AN INVESTIGATION INTO THE EFFECTIVENESS OF REHABILITATION PROGRAMMES IN SELECTED CENTRES OF FORMER STREET CHILDREN AND ADOLESCENTS IN NAIROBI, KENYA

BY

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DECLARATION

This research project is my original work and has not been presented for a degree in any other university.

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DEDICATION

This work is dedicated to my beloved husband J.J. Muturi for his immeasurable support, and encouragement through out my studies. My mothers Ann Warue and Maria Warue, exemplary orderly gentle ladies of extremely deep motherly sensitivity, dedication and love. I thank God for you. My dad Alfred Mvungu Ngoroi, a man with a huge heart and lover of learning and professionalism. Finally to my late grandmother Eugene Ngima (Riitawa) for the virtues you inculcated in me as I was growing up.
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ABSTRACT

The problem of street children is a worldwide social concern. There is virtually no city anywhere in the world without the presence of street children. Although the street children phenomenon is a global problem, it is more prominent in Latin America, Asia and Africa.

In Kenya, the problem of street children first began in the early 1950s when the colonial system broke up families by imprisoning men and women or taking them away to the concentration camps. Since then, the number of these children has been increasing to unmanageable levels by the year 2003 prompting the Kenya government to institutionalize all the street children and families so as to have them rehabilitated. The study was aimed at establishing the effectiveness of rehabilitation programmes in selected centres for former street children and adolescents manned by Nairobi City Council.

A descriptive survey method was used to collect the data for the study. A total of three centers were purposively sampled. From the centres, 151 children and adolescents out of a total population of 820 were also sampled using the same method. Fourteen staff members from the centres were also selected purposively for the study. Questionnaires were used as the main tool for data collection. Additionally, an interview schedule and an observation checklist were used to verify the data obtained. The data obtained were analysed using the Statistical Package for Social Sciences (SPSS). Descriptive statistics such as means, percentages and frequency distributions were used to analyze various
variables. The data were then organized, categorized and reported thematically. The results were presented in tabulated percentages. The findings of the study revealed that rehabilitation services provided include basic needs, counselling and medical care, among others. At the centres, the rehabilitatees are exposed to a number of activities such as laundry and personal grooming, cooking their meals and keeping the center clean that are viewed as being rehabilitative. The rehabilitatees declared that the programme had given them hope for a bright future.

The staffs in the centres were found to be adequate in terms of numbers but were said to be uncommitted in their work hence negatively affecting the performance of the programme. The study also found that all the three centres did not have enough facilities. However, the programme was found to be rehabilitative and the rehabilitatees' attitude towards it was positive. It was therefore concluded that the rehabilitation programmes in the three centres are reasonably effective.
CHAPTER ONE

1.0 Introduction

1.1 Background To the Problem

According to Gilmore (1940), street begging, homelessness and destitution among children are an age-old worldwide social problem. Leroux (1994) observes that the street children phenomenon is an alarming and escalating worldwide problem. It is more prominent in Latin America, Asia and Africa. (Chatterjee, 1992). The phenomenon, an offspring of the modern urban environment represents one of the most complex and serious challenges facing humanity.

Gilmore (1940) notes that historically, children were street beggars in medieval Europe. Children were often physically deformed by adult beggars to elicit sympathy and receive more alms from the public. Renting of children by beggars to create an atmosphere of pity and sympathy was also a common practice.

According to McCarthy (1988), there was an estimated 100 million street children in developing countries. In Brazil alone there are a reported 32 million street children. In Thailand 40,000 children are reported to sell sex on the streets. Industrialized countries also have the problem of street children. For example, in New York City the number of homeless children is growing. The Washington Post (1988) reported that a three-year-old New York girl was used as a prop for panhandling by her mother's boyfriend and died as a result of abuse and neglect. LeRoux (1994) notes that no country and virtually no city anywhere in the world is without the presence of street...
children. Both developing and developed countries face a broad spectrum of problems posed by these children yet few steps have been taken to address the issue.

In Africa, Bennani (1996) as cited in Wagenge (2003), reports that in Morocco, about 1,000 children live in the streets of Casablanca alone. In Sudan, armed conflicts, droughts and famine have led to a mass displacement of Sudanese population leaving many children either separated or orphaned. Most of these children find their way to the capital or other major cities where they try to eke out a living on the streets (Interpress Service, 1997, as cited in Wagenge (2003).

In South Africa, Mc Lachlan (1986) indicates that there are more than 10,000 children on the streets. Most of them live on the streets or in children's shelters unlike in Zimbambwe and Zambia where majority of street children have homes to go to.

1.1.1 Situation of Rehabilitation Centres in Kenya

Many interventions have been initiated to address the plight of children in the country by both the government and civil society. According to UNICEF (July 1999), currently there are eleven (11) approved schools, eleven (11) remand homes and two (2) borstal institutions. Because most of these were set up during the colonial period, they were intended to cater for very small populations but currently they cater for a population of about 7,000. The number of children in need of special protection in Kenya is projected to be about 600,000 yet our institutions both statutory and voluntary are only taking care of approximately 45,000 children.
In Nairobi alone, Gwada (July 1999) reports that there are more than 250 organizations focusing on both actual and potential street children. It is worth noting that most street children initiatives greatly rely on voluntarism and charity. These characteristics lead to various constraints in the operations of children’s organizations, such as poor management, high staff turnover, duplication of work and poor results in the rehabilitation centres. Although commitment is high, the staff’s good intentions do not surmount to such constraints.

According to Suda (January 1994), most NGOs leaders reported that they faced several constraints ranging from financial difficulties and shortages of qualified and dedicated staff to lack of land building facilities and public support. Based on these experiences as programme implementers, they suggested several aspects of their programmes, which need intensification. These are education, counseling, and linkages with families, preventive strategies, vocational training and co-ordination between the NGOs working with street children. In addition, many organizations admitted that they needed more committed and better trained social workers and counsellors with the expertise to help get these children off drugs. Similar expertise would also be required to intensify case analysis and home visits.

Bears (20-23, November, 2000), says that interventions are started without any assessment of the needs of children who may only be involved in the implementation of the daily running of the centre such as clearing, cooking and washing clothes. Under the guise of ‘rehabilitation’, children become mere recipients of services
offered by the projects and are provided with what is considered to be their basic needs such as food, shelter, clothing, some form of medical care, education and vocational training.

Where re-union with the family is possible, both children and relatives are generally poorly prepared. A common anecdote with much truth in it is that the children are back in the streets before the social worker gets back to the centre. The project's perception of the problem as described above is also reflected in their mission statement and objectives, which often are not specific or time framed. A project objective during PAR (Participatory Action Research) training in 1998 read:

To take children off the streets and provide them with basic needs such as food, shelter, clothing, medical care, to prepare the children and rehabilitate them for further formal education, to discipline them, to reunite the children with their families and make them to be accepted by the society. P.23.

It seems that many street children projects in Kenya deal with symptoms rather than the causes. The intervention scene of street children is characterized by foreign concepts, assumptions and wrong approaches that heavily influence the effectiveness of assistance to children in need. However, Wainaina, (1977, 1981) noted that the problem in Kenya is not as severe as in other countries and can be arrested given commitment and proper planning.

1.1.2 Role of Rehabilitation Centres

Suda, (Jan 1994), in her report of a baseline survey on street children in Nairobi, reports that 17 NGOs dealing with street children had their main objective as "to rehabilitate street children and other children in difficult circumstances into
responsible members of society." (P.13). They try to do this through a wide range of programmes. Most of the programmes are dealing with the provision of basic needs to the children. The majority programme activities are basically aimed at moulding the children's characters and restoring their dignity and self-esteem.

Several services are provided to the children on these programmes. They include feeding, education, medical care, counselling, shelter, vocational training and evangelism. Much of the appeal for these programmes is the love and attention, which the children have come to experience and a sense of family which most of them have never known before. The services provided to the children in these programmes are similar which indicates that there is quite a bit of duplicating of efforts between NGOs. Most of the children participating in the programmes are aged 7-18 years and had joined the programme either on their own, through friends or were referred from the juvenile courts and hospitals by the police or local administration.

1.2 Statement of the Problem

The Nairobi City Council in partnership with relevant agencies' efforts to institutionalize all street families has earned some admiration both at home and abroad. Even so, the problem of street children in Nairobi still remains unsolved in its entirety. The increasing numbers of children are often seen roaming about on the streets as well as in residential estates of the city. Some of these children have run away from the rehabilitation centres while others have gone through the rehabilitation programme but on being reintegrated with their families/guardians, they immediately
go back to the streets where they assume their former anti-social, dangerous, and self-destructive lifestyles.

This raises profound questions about these rehabilitation programmes and the manner in which they are executed. The rehabilitatees whether in or out of the rehabilitation centres continue to engage in dangerous lifestyles such as; drug and substance abuse, fights, quarrels, immoral acts like transvestism, homosexuality, lesbianism and sodomy. This is not a problem confined to the government’s rehabilitation programmes only but is also common with others run by NGOs, churches and individuals. While in the rehabilitation centres, the children steal and destroy items at the centres and lack sense of responsibility. They do not control their anger and become wild when talked to. Some fight and abuse their parents when they come to visit them or chase teachers with faeces. They also harass the social workers, smoke bhang, and sleep outside with watchmen.

This raises the question of what is amiss with these rehabilitation programmes that is hindering positive change and proper adjustment of the rehabilitatees. According to Hurlock (1973), the effectiveness of adjustment is measured in terms of how well a person copes with the changing circumstances. Good adjustment of an individual indicates a kind of inner harmony in the sense that they are satisfied with themselves and have harmonious relationships with the people with whom they are associated. The person seems to be happy in every walk of life whereas the maladjusted person is disturbed with marked failures in life and unsatisfactory relationship with others.
Beghum and Rahman (1991), as cited in Gatune (2002), observed that when individuals experience less meaning and unhappiness in life, they tend to become frustrated and show problem behaviour. It has been observed that most of the programmes do not seem to be succeeding in achieving their objective of moulding the street children's character and restoring their dignity and self-esteem.

It is with this view in mind that the researcher intended to carry out an investigation into the rehabilitation programmes for former street children and adolescents and the problems encountered in their rehabilitation. It was hoped that if these problems are identified, then appropriate solutions could be found. These will eventually lead to improved rehabilitation programmes by the government, churches, individuals, groups and Non-Governmental Organizations.

1.3 The Purpose of the Study

The purpose of this study was to investigate the effectiveness of rehabilitation programmes of former street children and adolescents in the rehabilitation centres and what corrective measures could be taken to change their behaviour. Adequate provision of services that are relevant to the needs of rehabilitateeis is of paramount importance if street children and families are to be gotten out of the streets. This will eventually lead to our urban towns acquiring decency and sobriety. The issue of insecurity in Kenya has been associated with the escalating and alarming increase of the street children particularly in the city of Nairobi.
Rehabilitation of street children is not only beneficial to the rehabilitatees but also to the public at large. They have been living a dangerous lifestyle that is characterized by drug and substance abuse, irresponsible sexual acts, and all sorts of anti-social behaviours for their survival. To many of the public members, the sight of these children spells danger to them, especially those who have been harassed, mugged, pick pocketed, or have had an unpleasant encounter with them. Their presence in the streets of the city has been and is a source of insecurity in Nairobi.

The rehabilitation programmes by the government and other organizations, which are aimed at moulding their character, restoring their self-worth and dignity seem to be yielding limited success. The programmes have been ineffective in controlling street children trickling back to the street as well as engaging in dangerous lifestyles which is an indication of something being amiss. Therefore, policy makers, administrators and social workers will need to look into this.

It was the expectation of the researcher that these different groups will benefit from the findings of this study in the sense that it will equip them in part with the picture of the outcome of the policies, methods and structures they have used in the past in as far as rehabilitation programmes are concerned. The study also unearthed possible weaknesses within the programmes that hinder effective rehabilitation of street children. This means that a basis for evaluation of their performance can be found.
If the findings of the study lead to improved dissemination of rehabilitation services in the rehabilitation centres, then the rehabilitatees will have benefited and even the rehabilitators too for realizing good fruits from their services. The study findings were also intended to act as a provocation as well as a springboard from which other researchers could conduct further investigations into effective ways of running rehabilitation programmes.

