting its impact on CW occurs mainly through IM, whereas QS and SP retained stronger independent contributions.

Table 4.26: Model Summary Statistics for Mediation Analyses

Predictor Variable	Model 1 (X → M)			Model 2 (X, M → Y)		
	R^2	F	p	R^2	F	p
Staff Adherence to Program Protocols	.1406	56.92	<.001	.7425	500.41	<.001
Quality of Program Delivery	.2718	129.88	<.001	.7349	480.91	<.001
Participant Engagement	.1154	45.41	<.001	.6569	332.19	<.001
Dosage of Services	.5742	469.21	<.001	.6725	356.34	<.001

Note. N = 350. Model 1 = predictor to mediator regression; Model 2 = full mediation model. All F-tests significant at p < .001.

Table 4.32 summarizes model fit statistics for mediation analyses. In the predictor-to-mediator models (Model 1), variance explained in IM ranged from 11.5% (PE) to 57.4% (DS), indicating

large differences in predictors' ability to shape Implementation Strategy. Dosage of Services was the strongest determinant of IM ($R^2 = .574$, $F(1,348) = 469.21$, $p < .001$), while PE was the weakest ($R^2 = .115$, $F(1,348) = 45.41$, $p < .001$). In the full mediation models (Model 2), inclusion of IM substantially increased explained variance in CW. R^2 values ranged from .657 (PE) to .743 (SP), all with highly significant F-statistics ($p < .001$). These findings highlight that adding IM considerably strengthens explanatory power, positioning it as a central mechanism linking program components to child welfare outcomes.

Table 4.27: Direct and Indirect Effects with Bootstrap Confidence Intervals

Predictor Variable	Direct Effect			Indirect Effect			Total Effect
	Effect	SE	95% CI	Effect	Boot SE	95% Boot CI	Effect
Staff Adherence to Program Protocols	.2649	.0217	[.2222, .3076]	.1831	.0280	[.1308, .2401]	.4480
Quality of Program Delivery	.2791	.0241	[.2317, .3264]	.2322	.0243	[.1850, .2815]	.5113
Participant Engagement	.1179	.0236	[.0716, .1643]	.1769	.0280	[.1242, .2334]	.2948
Dosage of Services	.1946	.0297	[.1361, .2531]	.2689	.0255	[.2186, .3196]	.4635

Note. N = 350. Bootstrap sample size = 5,000. CI = confidence interval; Boot = bootstrap. Indirect effects are significant if bootstrap confidence intervals do not contain zero. Total Effect = Direct Effect + Indirect Effect.

Table 4.33 presents direct, indirect, and total effects, supplemented by 5,000-sample bootstrap confidence intervals. All predictors had significant direct and indirect effects on CW, as confidence intervals did not include zero. For SP, the direct effect ($\beta = .265$, 95% CI [.222, .308]) was stronger than the indirect effect ($\beta = .183$, 95% BootCI [.131, .240]). Similarly, QS showed a stronger direct effect ($\beta = .279$, 95% CI [.232, .326]) than its indirect component ($\beta = .232$, 95% BootCI [.185, .282]). Conversely, PE and DS had greater indirect effects ($\beta = .177$ and $\beta = .269$, respectively) compared to their direct effects, suggesting their impact on CW is largely mediated by IM. Total effects were substantial, with QS producing the highest effect ($\beta = .511$) and PE the lowest ($\beta = .295$).

Table 4. 28: Summary of Mediation Effects and Proportion Mediated

Predictor Variable	R^2 (X→M)	Path a	Path b	Path c'	Indirect Effect (a×b)	Proportion Mediated	Mediation Type
Staff Adherence to Program Protocols	.141	.331***	.554***	.265***	.183***	40.9%	Partial
Quality of Program Delivery	.272	.462***	.502***	.279***	.232***	45.4%	Partial
Participant Engagement	.115	.286***	.619***	.118***	.177***	60.0%	Partial
Dosage of Services	.574	.571***	.471***	.195***	.269***	58.0%	Partial

Note. N = 350. ***p < .001. Proportion Mediated = Indirect Effect ÷ Total Effect × 100. All mediation effects are statistically significant based on bootstrap confidence intervals not containing zero. Path a = predictor to Implementation Strategy; Path b = Implementation Strategy to Children's Welfare; Path c' = direct effect controlling for mediator.

Table 4.34 summarizes mediation results by computing the proportion of each predictor's effect that is mediated through IM. All predictors exhibited partial mediation with very strong paths: $p < .001$ or less. The mediation for Staff Adherence was 40.9%, suggesting that most of its impact is both direct and indirect. For Quality of Delivery, mediation was 45.4%, indicating a balance between its direct and indirect effects. Participant Engagement had the largest proportion mediated: 60.0%, which reflects the fact that its influence on CW is highly dependent on IM. Similarly, Dosage of Services had 58.0% mediation, with most of its contribution to CW being conveyed through IM. These findings confirm that IM consistently increases the translation of program processes into welfare outcomes, with mediation especially high for PE and DS.