1.4 Objectives of the Study

i) To establish the services and activities availed in the rehabilitation programme.

ii) To identify the qualifications of the staff in the rehabilitation centres.

iii) To establish if guidance and counselling services are offered by the programme.

iv) To determine the attitude of the rehabilitatees towards the services offered in their rehabilitation programme.

v) To determine if the programme is helping the rehabilitatees to be rehabilitated.

1.5 Research Questions

The study sought to answer the following questions:

i) What are the services and activities availed in the rehabilitation programme?

ii) Who provides rehabilitation services in the rehabilitation centres (staff composition)?

iii) Are there guidance and counselling services in the rehabilitation programmes?

iv) What is the attitude of the rehabilitatees towards their rehabilitation programme?

v) Is the programme helping the rehabilitatees to be rehabilitated?
1.6 Assumptions of the Study

In this study, the following assumptions were made

1. That the sample was a good representative of the whole population.
2. That there were several services offered in the rehabilitation programmes.
3. That guidance and counselling is one of the services in the rehabilitation programme.

1.7 Scope and Limitation

Rehabilitation is such a broad subject that it may not be adequately and effectively handled. The study dealt with the nature of rehabilitation services in the rehabilitation centres for former street children and adolescents in Nairobi. The researcher was not able to go into other details due to financial constraints and the time limit as scheduled for the degree course.

Due to time factor, this study considered only a sample of rehabilitation centres in Nairobi. The results are not generalizable to all the rehabilitation centres in Kenya because the researcher only considered the centres that are under Nairobi City Council on assumption that most of the children and adolescents in the streets are or have been in the council rehabilitation centres.

1.8 Area of the Study

The study was conducted in rehabilitation centres in Nairobi that are manned by Nairobi City Council. It was geared towards finding out the effectiveness of rehabilitation programmes offered in centres for former street children and adolescents.
1.9 Definition of Terms.

Effectiveness: extent to which the rehabilitation programmes for street children have achieved their objective of rehabilitating children into responsible members of society by moulding their character and restoring their dignity and self-esteem.

Street children: young boys and girls who have adopted the streets as their abode or source of livelihood or both.

Rehabilitatees: the former street children/adolescents who are undergoing rehabilitation.

Rehabilitate: bring back to normal life by special treatment.

1.10 ACRONYMS:

CCCF: Canadian Christian Children Fund.

IYC: International Year of the Children.

NCC: Nairobi City Council.


PAR: Participatory Action Research.

PC: Provincial Commissioner.

AG: Attorney General.
1.11 THEORETICAL FRAMEWORK

This study was based on five different theoretical frameworks, which have profound implications for street children. These are disease model, behavioural model, and cognitive theory, theory of self-actualization and the theory of attachment.

Disease Model

The basic theoretical work on which much of behaviour modification is based on is human learning of Skinner (1953), Watson (1930), Hull (1943) and Pavlov (1928) and Yates (1970) as cited in Guchrus and Fischer (1975). Behaviour model which in its view of human behaviour, offers a major alternative to more traditional conceptions of human behaviour, particularly those which, because of similarities to medical views of physical illness, have come to be called 'disease model'.

The model focuses on internal ("intrapsychic") events (represented by such terms as, ego, self and super-ego), and the regard of overt maladaptive behaviour basically as a sign or symptoms of those more important internal factors. This would take the form of viewing a problem manifested in an overt behaviour (a "symptom") as an indication that there are more basic problems in underlying dispositions.

A basic assumption of the disease model is that "abnormal behaviour is substantially different from "normal behavior. Just as physical ill health caused, e.g. by a virus-often can be distinguished clearly from physical health, an individual suffering from social or emotional problems is viewed as "sick" within the context of disease model. Thus, "mental illness" becomes similar to any other illness. This sickness is seen as a
product of some underlying cause, so that when abnormal behaviour is displayed, it is seen as an indication that something is wrong underneath ("deep down"). Hence, symptoms or observable maladaptive behaviours may not be viewed at all as problems in themselves but as indicators of an underlying problem.

Behavioural Model
This model places more emphasis on understanding the functional relationship between the environment and behaviour. Specifically, it is assumed and there is abundant research that most behaviours are learned, that is, they develop out of the interaction between an individual and his/her environment. (Rotter et al., 1972, Mischel, 1968, Ullman and Krashner, 1969) all cited in Gochrus and Fischer (1975). The behavioral view calls for change to be brought via the manipulation of environmental consequences, something that can be done comparatively easy in an institutional setting.

Cognitive Theory
Garfield and Bergin (1971), indicate that cognitive theory is one of the sufficient conditions for producing behavioural change. It argues that changes are necessary antecedents to subsequent changes in concrete interpersonal behaviour; one must change the way a person attends to, perceives, construes, or symbolizes himself/herself and the events around him/her. Such approaches argue for the promotion of insight, understanding, elucidation of a problem or admission of hitherto inaccessible events into consciousness awareness. Others argue that changes are a
function of the automatic effects of reinforcement; one must arrange for extinction or desensitization, or conditioned or reciprocal inhibition, or engage in avoidance conditioning. Still others point out to changes in behaviour that can be accomplished by changing the situational conditions antecedent to the behavioural problem and upon which the occurrence of the behaviour depends.

Self-actualization

Maslow (1970) proposed the theory of self-actualization. This model presents human needs in a hierarchical manner and it holds that it is only when basic needs have been met do the higher needs emerge. There are five levels of needs which are, from the lowest; physiological, safety, belongingness and love, self-esteem and finally self-actualization.

Many researches done on street children show that majority of children go to the streets due to lack of basic needs back at home.

Theory of Attachment.

In the theory of attachment, "attachment", is a term used to refer to the psychological bond between a child and his/her parent (or others who care for the child). This relationship is considered by many to be essential to child development, because it enables a child to develop what Erickson (1950) called a "basic sense of trust" and to proceed into the world with a sense of "trust", competence, curiosity and self-reliance. It is widely argued that "the security of the early attachment bond predicts a child's ability to adapt to future developmental tasks (such as forming relationships with peers and non-parent adults and psychological stressors (e.g., separation from a
Secure attachment relationships with adults are thus considered essential protective factors for children who are separated from their families. Institutionalization of street children is one way through which the children can be provided with security as well as other human needs.

According to UNICEF (1997), "children on the street face the unhappy reality of increasing separation from their natural families and become at risk for losing their limited access to basic facilities, such as health, education and recreation. Once this process is underway, it is very difficult to hold in check, with the result that the child may end up abandoning the family or being abandoned by it" (P.7). Donald and Swart Kruger (1994) have noted that, in terms of emotional health, the lack of or loss of an adequate relationship with an adult caregiver poses the greatest problem for most street children. The theory of attachment by Bowlby (1988) has profound implications for street children.
CHAPTER TWO

2.0 Literature Review

2.1 Introduction

Rehabilitation is an institutionalized supportive programme for delinquent juveniles and youngsters of ages between 6-18 years Kariuki et al., (1991). Although the programme was not initially set up for street children, their delinquent nature has made them the programmes' main beneficiaries. The programme is organized in to two types of institutions: approved schools and juvenile remand homes.

Webster's Third New International Dictionary (1991), defines rehabilitation as the process of restoring an individual to a useful and constructive place in society through some form of vocational or corrective, or therapeutic retraining or through relief, or financial aid, or other constructive measure. The issue of street children is a worldwide phenomenon despite cultural differences.

Reasons that drive children to the streets are many and varied. They range from parental inability to cope with demands brought about by rapid social change to instabilities in families. In Kenya, according to Dallape (1987), few studies that have been done show that most children take to the streets because of poor relations at home, hence the street is considered to be a better alternative. In addition, Le Roux (1993) reports that some flee in search of excitement, adventure, personal freedom and self-fulfillment, a comfortable, independent and financially secure life, and to become part of the "action" in society.
According to Le Roux, majority of children abandon their families as a result of socio-economic and other unfavourable factors within the family or immediate environment. These family factors may include; abuse of alcohol and drugs; financial problems and poverty, family violence and family breakup; poor family relationships; parental unemployment and resulting stress; physical and/or sexual abuse of children; parents absent from home as a result of financial reasons, (e.g. migrant labour systems); collapse of family structure; collapse of extended family; and emergence of vulnerable nuclear families in urban areas. This is in line with Wainaina's 1981 report that some children have preferred street life to family life because of poor relations in their families. These children are said to find their home both materially and morally depriving. For instance, their parents brew chang'aa, abuse alcohol and welcome as many boyfriends as possible.

African Network for Prevention and Protection of Children Against Abuse and Neglect (ANPPCAN), (1995) reports that many children, both boys and girls are frequently abused by being beaten and ill-treated on the streets and in the remand homes. They are raped by older street dwellers or adults in remand prisons. Some of them have contacted STDs and AIDS from adults and even tourists. Most of street children contact STDs as early as 8 years and boys as early as 13 years of age. To cope with the above mentioned experiences, Pierre (1995) says that the children engage in drug and solvent abuse such as inhaling glue fumes to escape from reality,
to dull their senses and shut out the cold, loneliness, fear, hunger and so on which offer them solace.

Many interventions have been initiated to address the plight of street children in the country by both the government and civil society. However, there is relatively little detailed study focusing on rehabilitation programmes in rehabilitation institutions for street children. Therefore, most of the available material has been got from local and international NGO research reports and campaign material: reports and studies conducted by multilateral agencies, academic researches, seminar papers, and books on Behavior Change and Modification.

Related literature will be reviewed under the following areas.

- Historical development of rehabilitation centres
- Importance /role of rehabilitation
- Counselling in rehabilitation centres
- Personnel in rehabilitation centres.
- Rehabilitation services

2.2 Historical Development of Rehabilitation Centres

Agnelli (1986), recognizes that at global level, the issue of street children first appeared very late in the wake of the International Year of the Child (1YC), in 1979. Being adopted by the United Nations (UN) system, the idea of asking governments to make special effort for children had originally been proposed by the International
Catholic Child Bureau (ICCB) acting as a forum for the discussion of current child-related issues. During the international year (1979), the ICCB housed the secretariat of the sixty (60) international NGOs taking part in it. It found that many international programmes existed for various categories of children, but none catered for street children who through no fault of their own, fell outside conventional categories. The scope of the issue indicated that a purpose-built initiative should be launched in cooperation with other like-minded organizations. The inter-NGO programme on street children and street youth, the first to draw on the extensive body of expertise and built up in relative obscurity by field workers, appeared in 1982. Perhaps its main achievement beyond giving recognition to those too modest and publicizing their work with funding agencies was to crystallize and articulate the widespread concern throughout the private sector vis-à-vis the international community.

In Kenya, Onyango (1989) observes that according to researchers from various institutions, including the University of Nairobi, Kenya and the Nairobi City Commission (NCC), the problem of street children was first noted in 1969. This is in agreement with the Undugu Society of Kenya annual report (1989) which states that the phenomenon that gave birth to rehabilitation of former street children can be traced back to early ‘seventies’ barely 10 years into Kenya’s independence. The rural-urban migration began to produce what was quickly branded ‘parking boys’ on account of their function of directing motorists to parking lots. This also saw the emergence of slum settlements in the city of Nairobi.
Out of the emergent slum villages came unruly boys, trying to eke out a miserable subsistence either from begging, directing motorists into parking lots or stealing. At night, they would retreat to their shacks in slums or simply huddle on the cold pavements, hopelessly exposed to harsh weather conditions. In those formative years of this nation, there was hardly any institutionalized care system for such disadvantaged children. They were forever condemned to the streets where they had to brave harassment by policemen and thugs. (Undugu Annual Report, 1989).

It’s against such background that rehabilitation centres for street children started coming up. Undugu Society of Kenya is one of such rehabilitation centres. It was founded by Arnold Groi, a Dutch Priest in 1973, after he was struck by the snowballing vicious cycle of poverty and the attendant juvenile delinquency. It is then that this Dutch priest started a parking boy’s programme explicitly to rescue such boys from the stranglehold of urban poverty (Undugu Annual Report, 1989).

According to Epstein (1996), the problem of street children in Kenya first began in the early 1950s when the colonial system broke up families by imprisoning men and women or taking them away to the concentration camps. The children were then left helpless, and they wandered off to the streets of Nairobi with the hope of finding some means of survival.

It was not until 1982 as Onyango and Male (1983) report that the first real concern with street children phenomenon was noted in a National Workshop on Child Labour
in Kenya which was sponsored by the World Health Organization (WHO). During this workshop, the issue of street children was discussed for the first time in a more organized manner. Although the discussions did not generate public interest as such, the Nairobi Provincial Children’s Department in conjunction with the Provincial Commissioner (P.C) of Nairobi constituted a committee to further discuss the problem of street children in Nairobi. Subsequently, the P.C. directed a task force consisting of key ministries in Nairobi Province and major NGOs such as Undugu Society of Kenya be formed to study and write a position paper on the problem.

The Task Force produced a paper entitled "Street Wandering Children" which was later presented at the 1985 Regional Workshop on children in especially difficult circumstances held in Nairobi and sponsored by UNICEF (Khamala, 1985). This paper was subsequently revised based on comments from the workshop and later presented to the Provincial Commissioner's committee, which in turn forwarded the document to the Attorney General (AG). The presentation of the document coincided with growing public concern on the question of street children in Kenya.

It is with this background that the AG’s office approached the Kenya National Academy of Sciences to constitute a research team to objectively assess the state of street children throughout the country. The major purpose was to determine the nature and extent of the problem and appropriate course of action in terms of policies and programmes that could be undertaken by the government to address the problem.
Epstein (1996) reports that in 1990, the A-G's office commissioned a study on street children in Kenya. This study, which was supported by the Ford Foundation and completed in 1991, revealed that the number of street children was found to be rising not only in urban areas, but in the rural areas as well. Street children were found to be in large, medium and small urban and trading centres throughout the republic, at the time of the study. A major finding of the study was that there were no policies regarding the problem of street children. While this was the case, there were actually many organizations mainly NGOs and church groups dealing with the problem.

Since the study was completed, many initiatives have been launched in relation to the problem of street children. Among these we have "Nairobi cares for its children", a national steering committee on street children; a significant number of NGOs emerging to deal with the street children phenomenon increased research activity on street children. New Imprints reports that by 1989 according to some estimates, the city of Nairobi had close to 5,000 street children while national figures provided by the Ministry of Home Affairs and National Heritage stood at 16,300 according to the children's department.

New imprints notes that the situation of children in Kenya remains grim. This is attributed to the prevailing socio-economic hardships, which persist while at the same time, the HIV/AIDS pandemic continues to escalate. The number of AIDS orphans currently stands at one million. In addition, lingering drought has adversely affected the Kenyan populations across the board.
These hardships, combined with other prevailing problems such as ethnic clashes, and single parenthood have adversely impacted on the lives of Kenyan children. This study, which was supported by the Ford Foundation and completed in 1991, revealed that the number of street children was found to be rising, not only in urban areas but also in the rural areas. Street children were found to be in large, medium and small urban and trading centres throughout the republic, at the time of the study. A major finding of the study was that there were no policies regarding the problem of street children. While this was the case, there were actually many organizations mainly NGOs and church groups dealing with the problem.

New Imprints (Nov, 20-23,200) reports that according to Children's Department Annual Report, currently, it is estimated that over 600,000 children in Kenya are classified as children in need of special protection. About 45,000 of these children are requiring institutional care.

2.3 Importance/Role of Rehabilitation

UNICEF (1998) defines 'street children' as all the young girls and boys who have adopted the streets as their abode or source of livelihood, or both. Whether they maintain ties with their families or not, these children are inadequately protected, supervised and directed by responsible adults. Generally, left on their own, they keep to themselves or help their families survive by engaging in odd jobs, such as scavenging, begging, vending and even prostitution.
Ahua and Yoccouba (1985) hold that when working with street children, the ultimate hope is that they will eventually, through a supportive assistance and learning programme, become respected, integrated members of society with rights, opportunities and a future. Mann (2001), reports that it is widely argued that without the care and protection of adults, children are especially vulnerable to abuse, exploitation, malnutrition, disease and death. For example, according to Canadian Christian Children’s Fund (CCCF) "with their parents unable to feed, clothe, educate or protect their health, their only inheritance is destitution and desperation" P.14 Therefore to such children, being institutionalized could be one of the ways of solving some of their problems.

According to Ennew (2000) the institutional solution for street children that has been used historically and still predominates in most countries is some kind of residential setting, a school, an orphanage or a reformatory. Many children find themselves virtual prisoners in the closed environments even if they are not actually put into prison. In too many cases they are treated as delinquents and imprisoned with adults.

Ennew adds that however benevolent an institution may be, it is now recognized by childcare experts that it is not the ideal solution. Children fail to learn the full range of social and emotional skills they will need as adults. It is impossible for them to be treated as individuals and unlikely that they will be able to fully develop their human potential. Institutions are also not cost-effective. They can only take a limited number of children and are expensive to run.
She further notes that closed options are the option generally preferred by governments and municipal authorities, as well as religious and traditional NGOs. This is a tidy solution as it cleans the streets and the children. People, who provide funds, including many donor organizations, are satisfied with the image of a washed child, with clean clothes, elementary schooling, a plate of food and a mug. Children often wear uniforms and live regimented lives. Education is usually limited to provision of basic skills, which are typically carpentry and electrical wiring for boys and sewing and typing for girls.

Ahua and Yoccouba (1985) report that in the Grand Bassam Conference, Africa that it was concluded that the placement of street children in formal institutions for rehabilitation served no useful purpose. Although it suits society to have children out of sight the repressive strict character is considered to contribute to their isolation rather than to promote their reintegration. Swart (1986) expresses the same view by maintaining that, taking the children off the streets and putting them into an institution takes care of their physical needs, but is not a solution to the problem.

Agnelli (1986), maintains that the ability of institutions to rehabilitate the children and keep them out of trouble once they leave is poor. Further, street children are often shunted from one institution to another, becoming more and more difficult to handle. Cockburn (1991) notes that rehabilitation and resocialization are geared mainly to western, middle-class notions of child development, and efforts at "mainstreaming" these may infantalize them and blunt their survival skills.
On the other hand, however, ANPPCAN (1995) is of opinion that of the rehabilitation programmes that have been instituted for the street children, it is the residential ones that have had some measure of success. Notwithstanding the restricted availability of such programmes, they have the advantage of taking the child away from the allurements of the street environment and providing time and space for social re-orientation. A typical example is the Starehe Boy's Centre in Nairobi, one of the most successful school ventures in Kenya, which has turned helpless children into fine scholars, craftsmen and public servants.

Such programmes are much more limited in respect of girls, and where they exist, they have not had as much success as in the case of boys. Girls have proved more difficult to rehabilitate, especially because they have been more amenable to pressures from child abuse and molesters.

In regard to children's view of institutional care, Ennew's findings (2000), reveal that among the ones that have been institutionalized in observation/ remand homes as many as four or five times have expressed their aversion and negative feelings for these oppressive institutions that merely end up making 'criminals' out of innocent children...also, children, as used to being outdoors, resist closed and strictly structured institutions which seem oppressive and prison-like to them and therefore often run away from them. Reddy (1992) contends that one of the reasons why children are on the streets is to escape the confines of their homes and therefore they do not want to trade this for the confines of an institution
A research on street children in rehabilitation centers by Kariuki et al., (1991) reveals that out of 524 respondents, only 9% thought that their being institutionalized would help them. This probably explains why most of them run away from such institutions which are meant to mould them into good citizens.

Street children who are either; rejected, abandoned, or orphaned have a right like any other child to live a decent life. Swart (1998) notes that the Undugu Society of Kenya parking boys' programme was explicitly started to rescue the boys from the stranglehold of urban poverty. Suda (1994) in her report of a baseline survey on street children in Nairobi reports that 17 NGOs dealing with street children had their main objective as "rehabilitate street children and other children in difficult circumstances into responsible members of the society". They try to do this through a wide range of programmes. Most of the programmes are dealing with the provision of basic needs to the children. The majority of the programme activities are basically aimed at moulding the children's characters and restoring their dignity and self-esteem. ANPPCAN (1995) also reports that most of the existing programmes that cater for street children have endeavored to respond to their special needs. Since majority of these children are semi-illiterate or illiterate, the curriculum for their alternative educational syllabus includes the following essential elements: basic literacy, numeracy, nutrition, some vocational training, socializing skills and moral values.

Bellsmith and Peck (1965), assert that delinquents who continue to act in antisocial manner, which is dangerous to them and to the community, should not remain in the
community. Institutional care offers desirable, although limited alternatives. Nevertheless, even a poor placement may have advantages over "sports" of kindness from parent or relative or inadequate agency treatment if there is no continuing or reliable provision for supporting the adolescent in the community. The fact that a rejecting parent or an indifferent school is maneuvering to 'get rid' of an adolescent does not mean that there may not be a valid reason to go ahead with placement, even though one may not accept the rationalizations of the people who are rejecting. Unfortunately, the process mirrored by the campaign to send the adolescent away often makes his remaining in the community unfeasible.

The authors report that the adolescent in need of placement has usually experienced intense rejection from his family. This is either because of his own personality difficulties or because of the disturbances of the other members of his own family; typically, of course it is the result of interaction of negative factors in the parent-child relationship. The child responds to rejection by his family with anxiety and hostility; these feelings may be expressed in overt hostile acts, or they may take the form of destructive fantasies that must usually be rigorously repressed.

To the delinquent, placement appears to him to be not only a punishment for his delinquencies but also a reprisal for his destructive thoughts and fantasies; in consequence, it confirms his most distorted and exaggerated feelings of guilt and self-blame. For most of these young people, placements represent a final act of parental punishment and rejection.
In addition, Belsmith and Peck (1965), observed that some adolescents view the treatment agency from the outset as a place of refuge and help. Because they do not have too many distortions of feeling as a result of their previous experience with parents, siblings, schools or courts, they enter into a positive relationship with relative ease. Other young people however, think of treatment as a new form of adult control and punishment and react to the experience strongly and negatively, they add.

Belsmith and Peck (1965) also noted that in work with delinquents, it is axiomatic that placement as a remedy exacerbates the symptoms. This is true even when a suitable facility is available. When the facility is anything but desirable, which is frequently the case, placement may be a permanently damaging experience.

They continue to argue that parent(s) of an adolescent who is to be placed also goes through considerable emotional upheaval. He, too, is frequently ridden by feelings of guilt and anxiety. To him, placement is often tantamount to admitting that he has failed as a parent. Such an admission carries with it considerable pain, particularly in a culture which places primary responsibility for childcare and child rearing on the parents.

Because of his antisocial behaviour and also because of entrenched community attitudes, the child who has passed through the courts usually must be placed in an institution for delinquents. Most other childcare institutions accept only "neglected and dependent" children.
Levis (1970) states that the goals of rehabilitation programme for delinquent children are to change their current behaviour, to ameliorate social conditions and to better their current lives. The delinquents are taught the practical skills that are essential for them to adjust adequately to the community and to eliminate or markedly reduce forms of antisocial behaviour. Brown, (1980) adds that if the goal is successful adjustment in the community, the more attention need to be given to socially appropriate skills and maintenance outside the institutions.

2.4 Counselling in Rehabilitation Centers

Herbert, (1978) notes that procedures employed to effect various kinds of changes in the behaviour of people have tended to acquire labels so as to permit their ready identification. These labels also suggest significant differences in methodologies, calling for different sets of operations to be performed in different sequences. The labels include psychoanalytic psychotherapy, client-centred therapy, family therapy, operant conditioning therapy, direct counselling, narcosynthesis, play-therapy, psychodrama, encounter groups, rational-emotive psychotherapy, aversive conditioning, hypno-analysis, milieu therapy, residential treatment, LSD therapy, marathon groups, continuos narcosis, and didactic and re-educative procedures.

These alternative procedures have been drawn from varying conceptions as to how a behavioural change can be affected how it occurs and the conditions one needs to
arrange in order for it to take place. They rest upon different theories of behaviour change.