The mediation findings therefore call for integrated policies that bridge system-level strategies with individual-level competencies. The strong direct influence of staff adherence and program delivery in this study is consistent with Fixsen et al. (2005), who identify fidelity and professional competence as primary determinants of program success. However, some studies, such as Durlak and DuPre (2008), argue that delivery quality often exerts its greatest influence indirectly through system-level reinforcement rather than direct effects. This contrast may be explained by institutional variation: in highly structured care systems, adherence and delivery align with existing strategies, producing mediated rather than direct influence. In less structured contexts, such as the

present one, these factors independently shape welfare, compensating for weak institutional infrastructure.

The finding that dosage effects are largely mediated also diverges from some intervention studies where service intensity directly predicted welfare outcomes (e.g., WHO, 2018). This inconsistency can be explained by the role of implementation strategy: dosage alone does not guarantee effective exposure if services are fragmented or poorly integrated. In line with Pawson and Tilley's realist perspective, it is the interaction between intensity and delivery systems that generates outcomes. Thus, while higher service dosage is beneficial, its effect depends on being embedded in strategies that ensure consistency, coordination, and sustainability. This helps explain why, in this study, dosage showed its strongest effects indirectly.

Complete Mediation Model Analysis

Implementation Strategy as Mediator of Program Implementation Factors

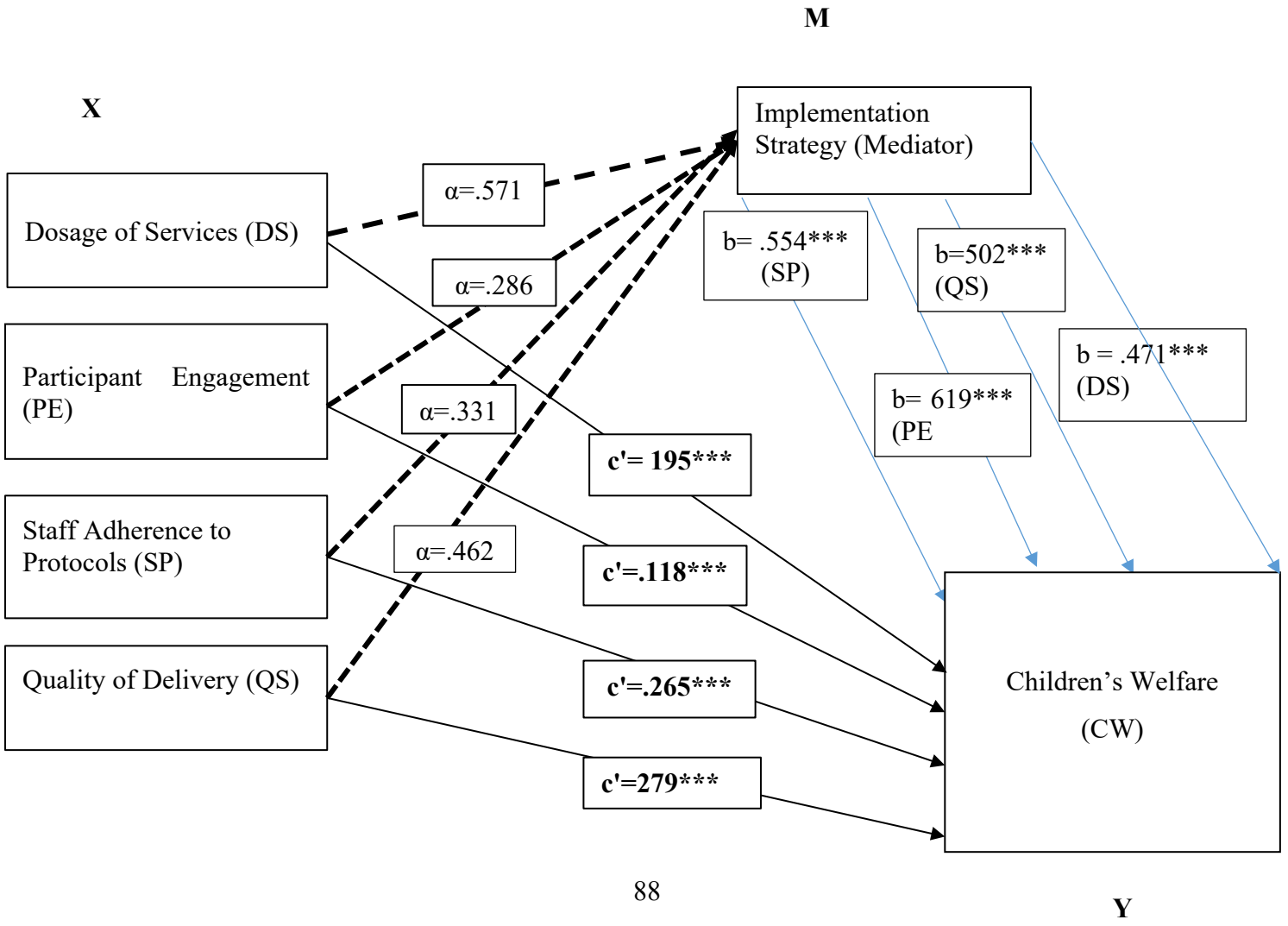

Figure 4.12: Complete Mediation Model Analysis

The model demonstrates how four program predictors Dosage of Services (DS), Participant Engagement (PE), Staff Adherence to Protocols (SP), and Quality of Delivery (QS) influence Children's Welfare (CW), both directly and indirectly through Implementation Strategy (IM) as a mediator. Dosage of Services has the strongest effect on IM ($\alpha = .571$), followed by Quality of Delivery ($\alpha = .462$), Staff Adherence ($\alpha = .330$), and Participant Engagement ($\alpha = .286$). IM in turn significantly predicts CW ($b = .554$). Direct effects of the predictors on CW, controlling for IM, remain positive but reduced: DS ($c' = .195$***), PE ($c' = .118$***), SP ($c' = .265$***), and QS ($c' = .279$***). This indicates partial mediation. Overall, the findings suggest that program inputs shape children's welfare both directly and, more powerfully, through implementation strategies.

The pattern of partial mediation across all predictors suggests that welfare outcomes emerge through both direct and mediated pathways. This balance between process and structure aligns with Bronfenbrenner's ecological framework, where both immediate caregiver interactions and systemic supports shape development. The evidence also extends Lansdown's notion of participation by showing that engagement must be coupled with strategic delivery mechanisms to have meaningful impact. Practically, this means that scaling child welfare programs should not only focus on expanding inputs but also on embedding those inputs within strong implementation frameworks. Such alignment ensures that institutional care achieves both quality and sustainability in promoting children's welfare.