According to Garfield and Bergin (1971), there are myriad techniques which rely upon verbal interventions of one sort or another to effect changes in attitude, perceptions, thoughts and feelings. These tactics have been in man's possession since earliest times, as witnessed by the efforts of Jesus to produce changes in the lives of people by reasoning and persuasion. These have become elaborated to extraordinary lengths following Breuer and Freud's discovery of the 'talking cure' which in effect demonstrated that a particular pattern of verbal procedures could serve to elicit and subsequently to modify dysfunctions in behaviour that had been proven recalcitrant to change by other sets of treatment strategies. These talking cures have proliferated in all manner of directions to effect changes. This rests upon a basic set of assumptions, viz: that a person's overall behavioural organization is governed by his cognitive functions amplified and attenuated by the emotional patterns that have been associated with them. The authors add that changes in ways in which a person perceives, thinks, remembers, evaluates, judges and recalls—in effect, construes and symbolizes events with respect to himself/herself and the surroundings can be effected by devising ways in which (s) he can be led to verbalize those "thoughts". Once they become elicited, they are subjected to modification by a therapist, an interested/friend, a sympathetic teacher or a stranger who has been artfully introduced into a group.
Since it is assumed that a person's actions are guided by such subjective behaviours, it is anticipated that if a person can be brought to think and hence feel differently, he will necessarily come to act differently as well. Ennew (2000) gives an interview report of 258 street children, where, when asked what they wished for, only 7 out of 258 wishes were antisocial or destructive. They wanted psychological support relationships, and a role in society. Less frequently they wished for biological necessities, such as food and shelter.

Eysenk (1952), reports that in spite of phenomenal growth in the field of therapeutic practice, there exists a considerable and growing amount of evidence that seems to suggest that counselling or psychotherapy is ineffective in institutions for delinquent children. Traux and Carkhuff (1967), agree with Eysenk by saying that the average counselling and psychotherapy, as it is currently practised, does not result in average client improvement greater than that observed in persons who receive no special counselling or psychotherapy treatment.

Frank (1961) says that about two-thirds of neurotic patients improve immediately after treatment regardless of the type of psychotherapy received, and that the same improvement rate also has been found for those persons who have not received psychotherapy. However, there also exist some relatively well controlled studies which show that certain counsellors or therapists produce beneficial effects beyond those observed in equivalent control groups.
Bellsmith, *et al.*, (1965) recognizes that there are very few institutions for delinquents today that offer much in the way of formal psychology. There are, however, an increasing number that offer a therapeutic atmosphere, sometimes including psychiatric consultation, and treatment-oriented services on various levels. He emphasizes that the delinquent adolescents are in need of skillful help and planning if they are not to travel the road from institutions for delinquents to reformatories and state prisons.

On the other hand, Garfield and Bergin, (1971) in measurement of client progress in vocation record of Hot Springs Rehabilitation Centre observed that counselling itself, even in the midst of the milieu effects of a comprehensive rehabilitation centre, had significant effects on client learning and vocational rehabilitation progress. In this case, he says that the counsellor relationship in the rehabilitation facility is a significant aspect of total vocational rehabilitation process.

Bellsmith *et al.*, (1965) further notes that in setting therapeutic goals for a delinquent adolescent, the counsellor must endeavor to learn something of the adolescent's own values and goals and of the extent to which these values conform with the standards of the community and with the counsellors' own. In working with the delinquents, certain values must be affirmed and certain limits must be set. Setting limits is a therapeutic device, based on diagnostic considerations. Therapeutic limits, as opposed to authoritative restrictions considers the changing needs of the adolescent within his/her total life situation. They are flexible and geared to the client's capacity to
handle certain aspects of his/her behaviour. When an effort is being made to help him/her understand the meaning of his/her act- such action would be counter-indicated within the context of therapy and authority should not be exercised arbitrarily. It must be used discriminatory to further the overall aim of treatment. The author also asserts that in attempting to set therapeutic goals, the counsellor must be aware of the multitude of personal, social and cultural factors that are operating in the lives of these young people who are in trouble with distrust of most of the accepted community institutions.

Usually, a wide disparity exists between the value system of this group of deprived adolescents and that of the general community. Many of these adolescents for example, have had frustrating and unhappy life experiences and they are therefore likely to look with disdain upon regulations in the society. The goal of treatment is obviously influenced by many diagnostic clinical, social, cultural, and familial elements. Consequently, the capacity of an adolescent to enter a treatment relationship depends not only on the extent and nature of his particular pathology but also on his total dynamic status. His external situation and his inner psychological struggle form an interacting unit. The various elements must be appraised and often must be dealt with in some sort of rotation, if not simultaneously.

Gallogly and Levine (1985), note that individual and group counselling are the major facets of any inpatient treatment programme. Most programmes have a staff member
assigned to each patient. The staff usually provide individual counselling as well as guidance through the programme.

**Group Therapy**

Bellsmith and Peck (1965), argue that some agencies may seize on group therapy as a device for saving staff's time only to discover later that it proves to have an opposite effect. Agencies that work with delinquent adolescents have initiated group treatment largely in an attempt to reach certain individuals who seem unable to profit from individual treatment. The failure of individual treatment for these delinquents is often the equivalent of a sense of doom, since most of them have had a try at many other available community resources.

Group therapy was undertaken in the hope that it would provide means of helping those for whom there are otherwise would be no help at all. Group therapy was initiated after many adolescents in an institutional clinic failed to keep their appointments or kept them sporadically or all of them had failed to establish even a minimal relationship with the therapist. Bellsmith and Peck, (1965), further add that they were either uncommunicative in their interviews or obviously evaded any kind of discussion or experience with the therapist which would involve them emotionally. A number of these adolescents were continuing to engage in serious delinquency, and placements seemed to be the only recourse for many of them.

Bellsmith and Peck again say that the group therapy may provide some help for these elusive and difficult adolescents. This was based on their cognition that many of them
in spite of their poor relationships with their therapists were able to enter into relationships with other people from whom they derived some satisfaction. Since group therapy largely depends on interactions between the members of the group, it seemed possible that productive results may be achieved by bringing a number of these individuals together in a carefully planned combinations. Hence, the authors emphasize that group treatment in inpatient programmes can be the basic means of therapy. They argue that group treatment has two advantages. One, it allows the patients to gain insight into other patients and their problems before looking into themselves and two, group treatment helps patients become more able to confront each other. When group members begin to confront each other, the staff can be facilitative of the process. Smart (1978) is of the view that if patients confront each other, then counsellors do not have to become adversaries of the patients. When patients confront each other, there is more likelihood that they will eventually confront themselves

The rationale of group therapy is described by Peck (1951) as follows: The patients in groups seem to have therapeutically significant relationships between themselves in addition to the shadowy reflection of parental or sibling conflicts; for even at the outset, one can detect the ties which represent the reality of the patient's present social relationships. These ties may assume the form of common problems, similar family or work experiences, or central cultural interests. In ordinary social relationships on meeting a stranger, we often find ourselves trying to dig up a mutual acquaintance or a common past experience. Slavson speaks of "social hunger"; but whatever we call
these social manifestations they seem to grow out of essential nature of man as an organism operating within a society in which his very existence depends upon the co-operative labour of his fellows.

Within the therapy group, some patients quickly proceed to establish and utilize these co-operative ties. Others distort or deny them and few may seek to establish such ties where none really exists. However, in the therapy group, we have access to these distortions very much as they occur in the patient's day-to-day relationships. For although the historical beginnings of such distortions may be traceable to early family life, they have been shaped and maintained by later life experiences which may contain elements similar to those in the earlier situations. This similarity is not simply a figment of the patient's distortions but often reflects the presence of those destructive forces in our society, which act on family, work and social life alike.

The patient may thus come to invest a mate, friend, or fellow worker with values inappropriate to the actual nature of their true social relationship to him. For example, a patient may react to a prolonged and continuous threats to his security with generalization that most people are only waiting to attack or get the better of him, and may then elaborate certain exploitative devices of his own designed to protect him. On the other hand, his defense against hurt may be to evade the brutal competitive struggle he feels life to be, and he may employ elaborate camouflage to deny to himself qualities in people or situations which may conflict with his own picture of himself. Characteristically, he fails to perceive the common elements existing between himself and others who have such basic ties to him as those of class, real goals, or mutual problems.

The patient's basic distortions may be most apparent in his relationships to certain types of people as for example the opposite sex or dominating and authoritative figures. On the other hand, he may be able to set up more
adequate and satisfying relationships with the same sex or with more submissive individuals.

A properly selected group will thus expose the patient's characteristic distortions as they appear in the interaction between him and certain members of the group. Since he is also capable of entering into relatively healthy relationships with certain other members of the group, he is able more easily to examine and work through his relationship distortions because reassuring reality of his healthy social ties within the group supports him. P.65.

**Individual Therapy**

Bellsmith and Peck (1965) are of the opinion that if treatment is to be appropriate to the delinquent's particular needs, it must be a fluid process continually modified to meet the change in his social situation and his feelings. The life situation of a delinquent must be carefully related to the clinical findings that emerge in the interview setting. They further assert that his responses to the treatment situation can have little meaning unless he is viewed within the framework of the many momentous and often overwhelming experiences with which he must cope. Unlike patients whose tensions are largely internal, the delinquent may not find great support in a few therapeutic sessions. One or two hours a week may have only this arithmetically proportional influence on him, since he is exposed during the remainder of the week to critical situations that counteract and often nullify the therapeutic influence.

The authors also are of the view that effective treatment for the delinquents as well as for others requires that the patient be helped to achieve an emotional experience that he has been unable to find, or accept, elsewhere. The delinquent as a rule has failed to establish a satisfactory relationship in which he has felt approved and accepted and
free to express hostility without fear of punishment or reprisal. To establish a relationship with fearful adolescents whose experiences with adults have been chiefly negative is a most difficult therapeutic task. Their defensive and hostile reaction to their recent court experiences obviously adds to the problems involved in establishing initial rapport. The approach, therefore, must be as non-threatening as possible.

Peer-Counselling.

Ahua and Yoccouba (25 Fé, 1985), advocates for introduction of peer counselling which is child-child teaching peer counselling workers on the assumption that street children are their own best confidants. Children who have already come to terms with and resolved some of their difficulties can be trained in basic counselling techniques. Having actually 'lived' similar problems to other street children they may be able to communicate more successfully with them. The shared experiences and language can lead to greater understanding and complicity.

2.5 Personnel in Rehabilitation Centre

Truax's (1967) research in relation to the therapist's interpersonal skills reveals that effort to isolate variables in the therapeutic process that effectively alter maladaptive client behaviour must involve the person of the therapist. Irrespective of whether we call him a therapist, a counsellor, a doctor, a social worker, a priest, an educator or simply a "helping person, he is officially employed as the agent or catalyst for change. He is basic to the psychosocial endeavor to change the patient for the better.
Bellsmith and Peck (1965), believe that it is the reinforcing and cumulative impact of many frustrating and traumatizing experiences which produce the acting out type of pathology in the adolescent, and that this same process may operate in reverse contributing to his survival. The authors further say that permission of the constructive use of such potential assets in delinquent adolescents takes considerable skill on the part of the worker. He may approach the task somewhat optimistically if he recognizes that sometimes he needs only to assist in developing the strengths and potentials already there rather than undertake the overwhelming and usually impossible tasks of trying to start from scratch to build a positive structure solely within the confines of the therapeutic relationship.

Truax and Wargo, (1966); Truax and Carkhuff (1967) outline three characteristics of an effective therapist from divergent viewpoints. One, an effective therapist is nonphony (narrow-minded), non-defensive, and authentic or genuine in his therapeutic encounter. Two, one who is able to provide non-threatening, safe, trusting, or secure atmosphere through his own acceptance, positive regard, love, valuing, or non possessive warmth, for the client; and finally, one who is able to understand, "be with", "grasp the meaning of, " or have a high degree of accurate empathic understanding of the client on a moment-by-moment basis. These ingredients of the psychotherapeutic relationship are aspects of human encounters that cut across the parochial theories of psychotherapy and appear to be common elements in a wide variety of psychoanalytic, client-centred, eclectic, or learning theory approaches to psychotherapy.
Le Roux (1994) observed that street children come from nuclear families, especially single-parent households headed by the mother. Frequently, they had no positive father figure and suffered parental rejection and physical hardship. Consequently, they are reluctant to trust adults and find any authority or control imposed on them irksome. Yet they yearn to return home provided that the familial factors that drove them away change. Therefore, the staff should as Smith et al., (1965) maintain; be warm, supportive, helpful, and realistic about the practical problems of the delinquents. Such an experience makes the adolescents feel that not all adults are allied against them and as a result, they begin to examine their projections of their hostile feelings towards their families, community and authority.