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter provides a detailed summary of the findings from the study, conclusions based on the research objectives, and recommendations. The research examined the impact of programme implementation elements on the well-being of at-risk children within care institutions in Nairobi County, Kenya. More specifically, the research sought to ascertain the impact of programme adherence, programme delivery, participation, and service delivery on the well-being of children. This chapter brings together the findings from the quantitative data analysis, implications for practice, as well as recommendations.

5.2 Summary of Key Findings

The response rate achieved in the study is remarkable, registering 92.11% from 350 valid questionnaires across 380, well beyond the threshold level considered adequate for research. The demographic breakdown showed a largely workforce-focused population, with 56.9% being full-time workers, equal distribution in gender (52.9% female, 47.1% males), and a workforce population within the working age group (25-54 years, 68.8% of participants). The sampled population composition assured a strong basis for testing implementation of the program elements from different stakeholders' view.

5.2.1 Adherence to De-institutionalization Program Protocols and Children's Welfare

The results showed a moderate level of compliance to the protocols of the De-institutionalization program, as indicated by a mean of 3.29 and a standard deviation of 0.688. The results indicated significantly high levels of adherence to the implementation of key programs, while slightly low levels were observed concerning timelines of service delivery, as well as documentation. The observation of high levels of both negative and positive responses concerning adherence levels indicated a lack of clarity on the implementation of the program protocols among the personnel. The regression line confirmed a positive relationship between the level of adherence to the implementation of the program protocols, as well as children's welfare. The equation demonstrated a variance of 36.7% on children's welfare, as indicated by adherence levels to the implementation of program protocols, per unit increase, indicating a positive impact on children's welfare.

5.2.2 Quality of Program Delivery and Children's Welfare

The quality of program delivery mean score stood at 3.06, while the standard deviation was 0.68. The individualized support quality received the highest score, while the competence of the program delivery personnel scored the lowest mean. The prevalence of neutral responses indicated lack of uniformity in the quality of program delivery, pointing to a lack of sufficiency in training personnel. Using linear regression, a very high positive correlation between quality of program delivery and children's welfare emerged ($R = 0.688$, $R^2 = 0.473$, $p < 0.001$). The equation explained 47.3% of the variance in children's welfare, while a one-unit increase in quality would result in a 0.511-unit improvement in children's welfare. This indicated the second strongest relationship among individual predictors, supporting the point that improvement in program delivery quality, achieved via quality training, resource, and development, would make a huge difference in children's welfare.

5.2.3 Participant Engagement and Children's Welfare

The indicators of participant engagement showed a relatively neutral level of perception on all items, registering a mean of 3.00 and a standard deviation of 0.717. The highest level of agreement on children's expression of opinions and feelings scored the highest, while the items on peer interaction, as well as interaction between peers and caregivers, showed a wide range of levels, registering the lowest levels of agreement. The results showed a neutral trend, implying a lack of strong incorporation of children's participant engagement practices in care institutions, thereby potentially hindering children from making deep, significant inputs into programs aimed at assisting their well-being. The results showed a moderate positive relationship between participant engagement and children's well-being, registering an R value of 0.418, an R^2 of 0.175, and a significance level of $p < .001$. The variable, though significant, explained a variance of 17.5% on the dependent variable, implying a 0.295-unit improvement on every one unit increase on children's well-being. It apparently indicated a lower direct value than other predictors on children's well-being.

5.2.4 Dosage of Services and Children's Welfare

Service dosage perceptions tended to be slightly positive, with mean values ranging from 2.96 to 3.01. Satisfaction with service duration turned out to be highest, while frequency tended to be lowest. The preponderance of slightly positive responses on service dosage dimensions tended to

indicate slight satisfaction without a conviction about service being completely satisfying for children. The results from the linear regression test indicated a strong positive correlation between children's well-being and service dosage strength ($R = 0.734$, $R^2 = 0.538$, p 0.001). The explained variable accounted for 53.8% variance in welfare, which depicted the strongest individual correlation among all predictors. For every unit increase in service dosage strength, the well-being variable increased 0.463 points, making it the most significant.

5.2.5 Combined Effect of Program Implementation Factors

The result of the multiple regression showed a strong model combining the four predictors for children's welfare. The model showed a high correlation value of 0.925, an R^2 value of 0.855, and significance at 0.001. The four predictors contributed 85.5% to explain the variance in children's welfare, with services dosage having a higher standardized coefficient of 0.423, followed by participants' engagement at 0.345, quality of delivery at 0.342, and adherence to the protocol at 0.273. The high value showed a significant impact on children's care welfare as a result of improvement in the four factors.

5.2.6 Mediation Effect of Implementation Strategy

Adding implementation strategy as a mediator variable greatly improved the explanatory power of the model from 85.5% to 87.4% ($\Delta R^2 = 0.018$, $p < .001$). The results from the mediation model using the PROCESS macro demonstrated implementation strategy as a partial mediator on all predictors. The proportion of mediation varied, ranging from 60.0% for participant involvement, 58.0% for services delivered, 45.4% for quality of delivery, to 40.9% for adherence. These results suggested the continued significance of the direct pathways, as well as a strong mediational component, suggesting the significance of implementation strategy in well-structured, well-coordinated attempts at delivery.

5.3 Conclusions

Based on comprehensive analysis, it can be concluded from this research study that implementation of programs is a strong determining factor affecting the well-being of children in care institutions. The following findings indicate a moderate level of compliance, along with a neutral point of view, which obstructs the implementation of de-institutionalization procedures despite being a strong predictor. In a similar manner, the result has demonstrated the importance of effective implementation, as the lack of proficiency, resource utilization, as well as training, has

brought about systemic flaws concerning the possibility of stable well-being. The results have supported the fact that well-being within the context of children can be achieved only through high-quality implementation.

Substantially, the research illustrates the importance of both participant engagement and service dosage in a complementary, not competing, fashion. Even though participant engagement has relatively smaller direct significant effects, it becomes much more significant as a constituent concept within comprehensive implementation strategy, proving the fallacy of tokenistic participation. In contrast, service dosage appears as the strongest individual predictor, being, however, dependent on the implementation structure. The conceptually most important message from the results of the mediation model supports systems theoretical ideas about the implementation strategy being the connecting link between inputs and actual outcomes within the welfare system, as it provides a framework for enhancing children's welfare, as indicated by joint 87.4% variance explanation concerning children's welfare. In this respect, it can be claimed that the research supports a multidimensional, strategically implemented approach as the most effective way to accomplish long-term, high-quality children's welfare practice.

5.4 Implications for Theory and Practice

The results of this research have very important implications for both theoretical and practical arenas related to child well-being programs conducted in care organizations. Theoretically, this research supports ecological systems theories because it demonstrates, through the mediation effects, that children's well-being outcomes are generated from interactive processes between individual, institutional, and system levels. The research supports social learning theories because it indicates, as it claimed, that adherence and quality are nurtured in favorable conditions, while participation theories are supported because it demonstrates, as it claimed, that participation leads to better outcomes. The results have very important implications because they confirm the value of implementation infrastructure as well as balanced investments on child well-being program factors.