Since the delinquents' suspicion and distrust of the worker and the agency tend to stimulate negative responses, the social worker (counsellor) must learn to deal with his own feelings of frustration and annoyance, and not permit them to interfere with the therapeutic opportunity. The authors further note that special precautions must be taken to ensure the establishment and maintenance of the relationship if the treatment is to proceed at all. As the relationship develops, the adolescent's negative responses must be carefully controlled therapeutically, since most of these young people have little capacity to tolerate sustained anxiety.

Mangwana (1992) advises that the rehabilitation staff should treat the children with respect and this will likely be reciprocated. But he further cautions that defensiveness, suspicion and mistrust often characterize initial contact. Schurink and Rip (1993), say
that research has shown that no treatment programme designed for street children can succeed unless the community is prepared to respect, protect and provide opportunities for them. Any human being hates being treated with contempt. Gebers (1990) research on "health of street children in Cape Town" indicates that street children tend to avoid seeking medical care because they find health facilities intimidating, and health care providers show a "lack of tolerance of the kids and their lifestyles" P. 13. Street children's bad experiences with the authorities generally make them suspicious of any official.

Scharf (1988) comments that it is unfortunate that the institutions where those childcare professionals work, which range in philosophy from "the benign to the punitive," do little or nothing to address the causes of the street child phenomenon. He adds that in S. Africa in particular, it is also felt that "children are forced to fit treatment programme instead of the other way round".

All in all, Mclachlan, (1986) commends the findings of the De mayer Commission, which was a step forward in S. Africa that called for qualified, motivated professional staff to meet the psychological and emotional needs of institutionalized children. On the other hand, Swart (1987) has observed that the burnout experience by childcare workers is high. Mc Lachlan (1986), confirms the stressful conditions faced by childcare professionals, who have to deal with socially and psychologically scared children on a daily basis.
2.6 Rehabilitation Services

Myers (1991) reports:

Effective programming depends on being able to comprehend the problem from a variety of perspectives, including some that appear contradictory. Without such comprehension, there is a risk of launching simplistic actions that are not only ineffective, but perhaps even detrimental to the welfare of the children involved. Unfortunately, this very situation has often occurred. P.123.

Levine and Gallogly (1985), say that general objectives for inpatient group services are important for programme and development structure. Each patient admitted to an inpatient programme may need some of the programme goals. Individual goals for such patients must be established according to individual needs. The same patient may need a different set of individualized goals upon admission (Peckham (1977)).

Kissin and Begleiler (1977) notes that one of the major problems in many current inpatient programmes arises from the attempt to meet all goals for all patients each time they are admitted. It is better to set a few realistic and achievable goals for each admission and concentrate the energies of the staff and patients on these, rather than to waste resources and efforts attempting to accomplish everything at once.

In addition to wasting staff and patient's effort, an overload of goals leads to increased chances of failure. The result is loss of staff and patients' morale. Small, realistic, achievable goals increase the chance of success and can lead to improved staff and patients' morale. It is almost redundant to suggest that improved patient morale through success in achieving goals can increase hope for recovery and result in more recovery effort (Levine and Gallogly, 1985).
Levine and Gallogly further argue that, there are three kinds of services in an inpatient programme.

1) Patient/staff meetings: meetings and procedures that develop and maintain the social atmosphere and growth of the unit.

2) Education: discussions and class sessions that provide an understanding of alcoholism.

3. Treatment: Counselling sessions aimed at helping patients achieve sobriety and developing alternative behaviours for coping with stress.

Balance and Flow of Communication in an Inpatient Programme

According to Margolis et al., (1978) ideally, the ebb and flow of communication in an inpatient programme is balanced among the patients and staff. Balance in the flow of communication means that both the patients and staff freely contribute to the communication system. Ideas and initiatives can begin with the patients or the staff. Most important, there must be freedom for feedback from patients to staff. If this freedom exists in the social environment, the feedback will be both positive and negative and will be shared not only among the patients but also between patients and staff. However, in an observational survey of fifteen inpatient programmes, the observer found that most of the programmes had extremely imbalanced communication. According to Levine (1983), there were few or no initiatives from the patients, nor feedback from the patients to staff. Many programmes featured individual and group services and, perhaps, responded. Rogers, (1962) comments that
there is little learning that can take place in a structure that does not allow for feedback and questioning of the issues.

A major task in developing a two-way flow of communication in an inpatient programme is staff preparation. In general, counsellors who have been involved in alcoholic treatment and/or training system have been exposed primarily to educational methods of helping. They have learned to "tell and convince" information from alcoholic clients. There are many ways in which the listening skills of counsellors can be developed through training, consultations, and workshop with professionals who are experts in therapeutic communication.

According to Margolis et al., (1978), counsellors who are truly comfortable with their own mixed feelings about drinking and sobriety are more able to learn or are already open to listening to clients. Counsellors who are uncomfortable or unaware of their own mixed feelings need help to develop awareness and ease with these feelings in order to develop an increased capacity for listening to clients. If counsellors do understand and accept their own mixed feelings they are more likely to resort to lecturing and convincing when confronted with the mixed feelings of their clients.

**Groups for Development and Sustenance of Social Interaction**

For an inpatient programme to use effectively the various structures and services, it is important for each service to have clear and realistic goals, (few in number) that distinguish the service from all others. When goals for each service are clear, it is
surprising how easily patients not only bring appropriate material, but also use each group for its intended purpose. When patients do not understand what is expected or when too much is expected, they will have difficulty with a multiplicity of groups.

Morning Meetings

The early morning meetings can be the foundation of good interaction. Morning meetings function to clarify any difficulties from yesterday and to set a treatment atmosphere for today. Therefore, morning meetings are best scheduled as the first meeting of the day. Morning meetings often run from 30 minutes to 1 hour. If they are held daily, perhaps 30 minutes is adequate. It is important that these meetings include all patients and staff. Representatives of the evening and the night's staff can be helpful. Morning meetings focus on reaction to the programme of the previous day and expectations of the current day.

Perhaps it is important to consider the feedback and criticism and initiate some changes in the programme. However, the most important function for the morning meetings is to release pent-up feelings about the programme. Almost as soon as a staff expresses understanding of the negative feelings, patients begin to feel better about the particular staff member and the programme as well. Even if nothing is changed, the more expression and understanding of the feelings facilitates the process for the day. If the patients suggest changes for the unit, the ideas can be transferred to the patients-government's meetings. Morning meetings are more useful if the goal is expression and reaction, rather than decision about the unit.
Patients-Staff Meetings

Patients-staff meetings are the focal points of inpatient services. There are three purposes for patient-staff meetings. One is to keep the channels for patient-staff communication open. Two, is to resolves issues between patients and staff and the last purpose is to resolve issues among patients.

Although patients-staff and patient-patient communication is the goal of patient-staff government meetings, these meetings can also provide opportunities for staff to express their thoughts to the patients. For example, if the staff want to initiate change in the programme, the patients-staff meetings provide a place to share the proposed changes and get feedback from the patient about the change. If patients have an opportunity to react to the change, they will be more able to accept the change when it is implemented. Patients often have good ideas. Listening to their ideas may help staff make plans more suitable to the patients.

The structure of the patient-staff meetings varies greatly among programmes. One or two meetings a week, for one-to-one and one-and half-hours are usually sufficient for conducting patient-staff business. All staff and patients must be included in the meeting. Many programmes include housekeeping and dietary staff, especially if the patients have duties in these departments. Also, inpatients frequently have problems with dietary and housekeeping departments. In this case, mutual discussion may not only clear up the problem but also serve as a good experience for patients to solve
problems instead of resolving to drink. A town meeting concept works well for patients-staff meetings. The concept assumes that all staff and patients are members of the community. Some members of the community each have their role (provider of services, consumer of services) and each has ideas, feelings and reactions to life in the community. Staff and patients can offer their respective points of view as members of the community.

The best focus for the patients-staff meetings are the issues arising in the life of the community. Good examples are incidents in the daily life of the community: time schedules, changes, reaction to behavioural of individual staff or patients and, above all, conflicts between staff and patients or among patients (Stead and Viders (1979). Thus, the patients-staff's meeting provide a living opportunity for patients to experiment with the new ways of coping with interpersonal situations, rather than flight or drink. The quality of the interaction between staff and patients and among patients occurring in patient-staff meetings usually reflect the quality of interaction in the patient-staff meeting and this will facilitate the change in the interaction through out the life of the programme.

**Progress Meetings**

This is a weekly meeting in which patients can evaluate their progress or lack of progress with the help of their counsellor and other patients. Progress meetings can help patients gain support for their effort and growth during the week. These meetings can also be a place for earlier detection and action with patients who are not engaged
help patients gain support for their effort and growth during the week. These meetings can also be a place for earlier detection and action with patients who are not engaged in treatment. They are more useful if counsellors hold them with the patients for whom they have major responsibility. The importance of having this evaluation in a meeting, rather than individually, is that the other patients can often learn more about their own progress by first evaluating others.

Although the focus is on the effort or lack of effort of the patient during the past week, the meetings should be opened to the re-evaluation of the patient's programme. A progress group must consider why patients are not making sufficient effort and progress. A patient who is not responding to one group may have a better response to a different group.

Criteria for evaluation must coincide with the goals of the programme and goals of the particular patients Pattison et al., (1969). The more specific the criteria, the better the evaluation. If patients in the group are aware of the criteria, they can be more active in evaluating each other and themselves. Evaluation group functions best when the emphasis is on specific and current ideas about the progress or lack of progress. Progress groups are useful for considering passes and discharges. Specific criteria for evaluation plans for passes and of prior passes are important. The specific criteria, however, must coincide with the goals of the programme for the patient.
Recreation Groups

Levine and Gallogly (1985) say recreational groups can serve several major purposes in an inpatient treatment programme. These include helping to develop and sustain the communication and interaction level of the programme, providing opportunities for the patients to raise their self-esteem and helping patients to develop ways to relieve the boredom that often contributes to drinking and so forth. A well-conceived recreational programme can help introduce patients to different ideas of their leisure time and socialization.

Development or reactivation of hobbies of interest to the patients can help dissolve boredom and raise self-esteem. However, it is crucial to discover realistic past or potential interests of the patients and help them develop and begin to pursue those interests while inpatient. The services of skilled recreational or occupational therapists can be very helpful for this task.

Focusing on activities and games that are interesting and appropriate to age group is helpful in meeting the socialization needs of the patients. These activities can also serve as vehicles for meeting and joining others with similar interests. Some examples are card games, table games and lifelong athletics like golf and tennis. Current interests in physical fitness and exercise are potentially useful for leisure time and socialization. In addition, aerobic exercise such as jogging, running and bike riding have demonstrated potential for mood evaluation. Aerobic exercise could help replace alcohol for good feelings. Exercise may also be helpful for the deteriorated physical
condition that often accompanies alcoholism. A balanced inpatient programme cannot overlook the usefulness of helping patients to develop an interest in physical conditioning.
CHAPTER THREE

3.0 METHODOLOGY

This chapter presents a discussion on the following: Research design, subjects identification, area of study, sampling procedures, research instruments, pilot testing, data collection and analysis of the data.

3.1: Research Design

This was a descriptive study and was therefore conducted as a survey design. According to Cohen and Lawrence (1995), a descriptive study gathers data at a particular point in time with intention of describing the nature of existing conditions or identifying standards against which existing ones can be compared or determining relationships that exist between specific events. This method has the advantage of being an effective way of collecting data from a large number of sources relatively in a cheap and perhaps in a short time (Verma and Beards, 1981). Opinions of two groups of respondents were considered, that is, the street children and adolescents (rehabilitatees) and the centres staff. The study investigated the perception the two groups have towards the rehabilitation programmes for former street children.

3.2: Subjects

In investigating the effectiveness of rehabilitation programmes for former street children and adolescents, the centres' staff (social workers) and the rehabilitatees were used as respondents. The subjects were selected from the rehabilitation centres for former street children/families in Nairobi that are run by the City Council. The research was conducted in the month of May 2004.
A total of 14 staff and 151 former street children and adolescents aged between 10 to 21 years were involved in the study. Those below 10 years were assumed to be too young to understand themselves and their environment.