The findings further, underscore the symbiotic relationship between ecological layers and program success. At the microsystem level, staff adherence directly shapes the child's immediate environment, where consistent care acts as a primary driver for stable development. This is bolstered by the mesosystem, where inter-agency collaboration determines the quality of service

integration. Furthermore, the macrosystem, encompassing national de-institutionalization policies, provides the structural blueprint that dictates resource allocation. The study reveals that "moderate adherence" often stems from a "trickle-down" failure, where macrosystemic policy shifts are not fully synchronized with microsystemic staff training, ultimately hindering the holistic social welfare of vulnerable children.

5.5 Recommendations

Based on the findings and conclusions derived from the research, the following recommendations are proposed according to the specific objectives:

Objective 1: To analyse the influence of adherence to de-institutionalization program protocols on the welfare of vulnerable children.

It is advocated within the research that care institutions should improve mechanisms for the monitoring and supervision of adherence to de-institutionalization procedures. The directors of care institutions should implement mechanisms such as audits, checklists, and feedback systems to avoid uncertainty within the workforce. The children's welfare officers within the government should establish compliance levels, while a system of appraising the workforce within care institutions, which motivates adherence to children's protection procedures, should be implemented.

Objective 2: To examine the influence of the quality of program delivery on the welfare of vulnerable children.

The research recommends the following: The directors of care institutions should provide comprehensive capacity development initiatives for competence development of social workers, trauma-informed care, and skill development. Care institutions for children should prioritize resource adequacy, such as ratio, equipment, and infrastructure, in order to avoid disparities in program implementation. The government along with NGOs should work together on the development of training modules, so as to achieve common quality standards for all care institutions.

Objective 3: To examine the influence of participant engagement on the welfare of vulnerable children.

The research recommends that mechanisms, such as forums, suggestion boxes, as well as advisory committees, which are child participation friendly, be institutionalized within the government to enable children to make a contribution towards the decisions concerning their well-being. Workers in care organizations should be empowered to take part, so children's voices can be taken seriously. The government should include participation standards within child protection policies, while NGOs should support children's initiatives within care.

Objective 4: To assess the effect of the dosage of services on the welfare of vulnerable children.

The study recommends that children care institutions' directors create schedules for service delivery with high intensity, frequency, and duration based on children's development. The funding model of the government children welfare department should prioritize long-term service delivery as opposed to those conducted on a random basis. The development partner should support scaling up services on a programmatic basis which has a high level of dosage effectiveness, while the organization should monitor services' delivery based on children's emerging needs.

Cross-cutting recommendation:

Because the total impact of all program factors accounted for a large percentage of variance in the outcomes, the study further recommends a comprehensive approach in implementation. There should be a systems approach based on adherence, quality, participation, and dosage implemented by institutions, the government, and stakeholders. There should be common monitoring mechanisms, learning, and policies for comprehensive improvement in child welfare.

5.6 Suggestions for Future Studies

- Comparative research can be conducted within the public, faith-based, and private sectors in order to identify the factors within these institutions that contribute to successful implementation. Cross-cultural research can also be helpful in determining cultural elements affecting implementation success.
- Child-focused research conducted in collaboration with children as co-researchers should be considered as a means of gathering genuine views, informed by children's rights, for more responsive program design.

- Research should include cost-effectiveness studies on implementation approach versus component-specific research, focusing on optimizing resource allocation, particularly within resource-challenged environments.

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APPENDIX I: QUESTIONNNAIRES

Introductory Letter and Consent Form

To: The Respondent

From: Phelister Awuor Mbwayo (Student), Master of Arts in Social Work, Catholic University of Eastern Africa

Subject: Request for Participation in Research Study on the Implementation of De-Institutionalization Programmes on the Welfare of Vulnerable Children in Care Institutions in Nairobi, Kenya

Dear Respondent,

I am writing to invite you to participate in a research study that I am conducting as part of my Master's degree in Social Work at the Catholic University of Eastern Africa. The study aims to explore the impact of de-institutionalization programmes on the welfare of vulnerable children in care institutions in Nairobi, Kenya. Your participation would involve answering some questions about your experiences and observations related to these programmes. Your insights would be invaluable in helping us understand the effects of these initiatives and how they can be improved to better serve the needs of vulnerable children.

Please note that your participation is entirely voluntary, and you may choose to withdraw at any time without any repercussions. All information provided will be kept confidential and used solely for the purposes of this research. Attached is a consent form that provides more details about the study and the safeguards in place to protect your privacy. Please review it carefully and sign it if you agree to participate. Thank you for considering this request. Your contribution could significantly impact the development and implementation of effective programmes for vulnerable children in Nairobi.

Sincerely, Phelister Awuor Mbwayo 1042240 Master of Arts in Social Work Catholic University of Eastern Africa

ection A: Demographic Information

1. Age:

- What is your age?
- Please select your age range: 12-17 [ ] 18-24 [ ] 25-34 [ ] 35-44 [ ] 45-54 [ ] 55-64 [ ] 65+

2. Gender:
    - What is your gender? [ ] Male [ ] Female [ ] Non-binary [ ] Prefer not to say [ ] Other (please specify: _____)
3. Employment Status:

What is your current employment status?

☐ Employed full-time

☐ Employed part-time

☐ Self-employed

☐ Unemployed

☐ Student/pupil

☐ Retired

☐ Other (please specify: _____)

Section B

Instructions

- For each statement, please indicate the extent to which you agree or disagree using the scale provided.
- Select the response that best reflects your opinion or experience.
- There are five response options:
    - **Strongly Disagree (1):** If you strongly disagree with the statement.
    - **Disagree (2):** If you disagree with the statement.
    - **Neutral (3):** If you neither agree nor disagree with the statement.
    - **Agree (4):** If you agree with the statement.
    - **Strongly Agree (5):** If you strongly agree with the statement.

Objective 1: Staff Adherence to Program Protocols

To analyze the influence of adherence to de-institutionalization program protocols on the welfare of vulnerable children.

Item	1	2	3	4	5

All core components of the de-institutionalization program were consistently implemented in accordance to laid policy.					
Staff followed the program guidelines without deviation.					
Case plans for children were completed as per the protocol.					
Staff members complied with organizational and governmental policies.					
Program documentation and reporting were completed on time and accurately.					
The delivery of services adhered to the prescribed timelines and sequence.					
Staff regularly reviewed program procedures to ensure ongoing compliance.					

Objective 2: Quality of Program Delivery

To examine the influence of the quality of program delivery on the welfare of vulnerable children.

Item	1	2	3	4	5
Caregivers received adequate training to deliver the program effectively.					
Staff demonstrated high competence in delivering the program to children.					
Adequate resources were provided to ensure the quality of program delivery.					
The program was delivered in a clear and understandable manner.					
Staff consistently demonstrated empathy and professionalism.					
There were no delays or disruptions in the delivery of program components.					
Children received individualized support based on their unique needs and challenges.					

Objective 3: Participant Engagement

To examine the influence of participant engagement on the welfare of vulnerable children.

Item	1	2	3	4	5
Children actively participated in all program activities.					
Caregivers provided regular feedback on the program's impact on children.					
Community members were actively involved in supporting the program.					
The program encouraged children to express their opinions and feelings.					
Children showed enthusiasm and interest during the program sessions.					
Caregiver involvement positively influenced children's participation.					
The program facilitated opportunities for children to interact with peers and caregivers.					

Objective 4: Dosage of Services

To assess the effect of the dosage of services on the welfare of vulnerable children.

Item	1	2	3	4	5
The frequency of program sessions was sufficient to meet the needs of the children.					
Children received the recommended number of visits and support sessions.					
The duration of services provided to each child was adequate for achieving program goals.					
Follow-up visits were conducted regularly to ensure children’s welfare.					

Children and their caregivers received adequate time and attention during each session.					
The program-maintained consistency in the timing and duration of sessions.					
Services were appropriately tailored to the individual needs of each child.					

Implementation Strategy Objectives:

Statement	**1**	2	3	4	**5**
The support services provided by the program adequately meet the needs of vulnerable children.					
The availability of support services positively impacts the welfare of children.					
The program effectively connects children with essential support services.					
The program facilitates meaningful integration of children into their communities and families.					
Community involvement enhances the well-being of children in care institutions.					
The program promotes family engagement and support for children in care.					
The program helps prevent unnecessary institutionalization of vulnerable children.					
Efforts to keep children out of institutions contribute to their overall welfare.					
The program provides alternatives to institutional care that are beneficial for children.					

Children Welfare Indicators:

Statement	1	2	3	4	5
Children in the program have access to adequate healthcare services.					
The program promotes healthy lifestyles and habits among children.					
The physical health needs of children are effectively addressed by the program.					
Children's emotional and social needs are supported by the program.					
The program fosters a supportive and nurturing environment for children's mental well-being.					
Children in the program experience a sense of belonging and security.					
The program supports children's educational goals and aspirations.					
Educational resources and opportunities provided by the program contribute to children's academic success.					
Children in the program demonstrate improvements in educational outcomes.					

APPENDIX II: INTERVIEW GUIDE

Interview Guide

Objective 1: Staff Adherence to Program Protocols.

1. How consistently do staff members follow the de-institutionalization program protocols, and what challenges do they encounter in adhering to these guidelines?
2. In what ways do you ensure that case plans for children are completed according to program protocols, and how do staff manage any deviations from the plan?
3. What measures are in place to ensure that staff fully understand and comply with both internal and external (governmental) policies related to de-institutionalization?