3.3: Location

The study was conducted in Nairobi in three rehabilitation centres for former street children/families. These centres were Kayole, Bahati and Pumwani/Mbotela and selected purposively.

3.4: Sampling Procedures

In this study, two groups of subjects were involved. These are the rehabilitatees and the social workers. The two groups were selected from three centres although two centres had been put together to make one centre. These were sampled out purposively from the four centres run by Nairobi City Council. The respondents were also sampled using the same method. Purposive sampling was found appropriate following the experience of pilot testing. The experience revealed that most of the rehabilitatees had extremely low levels of literacy besides low concentration levels, while a few of them were not sober enough to answer the questions adequately as a result of the effects of drugs they were using or had used. Again, two of the centres were found to have elderly men and women who were above the age that the study was interested in.
Since the staff had considerable knowledge of the rehabilitatees, the researcher sought their help in getting the research sample. Singleton, Straits & Straits (1993) explain that in a situation that impedes random sampling, purposive sampling is an acceptable alternative. They state that the basic assumption behind purposive sampling is that with good judgement, we can handpick the cases to be included and thus develop samples that are satisfactory in relation to our needs. Considerable knowledge of the population is paramount for purposive sampling to be effective.

3.5: Research Instruments

Data were collected using two sets of questionnaires as the main instruments. One for the social workers and the other for the children and adolescents. Key informant interview schedule and an observation checklist was also used. Gay (1992) and Mugenda and Mugenda (1991) contend that descriptive data are typically collected through questionnaires, interviews or observations.

3.6: Pilot Testing

This involved fifteen children and four social workers from two institutions. The main purpose was to cross check the suitability of the questionnaires and the adequacy of the whole questionnaire. Specific areas that were checked during this time included:

- The clarity of each questionnaire and the instructions.
- The length of time taken by a respondent to complete filling a questionnaire.
- The adequacy of the spaces provided for the written responses and
The simplicity and suitability of the language used.

After piloting, the questionnaires were discussed with respondents, colleagues and the supervisor. The following questions were used as guidelines.

- Were the instructions clear?
- Were any of the questions unclear or ambiguous?
- How long did it take you to complete?
- Did you object to answer any of the questions?
- In your opinion, has any major topic been overlooked?
- Was the layout of the questionnaire clear?
- Any comments?

After this discussion, the questionnaire was revised and the copy refined.

3.7: Data Collection

The researcher presented herself in person in the selected rehabilitation centres so as to make the necessary arrangements with the institution heads. On the agreed date, the researcher visited each rehabilitation centre together with her two research assistants to administer the questionnaires. The researcher requested the centres' head to fill in their questionnaires. The other members of staff (social workers) were also approached through the head of the centre to complete their questionnaires. The staff were selected purposively. Questionnaires in a rehabilitation centre were completed the same day to avoid leakage.
The researcher introduced herself and her assistants to the rehabilitatees and the staff before commencing the administration of the questionnaires. The researcher also emphasized on the need for honesty and also informed her audience that their honesty in their responses would assist in improving rehabilitation programmes in rehabilitation centres, which would benefit them a great deal. The researcher and the research assistants through the help of social workers dealt with the children one after another.

Finally, the researcher thanked the rehabilitatees for their cooperation. The programmes' administrators and the general staff were also thanked.

3.8: Data Analysis

After collecting the data from the rehabilitatees and the staff, interpretation was done using the Statistical Package for Social Sciences (SPSS). Descriptive statistics such as frequencies and percentages were used to summarize data on closed-ended items. The data were organized into themes pertinent to the study and presented using descriptions and quotations.

For objective items on the questionnaire, first, the data were computed in terms of percentages according to the categories on the true or false responses. Thus responses were tabulated on the basis of how many gave TRUE responses and FALSE
responses respectively and presented as percentages of the total number of responses. The analysis of the data from the two sets of questionnaires was organized to address the research questions of the study. Results from the key informant interview schedule and the observational checklist were used to countercheck and reinforce findings from the staff and the rehabilitatees.
CHAPTER FOUR

4.0 Results of the Study

4.1 Introduction

This chapter presents the results of the present study which were collected from 151 former street children and adolescents out of the 820 rehabilitatees in three rehabilitation centres in Nairobi manned by the Nairobi City Council (NCC) and 14 staff working in the centres. Out of a population of 151, fourteen were females and the rest were males. The concern of the study was to investigate the effectiveness of the rehabilitation programmes in the centres for former street children and adolescents. A descriptive analysis was done to determine the frequencies of variables followed by a qualitative analysis of open-ended questions.

The organization of the results is tied to the research questions that guided this study.

a) What are the services and activities available in the rehabilitation programmes?

b) Who provides rehabilitation services (staff composition)?

c) Are there guidance and counselling services in the centres?

d) What is the attitude of the rehabilitatees towards their rehabilitation programme?

e) Is the programme helping the children and adolescents to be rehabilitated?

4.2 Research question one: What are the services and activities available in the rehabilitation programmes?

This question sought to identify the kind of services and activities that children admitted in these centres benefit from. They are presented in Table 4.2(a).
Table 4.2(a): Services Provided

<table>
<thead>
<tr>
<th>Services</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic needs (food, clothing and shelter)</td>
<td>14</td>
<td>100</td>
</tr>
<tr>
<td>Counselling</td>
<td>13</td>
<td>92.9</td>
</tr>
<tr>
<td>Medical care</td>
<td>11</td>
<td>78.6</td>
</tr>
<tr>
<td>Spiritual nurture</td>
<td>9</td>
<td>64.3</td>
</tr>
<tr>
<td>Formal education and vocational training</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Linkages with families</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Rehabilitatees versus staff meetings</td>
<td>5</td>
<td>35.7</td>
</tr>
</tbody>
</table>

From the information contained in Table 4.2(a) above, provision of basic needs was rated as the top priority in the centres (100%) followed by counselling and medical care. Rehabilitatees versus staff meetings had the least percentage (35.7%). However, some of the services mentioned in Table 4.2(a) were highlighted for improvement in addition to others. This is reflected in Table 4.2(b).

Table 4.2 (b): Areas/Services Requiring Improvement

<table>
<thead>
<tr>
<th>Areas/Services</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities like offices</td>
<td>11</td>
<td>78.6</td>
</tr>
<tr>
<td>Counselling</td>
<td>10</td>
<td>71.4</td>
</tr>
<tr>
<td>Follow-ups between and after rehabilitation</td>
<td>10</td>
<td>71.4</td>
</tr>
<tr>
<td>Formal education</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Home visits and reintegration</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Increase in number of appropriately trained personnel</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>Vocational training in the centre</td>
<td>3</td>
<td>21.4</td>
</tr>
</tbody>
</table>

Information in Table 4.2(b) reveals facilities like offices as the most urgent concern requiring improvement (78.6%). Counselling and follow-ups between and after rehabilitation were also pointed out with an equal magnitude of 71.4%. Besides the
services provided to the rehabilitatees, there are activities availed to them that are aimed at enhancing the services in order to facilitate their rehabilitation. Information contained in Table 4.2(c) shows the details of these activities.

**Table 4.2c: Activities the Adolescents are Involved at the Centers**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laundry and personal hygiene</td>
<td>146</td>
<td>96.7</td>
</tr>
<tr>
<td>Recreational activities</td>
<td>128</td>
<td>84.8</td>
</tr>
<tr>
<td>Cleaning of the centre and preparing meals</td>
<td>102</td>
<td>67.5</td>
</tr>
<tr>
<td>Holding prayers and going to church</td>
<td>100</td>
<td>66.5</td>
</tr>
<tr>
<td>Learning(studying)</td>
<td>75</td>
<td>49.7</td>
</tr>
</tbody>
</table>

The information in Table 4.2(c) indicates that laundry and personal hygiene are activities that majority of the respondents engage in (96.7%) at the centre followed by recreational activities. Learning /studying had the least participants (49.7%). Finally, the centres' objectives were also considered on the assumption that the services and activities availed to the rehabilitatees are all basically geared towards realization of these objectives. Information on the objectives is presented in Table 4.2(d) as was given by the staff.
Table 4.2(d): Objectives of the Programmes

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mold their character and restore their dignity and self-esteem</td>
<td>11</td>
<td>78.6</td>
</tr>
<tr>
<td>Rehabilitating them into responsible members of society</td>
<td>10</td>
<td>71.4</td>
</tr>
<tr>
<td>Provide basic needs to the rehabilitatees</td>
<td>7</td>
<td>50</td>
</tr>
</tbody>
</table>

The second question sought to know the characteristics of the personnel who provide these services. Information on their characteristics is presented next.

4.3: Research Question Two: Who provides rehabilitation services in the centre (staff composition)?

The ages of the staff in these centres were collected and are presented in Table 4.3(a).

Table 4.3(a): Age of the Staff in the Centres.

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-35</td>
<td>11</td>
<td>78.6</td>
</tr>
<tr>
<td>Above 35</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Below 25 years</td>
<td>1</td>
<td>7.1</td>
</tr>
</tbody>
</table>

A close examination of the information in Table 4.3(a) clearly shows that the highest number of the staff in the centres is in 25-35-age bracket. Only one was below 25 years of age and 2 were above 35 years. Gender composition of the staff was also examined as indicated in Table 4.3(b).
Table 4.3(b): Gender Distribution of Respondents (Staff)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>10</td>
<td>71.4</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>28.6</td>
</tr>
</tbody>
</table>

Details in Table 4.3(b) indicate that the staff is composed of both males and females with the females constituting the majority. The staff's academic qualification was also considered and table 4.3(c) contains the information on this variable.

Table 4.3 (c): Academic Qualification of the Staff

<table>
<thead>
<tr>
<th>Academic Qualification</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Certificate</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>Degree</td>
<td>3</td>
<td>21.4</td>
</tr>
</tbody>
</table>

Information in Table 4.3(c) shows that more than half of the staff (57.1) had diploma certificates with the rest sharing an equal number as degree and certificate holders. However, these staff had different professions as detailed in table 4.3 (d).

Table 4.3 (d) Staff’s Profession

<table>
<thead>
<tr>
<th>Profession</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellors</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Social workers</td>
<td>6</td>
<td>42.9</td>
</tr>
<tr>
<td>Teachers</td>
<td>1</td>
<td>7.1</td>
</tr>
</tbody>
</table>
Information from the above table 4.3(d) shows that the staff is composed of counsellors, social workers and a teacher. The dominant profession is counselling which is accounting for exactly one half of the staff population and closely followed by the social workers. Teachers had the least representation 7.1\%).

Out of the thirteen respondents on this item, almost all of them in the three rehabilitation centres were working on volunteer basis (92.3\%) with only one (7.1\%) on attachment. This information is contained in Table 4.3(e)

**Table 4.3(e): Terms of Service**

<table>
<thead>
<tr>
<th>Terms of Service</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer</td>
<td>12</td>
<td>92.3%</td>
</tr>
<tr>
<td>Attachment</td>
<td>1</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Also put into consideration was the staff's working experience. The results indicated that none of the staff had worked with the street children for over five years. While in the centre, the staff is assigned duties as shown by the information in Table 4.3(f).

**Table 4.3(f). Assignment of Responsibilities**

<table>
<thead>
<tr>
<th>Responsibilities</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellors</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Teachers</td>
<td>5</td>
<td>35.7</td>
</tr>
<tr>
<td>Nurse aid</td>
<td>2</td>
<td>14.3</td>
</tr>
</tbody>
</table>
The information in Table 4.3(f) indicates that half of the staff are assigned counselling responsibilities while 35.7% are given teaching role and the remaining two had nursing duties. The next section deals with research question three.

4.4: Research Question Three: Are there guidance and counselling services in this center?

Table 4.4(a): Guidance and Counselling Services Offered

<table>
<thead>
<tr>
<th>Offered</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>146</td>
<td>96.7</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>3.3</td>
</tr>
</tbody>
</table>

The rehabilitatees gave the information contained in Table 4.4(a) which shows that, guidance and counselling services were offered in the three rehabilitation centres as indicated by 96.7% of the respondents. This information is confirmed by the staff's response where all of them indicated the presence of services. Presence of guidance and counselling services is further enhanced by the children's response on the question asking them whether they had received guidance and counselling services where 89% consented to have received the services. However, 67% of the staff respondents indicated that they did not have a counselling office in their centres. This was also confirmed by the results of the observational checklist where absence of counselling offices was noted in all the three centres visited. Different professionals as depicted by the information in table 4.4(b) offered guidance and counselling services in the centers in respect to staff's responses.
Table 4.4(b): Personnel Offering Guidance and Counselling Services at the Centres

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellors</td>
<td>10</td>
<td>71.4</td>
</tr>
<tr>
<td>All above</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Teachers</td>
<td>1</td>
<td>7.1</td>
</tr>
<tr>
<td>Social workers</td>
<td>1</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Information in Table 4.4(b) indicates that counselling by the centre staff is mainly done by the counsellors (71.4%). However, the rest of the staff also assist but in a relatively low magnitude. The results of rehabilitatees response on the same question revealed that guidance and counselling services are offered by both the staff in the centre (who the rehabilitatees generally refer to as teachers) and health workers. This concurred with the results of the response from the staff and key informant interview schedule. Heath workers are the ones mainly involved in the service (97.4%). These counsellors (health workers as known by the rehabilitatees) are not part of the centre staff as indicated by 89.4% of the respondents. They visit the rehabilitatees in the centres for counselling more than once in a month (57.0%) and the main mode of counselling is group approach.
The above information can be observed in Tables: 4.4(c), 4.4(d) and 4.4(e) in that order.

Table 4.4(c): Where the Counsellors (Health Workers) Come From

<table>
<thead>
<tr>
<th>From</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without</td>
<td>135</td>
<td>89.4</td>
</tr>
<tr>
<td>Within</td>
<td>16</td>
<td>10.6</td>
</tr>
</tbody>
</table>

Table 4.4(d): Counselling Frequency

<table>
<thead>
<tr>
<th>Counselling frequency</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than once in a month</td>
<td>86</td>
<td>57.0</td>
</tr>
<tr>
<td>Once a month</td>
<td>43</td>
<td>28.5</td>
</tr>
<tr>
<td>Once a week</td>
<td>22</td>
<td>14.6</td>
</tr>
</tbody>
</table>

Table 4.4(e): How Counselling is done

<table>
<thead>
<tr>
<th>How counselled</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a group</td>
<td>108</td>
<td>71.5</td>
</tr>
<tr>
<td>Alone</td>
<td>43</td>
<td>28.5</td>
</tr>
</tbody>
</table>

The results on the staff’s response on the methods they used in guiding and counselling the rehabilitatees showed that both individual and group approach were used. However, on the mode of counselling preferred, majority of the rehabilitatees
indicated an inclination towards group counselling (55.6%) and many of them preferred male counsellors (39.1%). An almost equal number (38.4%) had preference for either male or female counsellors.

The study also endeavoured to establish the areas that the rehabilitatees had received counselling on. The findings were as presented in Table 4.4(f).

Table 4.4(f): Areas Received Counselling on

<table>
<thead>
<tr>
<th>Areas counselled on</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>STIs and HIV/AIDS</td>
<td>143</td>
<td>94.7</td>
</tr>
<tr>
<td>Effects of drugs on human health</td>
<td>134</td>
<td>88.7</td>
</tr>
<tr>
<td>Relating with others</td>
<td>103</td>
<td>68.2</td>
</tr>
<tr>
<td>Career and vocation</td>
<td>71</td>
<td>47.0</td>
</tr>
</tbody>
</table>

A look at the information contained in Table 4.4(f) indicates the area that most rehabilitatees had been counselled on is STIs and HIV/AIDS (94.7%). Effects of drugs on human health was the second with also a relatively high percentage (88.7%). Career and vocation emerged as an area that the rehabilitatees had least been counselled on.
4.4: Research question four: What is the attitude of the rehabilitees towards their rehabilitation programme?

To answer this question, items on the rehabilitees' feelings and their level of satisfaction with services and activities availed to them were considered among other things. The staff's opinion was also sought to determine whether the rehabilitees' attitude was positive or negative. This was aimed at reinforcing the responses of the two groups of respondents (rehabilitees and the staff).

The centre staff was of opinion that the rehabilitees were happy with the services they provided to them. This was indicated by 100% agreement hence the rehabilitees' attitude can be said to be positive. They were also asked whether they enjoyed participating in the activities that were availed to them as part of their rehabilitation programme. The number of rehabilitees who enjoyed participating in the activities offered by the programme was overwhelming. Only 8.6% declared that they did not enjoy being involved in these activities. This also indicates positivism towards the programme. The information in the following table also shows the rehabilitees attitude towards their rehabilitation programme.

Table 4.5(a): Attitude towards Rehabilitation Programme

<table>
<thead>
<tr>
<th>Activities</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I like going to the field to play</td>
<td>134</td>
<td>88.7</td>
</tr>
<tr>
<td>2. I feel better after going to church/mosque</td>
<td>123</td>
<td>81.5</td>
</tr>
<tr>
<td>3. I like sticking in the centre</td>
<td>115</td>
<td>76.2</td>
</tr>
<tr>
<td>4. I like going to school/learning</td>
<td>113</td>
<td>74.8</td>
</tr>
<tr>
<td>5. I like cooking and cleaning activities</td>
<td>108</td>
<td>71.5</td>
</tr>
</tbody>
</table>
Details contained in Table 4.5(a) clearly show that majority of the respondents are comfortable with their rehabilitation programmes. This is because the magnitude of the percentage is by far above average (71.5-88.7%). However, when they were joining the rehabilitation programmes, they had varied expectations. Information in Table 4.5(b) shows these expectations in order of importance of preference attached to them by the children.

Table 4.5(b): What were your expectations when you were joining the rehabilitation programme?

Table 4.5(b): Expectations of the Rehabilitatees.

<table>
<thead>
<tr>
<th>Expectations</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place to sleep</td>
<td>136</td>
<td>90.1</td>
</tr>
<tr>
<td>Shoes and clothes</td>
<td>124</td>
<td>82.1</td>
</tr>
<tr>
<td>Vocational training/education</td>
<td>115</td>
<td>76.2</td>
</tr>
<tr>
<td>Love and care</td>
<td>70</td>
<td>46.4</td>
</tr>
<tr>
<td>Joining National Youth Service(NYS)</td>
<td>51</td>
<td>33.8</td>
</tr>
</tbody>
</table>
The content of Table 4.5(b) indicates provision of a place to sleep as the highest expectation of the respondents (90.0%) followed by shoes and clothes (82.1%). Joining National Youth Service (NYS) had the lowest magnitude (33.8%).

When asked whether there were some of their expectations which had not been met, 70% of the respondents indicated that some of their expectations had not been met by the time of the study while the other percentage (29.1%) indicated that all their expectations had been met. This implies that majority of them were not fully satisfied with what the programme was providing to them. The unmet expectations were sought as illustrated in Table 4.5(c).

<table>
<thead>
<tr>
<th>Unmet expectations</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of shoes and clothes</td>
<td>73</td>
<td>48.3</td>
</tr>
<tr>
<td>Vocational training/going back to school</td>
<td>67</td>
<td>44.4</td>
</tr>
<tr>
<td>Joining NYS</td>
<td>44</td>
<td>29.1</td>
</tr>
<tr>
<td>Education/going back to school</td>
<td>32</td>
<td>21.2</td>
</tr>
<tr>
<td>Good and enough food</td>
<td>27</td>
<td>17.9</td>
</tr>
</tbody>
</table>

Observation from Table 4.5(c) shows that the most unmet need among the respondents is provision of shoes and clothes (48.3%) followed by vocational training/formal education and good and enough food in that order. However, when we consider attitude of the respondents towards the rehabilitation programme in relation
to age, gender, centre, and mode of joining the programme the following conclusions can be derived.

**Table 4.5(d): Rehabilitates' Attitude in Relation to Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>Rehabilitates' attitude</th>
<th>Attitude as a percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-13</td>
<td>15.4615</td>
<td>96.6346</td>
</tr>
<tr>
<td>14-17</td>
<td>14.3421</td>
<td>89.6382</td>
</tr>
<tr>
<td>18-21</td>
<td>13.1700</td>
<td>82.3125</td>
</tr>
<tr>
<td>Total mean</td>
<td>13.6623</td>
<td>85.3891</td>
</tr>
</tbody>
</table>

Details in Table 4.5(d) indicates that the age of the rehabilitates had some influence on their attitude towards their rehabilitation programmes. Attitude decreases with increase in age and vise versa. Those in the lowest age bracket (10-13 years) have 96.6% followed by age bracket (14-17 years) with 89.6 and lastly age bracket (18-21 years) with 85.4% attitude. The above information concurs with the results of attitude as per centre.

**Table 4.5(e): Attitude as per Centre**

<table>
<thead>
<tr>
<th>Center</th>
<th>Rehabilitates attitude</th>
<th>Attitude as a percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahati</td>
<td>15.1379</td>
<td>94.6121</td>
</tr>
<tr>
<td>Kayole</td>
<td>13.6429</td>
<td>85.2679</td>
</tr>
<tr>
<td>Pumwani + Mbotela</td>
<td>12.5823</td>
<td>78.6392</td>
</tr>
<tr>
<td>Total</td>
<td>13.6623</td>
<td>85.3891</td>
</tr>
</tbody>
</table>
Bahati where the majority are below 18 years of age are shown to have the highest attitude percentage (94.6) followed by Kayole (85.3%) and Pumwani combined with Mbotela with 78.6% where most of them are above 18 years of age. Difference in attitude magnitude within and between age groups was also considered using Analysis of Anova (ANOVA) and the results were as demonstrated in Table 4.5(f).

### Table 4.5(f): ANOVA

<table>
<thead>
<tr>
<th>Rehabilitation attitude</th>
<th>Sum of squares</th>
<th>Df</th>
<th>Mean squares</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>83.881</td>
<td>2</td>
<td>41.941</td>
<td>5.445</td>
<td>.005</td>
</tr>
<tr>
<td>Within groups</td>
<td>1139.893</td>
<td>148</td>
<td>7.702</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1223.775</strong></td>
<td><strong>150</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Attitude as a percentage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between groups</td>
<td>3276.619</td>
<td>2</td>
<td>1638.309</td>
<td>5.445</td>
<td>.005</td>
</tr>
<tr>
<td>Within groups</td>
<td>44527.086</td>
<td>148</td>
<td>300.859</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47803.704</strong></td>
<td><strong>150</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In consideration to details in Table 4.5(f), it is observable that there is a significant difference in the level of attitude between and within age groups with Analysis of Anova being $f=5.445$; $df=2$; $P=.005$

### Table 4.5(g): Attitude in Relation to Gender.
When the rehabilitatees' attitude is considered in relation to their gender, there is no significant difference between age and sex as illustrated by the information contained in Table 4.5(g). Considering the attitude of the rehabilitatees in reference to their mode of joining the rehabilitation centre the results were as demonstrated in Table 4.5(h).

Table 4.5(h): Attitude in Relation to Mode of Joining the Program.

<table>
<thead>
<tr>
<th>Mode of joining programme</th>
<th>Attitude as a percentage</th>
<th>Rehabilitatees attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
<td>97.9167</td>
<td>15.6667</td>
</tr>
<tr>
<td>Self</td>
<td>81.8452</td>
<td>13.0952</td>
</tr>
<tr>
<td>City council police</td>
<td>85.7500</td>
<td>13.700</td>
</tr>
<tr>
<td>Total</td>
<td>85.3891</td>
<td>13.6623</td>
</tr>
</tbody>
</table>

Information in Table 4.5(h) indicates that the mode or manner used to join the centres has no direct influence on the rehabilitatees' attitude to their rehabilitation programmes.
4.6: Research question five: Is the programme helping the rehabilitatees to be rehabilitated?

This question sought to establish whether the programme had benefited the rehabilitatees in relation to the main objectives of the rehabilitation programme. In response to whether the activities they engaged in while at the center were rehabilitative, all the staff (100%) acknowledged the activities to be rehabilitative. Efforts were also made to find out the specific ways through which some of these activities were facilitating the rehabilitation of the rehabilitatees. The results were as shown in Table 4.6(a).