Objective 2: Quality of Program Delivery

1. How does the training provided to caregivers equip them to deliver the program effectively, and what ongoing support is available to ensure high-quality delivery?
2. How would you rate the competency of staff in delivering the program, and what processes are in place to continually assess and improve their performance?
3. How does the availability of resources (e.g., materials, staff, funding) affect the quality of program delivery, and are there any gaps in resources that need to be addressed?

Objective 3: Participant Engagement

1. How do you ensure that children are actively engaged in the program, and what strategies do you use to overcome barriers to their participation?
2. How do you collect and incorporate caregiver feedback into the program, and how does this feedback influence the way the program is delivered?
3. How do community members contribute to the program, and what role does their involvement play in improving the outcomes for vulnerable children?

Objective 4: Dosage of Services.

1. How is the frequency of visits determined for each child, and do you feel the current frequency is adequate to meet their needs?
2. How do you determine the appropriate length of service for each child, and what factors influence decisions to extend or reduce the duration of services?
3. How effective do you find the support sessions in addressing the needs of children and caregivers, and are there any additional support services that could enhance their well-being?

Implementation Strategy Objectives:

2. **Provision of Support Services:**
    - Can you tell me about the support services provided by the program for vulnerable children?
    - How do these services meet the needs of the children?
    - In your opinion, how do these support services impact the overall welfare of the children?
3. **Community/Family Integration:**
    - How does the program facilitate the integration of children into their communities and families?
    - What efforts are made to involve the community in supporting children in care institutions?
    - How important is family engagement and support for the well-being of children in care?
4. **Prevention of Institutionalization:**
    - How does the program work to prevent unnecessary institutionalization of vulnerable children?
    - What alternatives does the program provide to institutional care?
    - In your experience, how effective are these efforts in preventing institutionalization?

Children Welfare Indicators:

5. **Physical Health:**
    - Can you describe the healthcare services available to children in the program?
    - How does the program promote healthy lifestyles and habits among the children?
    - Do you feel the physical health needs of the children are adequately addressed by the program?
6. **Psychosocial Well-being:**
    - How does the program support the emotional and social needs of the children?
    - In what ways does the program create a supportive and nurturing environment for the children's mental well-being?
    - Do you observe a sense of belonging and security among the children in the program?
7. **Educational Attainment:**
    - How does the program support the educational goals and aspirations of the children?
    - What educational resources and opportunities are provided by the program?
    - Have you noticed improvements in educational outcomes among the children in the program?

APPENDIX III: RESEARCH TIMELINE:

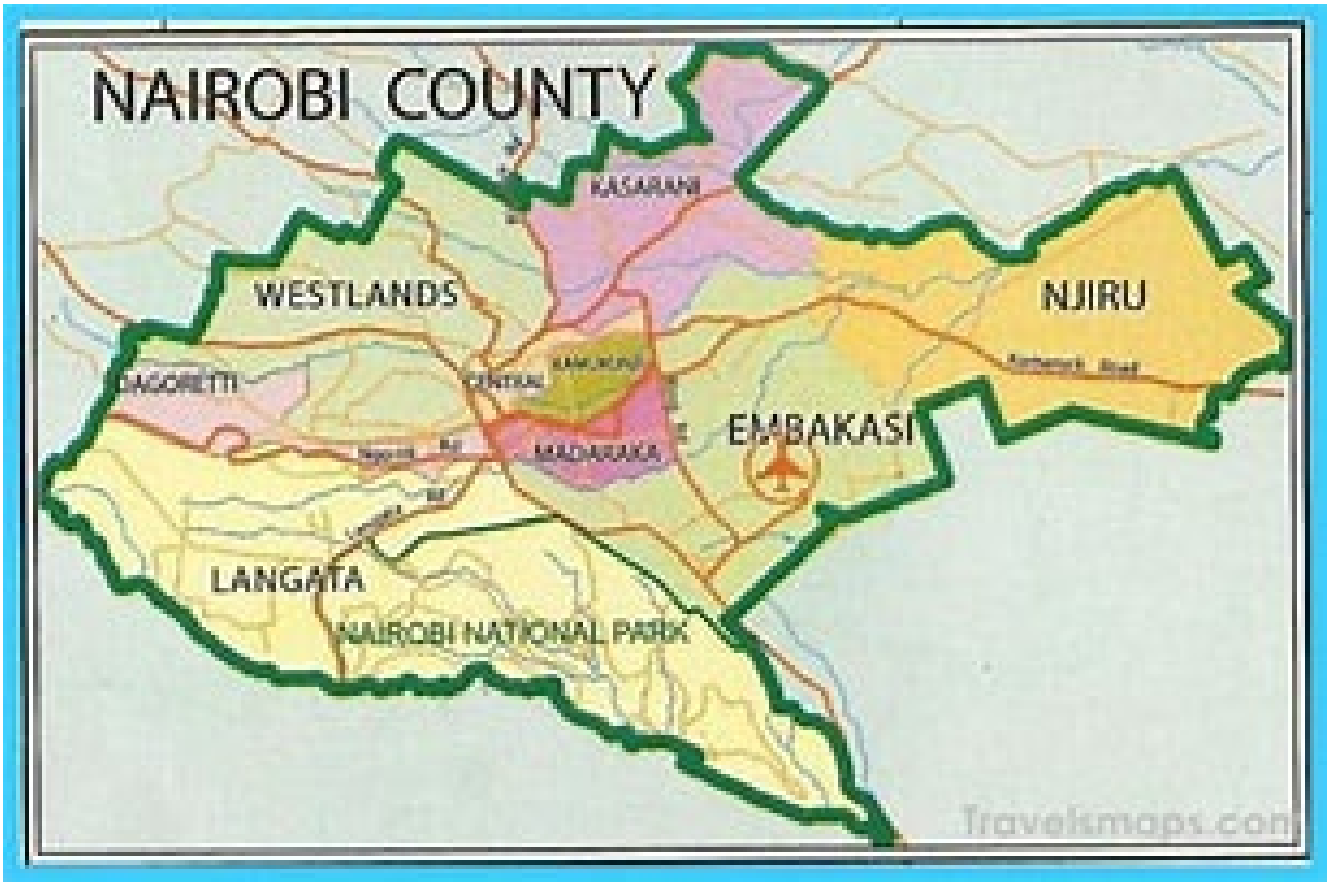
Phase	Activities	Timeline
Proposal Defense	Present research proposal to committee for approval	April 2024
Planning and Preparation	Define research objectives and methodology	April-May 2024
	Develop survey questionnaire and interview guide	April-May 2024
	Obtain necessary ethical approvals	April-May 2024
	Hire research personnel	April-May 2024
Data Collection	Conduct surveys with participants	June-July 2024
	Schedule and conduct interviews with key stakeholders	June-July 2024
	Gather relevant data from care institutions and program records	June-July 2024
Data Analysis	Clean and organize collected data	August-September 2024
	Analyze survey responses and interview transcripts	August-September 2024
	Conduct statistical analysis of quantitative data	August-September 2024
	Interpret qualitative data for thematic analysis	August-September 2024
Report Writing	Summarize findings from data analysis	October 2024
	Draft research report outlining key results and conclusions	October 2024
	Review and revise report with input from research team	October 2024

Dissemination and Presentation	Prepare presentations of research findings	November 2024
	Organize dissemination events for stakeholders	November 2024
	Publish research report in relevant journals or platforms	November 2024
	Collect feedback and address any further inquiries	November 2024

APPENDIX IV: BUDGET:

Category	**Item**	**Cost (KES)**
Personnel	Researcher(s)	40,000
	Data Analyst	20,000
Materials and Supplies	Survey Software Subscription	5,000
	Printing and Stationery	5,000
Travel and Accommodation	Field Visits	10,000
Participant Incentives	Gift cards or vouchers	10,000
Miscellaneous	Contingency Fund	10,000
Total Budget		**100,000**

APPENDIX V: MAP



APPENDIX VI: CUEA APPROVAL

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

Faculty of Arts and Social Sciences

Department *of Social Sciences and Development Studies*

9th May 2025

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: PHELISTER AWUOR MBWAYO- REG. NO. 1042240

This letter is to confirm that the above-named individual is a Post-graduate student pursuing a ***Master's of Arts Degree in Social Work*** at The Catholic University of Eastern Africa.

As part of the degree requirements, the student is required to undertake a research study with the title:

> ***"The Implementation of De-Institutionalization programs on the social welfare of vulnerable children in care institutionalization in Nairobi, Kenya".***

The information gathered during this study will be used solely for academic purposes and will be handled with strict confidentiality.

Any assistance accorded to her will be highly appreciated.

Yours faithfully,

09 MAY 2025

Dr. Mary Mutisya
HoD, Department of Social Sciences and Development Studies

APPENDIX VII: NACOSTI APPROVAL

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 380813

Date of Issue: 20/June/2025

RESEARCH LICENSE



This is to Certify that Miss.. Phelister Awuor MBWAYO of Catholic University of Eastern Africa, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in on the topic: THE IMPLEMENTATATION OF DE-INSTITUTIONALIZATION PROGRAMS ON THE SOCIAL WELFARE OF VULNERABLE CHILDREN IN CARE INSTITUTIONS IN NAIROBI, KENYA for the period ending : 20/June/2026.

License No: **NACOSTI/P/25/4174259**

380813

Applicant Identification Number

Deputy Director
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

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See overleaf for conditions