Table 4.6(a): Ways in Which the Activities are Rehabilitative

<table>
<thead>
<tr>
<th>Ways the activities are rehabilitative</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learn to be responsible</td>
<td>12</td>
<td>85.7</td>
</tr>
<tr>
<td>Learn to follow rules and regulations</td>
<td>9</td>
<td>64.3</td>
</tr>
<tr>
<td>Relate with each other</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Learn practical life skills</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Refreshes the mind</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Physically relaxing</td>
<td>5</td>
<td>35.7</td>
</tr>
</tbody>
</table>

Considering the information in Table 4.6(a), it is clearly observable that all the activities are rehabilitative though with varying intensities. The activities have contributed most in enabling the rehabilitatees to be responsible (85.7%). Learning to follow rules and regulations is second (64.3%) followed by learning to relate with
each other, practical life skills and having refreshed minds with equal magnitudes (57.1%). Physical relaxation has the least contribution from the activities (35.7%).

Statements whose response was aimed at reflecting the attitude of rehabilitees were also used. Two alternatives (True and False) were given against each statement as options where a rehabilitee was to tick one that matched his/her feelings towards the statement. An attitude scale was developed whereby A 'true' choice was given a score of 2 and a 'false' choice a score of 1.

Table 4.6(b): Indicators of Rehabilitation

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Street life was bad for me</td>
<td>150</td>
<td>99.3</td>
</tr>
<tr>
<td>2. The programme has given me hope for a better future</td>
<td>148</td>
<td>98.0</td>
</tr>
<tr>
<td>3. I am happy to be in this centre</td>
<td>145</td>
<td>96.0</td>
</tr>
<tr>
<td>4. Services given to me in this centre have made my life better</td>
<td>143</td>
<td>94.7</td>
</tr>
<tr>
<td>5. This centre is a good and safe place for me</td>
<td>136</td>
<td>90.1</td>
</tr>
<tr>
<td>6. I relate well with other children</td>
<td>135</td>
<td>89.4</td>
</tr>
<tr>
<td>7. The staff in this centre is friendly to me</td>
<td>131</td>
<td>86.8</td>
</tr>
<tr>
<td>8. Many children in this centre behave well</td>
<td>126</td>
<td>83.4</td>
</tr>
<tr>
<td>9. I eat and sleep well</td>
<td>124</td>
<td>82.1</td>
</tr>
<tr>
<td>10. I am comfortable with rules and regulations in this centre</td>
<td>123</td>
<td>81.5</td>
</tr>
<tr>
<td>11. I like sticking in the centre</td>
<td>115</td>
<td>76.2</td>
</tr>
<tr>
<td>12. I like learning-going to school</td>
<td>113</td>
<td>74.8</td>
</tr>
<tr>
<td>13. I am able to live without drugs and alcohol</td>
<td>109</td>
<td>72.2</td>
</tr>
</tbody>
</table>

75
Content in Table 4.6(b) shows that most of the rehabilitatees have benefited highly from the programme as indicated by the high percentages of their acceptance. The first five items have a percentage of between 99.3%-90.1% with the next five items having a range of between 89.4%-81.5% and the last three items ranging between 76.2%-72.2%. Information on whether there were some rehabilitatees who had completed rehabilitation programme was also sought and according to the results, 85% of the staff said that there were rehabilitatees who had completed their rehabilitation programme. Only 14.3% said none of the rehabilitatees had completed the programme. The study further revealed the number of those who had completed the programme to be within the range of 0-25% as given by 57.1% of the respondents (staff). However, the percentages of the rehabilitatees who had completed the programme and were said to be living a happy and responsible life were between 0-25% as derived from the staff's response.

Asked where the rehabilitatees go after leaving the centres (completing their rehabilitation programme), the staff gave the information contained in Table 4.6(c)

Table 4.6(c): Where the rehabilitatees go after completing their rehabilitation programme

<table>
<thead>
<tr>
<th>Destination after rehabilitation programme</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home to their relative(s)/guardian(s)</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Seek employment</td>
<td>6</td>
<td>42.9</td>
</tr>
<tr>
<td>Self-employed</td>
<td>7</td>
<td>50</td>
</tr>
<tr>
<td>Streets</td>
<td>2</td>
<td>14.3</td>
</tr>
</tbody>
</table>
The information contained in Table 5.6(c) shows that the highest number of rehabilitees (57.1%) go to their relatives/guardians, followed by those who go to be self-employed (50.0%), those who go to seek employment (42.9%) and those who go back to the streets are the minority (14.3%). This information contradicts the rehabilitees' response on where they hoped to go after completing their rehabilitation programme as it is observable in Table 4.6(c).

Table 4.6(d): Where the Rehabilitatees hope to go after completing their Rehabilitation Programme

<table>
<thead>
<tr>
<th>Destination</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seek employment</td>
<td>94</td>
<td>62.3</td>
</tr>
<tr>
<td>To be self-employed</td>
<td>64</td>
<td>42.4</td>
</tr>
<tr>
<td>Relatives/guardians/home</td>
<td>37</td>
<td>24.5</td>
</tr>
</tbody>
</table>

Information contained in Table 4.6(d) indicates that the number of those who hope to seek employment on completion of their rehabilitation programme is the highest (62.3%) followed by those who hope to be self-employed and those who hope to join their relatives/guardians. This is contrary to the staff's response on the same issue on those who have left the centre after completing their rehabilitation programme.
5.1 Conclusion

Major findings of the study are discussed and interpreted in this chapter and where possible explained.

5.2 Discussion

The discussions of the findings of the present research are centered on the major research questions guiding the study.

5.2.1: Research question one: What are the services and activities available in the rehabilitation programme?

Table 4.2(a) summarized respondent's reaction to this question. Information contained in Table 4.2(a) indicates that various services are availed to the rehabilitatees in the centres but with different magnitudes. Provision of basic needs is depicted to be the top priority in the three centres followed by counselling and medical care respectively. This concurs with findings by Suda (1994) that most NGO programmes dealing with street children try to rehabilitate the children through a wide range of programmes one of which is provision of basic needs. Counselling was also offered with an almost equal emphasis. The provision of medical care is of paramount importance since most of the rehabilitatees had used and some of them were still using drugs and solvents which are detrimental to their health not forgetting the unhygienic conditions in which most of them had lived while in the streets. The street
children are also victims of physical violence or accidents. Velis (1995) notes that they are at high risk from sexually transmitted diseases notably AIDS about which they are ill-informed. Spiritual nurture, formal education and vocational training as well as linkages with the families were also mentioned (63.3-50.0%). Rehabilitatees versus staff meeting had the least recognition.

There were some areas that were identified by the staff as shown in Table 4.2(b) that required to be improved in order to facilitate rehabilitation. Provision of facilities like a staff office was the first in the list (78.6%). Counselling and follow-ups between and after rehabilitation followed with an equal emphasis (71.4%). Eyesenck (1952) reports that there exists a considerable and growing amount of evidence that seems to suggest that counselling is ineffective in institutions for delinquent children. Formal education and vocational training were also singled out as needing improvement, among others. Ennew (2000) indicates that education is usually limited to provision of basic skills, which are typically carpentry and electrical wiring for boys and sewing for girls. Mclaughlin (1990) as cited in Leonardos (1999) notes that vocational training means to a great extent matching programme services with market demands. Successful programmes can in turn be considered to be those internally efficient (i.e. structured to impart useful skills and externally efficient (learners manage to make a living out of acquired skills).

If training responds to trainees' needs and interests as well as to market opportunities, besides being delivered in a 'hands-on' learning environment, which might include a
production aspect, non-formal vocational training intervention will be successful in inserting young people into the world of work.

Another area pointed out for improvement is meetings between the rehabilitatees and the staff. Considering the fact that it is an area with the least emphasis as shown in Table 4.2(a), it can be concluded that there is minimal flow of communication between the rehabilitatees and the staff. This is in agreement with Margolis et al., (1978) who in an observational survey from fifteen inpatient programmes found out that most of the programmes had extremely imbalanced communication. Levine (1983) is of view that lack of such meetings is a manifestation that there are few initiatives from patients to staff. In such a situation, Roger (1962) says that there is little learning that can take place in a structure that does not allow for feedback and questioning of issues.

Alongside the services provided in the centres are activities that rehabilitatees are engaged in while at the centre as shown in Table 4.2(c). Among these activities mentioned, laundry and personal hygiene are what the majority of rehabilitatees engage in.

This could be because the rehabilitatees who keep themselves and their clothes clean, are usually rewarded by being given more clothes and detergents when these items are available. Other activities that many of the rehabilitatees engage in are recreation and preparation of their meals. Learning/studying had the least participants and this could
be attributed to the fact that most of the rehabilitatees are above 18 years who may be viewing formal education at their age as having minimum benefits to them. Information contained in Table 4.2(d) indicates that the rehabilitation programmes of the three centres have three objectives namely; molding the rehabilitatees' character and restoring their dignity and self-esteem. The latter which emerges as the one that is given the greatest emphasis. Making them responsible is the second and it is also given a considerable emphasis. Provision of basic needs is given the least emphasis. This to some extent concurs with findings by Suda (1994) that many street children programmes run by NGOs had their main objective as "to rehabilitate street children and other children in difficult circumstances into responsible members of society". However, this objective has emerged as second in our present study with a reasonable weight.

5.2.2: Research question two: Who provides rehabilitation services (staff composition)?

This research question was broken down into age, gender, academic qualifications, profession and the staff's terms of service so that tables presenting the results of each variable could be drawn. Information in Table 4.3(a) in the previous chapter shows that majority of the staff are aged between 25-35 years of age with only two being above 35 years and one below 25 years. In terms of gender, majority are females as depicted in Table 4.3(b).
For any enterprise to be successful, the quality and quantity of staff is paramount. With regard to the staff's academic qualifications, those with diploma level of training were the majority (57.1%) as depicted in Table 4.3(c). The remaining percentage is shared by those with degree and certificate qualifications in equal proportions. With regard to professional orientation, three professions were found among the staff: counsellors, teachers, and social workers. From the results of the key informant interview schedule, some of the staff were said to be uncommitted to their work, others were not qualified in the sense that they did not have any professional training at all. Mc Lachlan (1986) reports a finding of the De Mayer Commission, which called for qualified and motivated professional staff to meet the psychological and emotional needs of institutionalized children. An impact assessment on street children programmes in Metro Manila by UNICEF and ICDC (1989) emphasizes more staff training as a critical component of programme involvement. ANPPCAN (1995) also recommends more specialized training and additional resources for street children educators.

Details in Table 4.3(d) indicate that half of the staff were counsellors by profession and an almost equal number were social workers and only one teacher. The study therefore established that the recruitment of staff took care of the importance of counselling in rehabilitating the children and the adolescents. Truax's (1967) research findings indicated that effective alteration of client's maladaptive behaviour must involve the person of a therapist. A critical look at information presented in Table 4.3(e) suggests that only one respondent was on attachment in one of the centres with
the rest working on volunteer basis. This is not unusual as is evidenced by Oudenhoven's (1989) report that volunteer teachers fuel education programmes for street and working children in great measure. Also considered was the staff's working experience. All of them had worked with street children for less than five years.

Assignment of duties to the staff was another area that was looked into. The content of Table 4.3(f) shows that half of the respondents were given the responsibility of counselling the rehabilitatees. It can be assumed that counselling is mainly administered by those who are trained as counsellors as the number is exactly equal to those who are trained as counsellors as shown in Table 4.3(d).

5.2.3: Research question three: Are there guidance and counselling services in the rehabilitation centres?

A look at the content in Table 4.4(a) indicates that guidance and counselling is provided in the rehabilitation programmes. This finding is further confirmed by the staff's response where all of them (100%) indicated that guidance and counselling was offered. The rehabilitatees also consented that they had received the services. However, there were no counselling offices at the centres as indicated by the staff's response. This was also confirmed by the results of the observational checklist where absence of counselling offices was noted in the three centres visited.
All the staff in the centres offer guidance and counselling in reference to the staff's response on who offers the services, but the counsellors mainly provide the services (see Table 4.4(b). The rehabilitatees' responses on the same issue of who offers them guidance and counselling indicated that teachers and health workers provided them with the services. It is important at this point to note that according to the rehabilitatees all the staff in the centres were 'teachers' and the health workers are those from outside who come to treat and talk to them (Table 4.4(c). Findings from key informant schedules agree with the responses above that counselling was done by the centre staff as well as health workers who were mainly from Goal Kenya Organization. These counsellors usually offer guidance and counselling services more than once in a month whereby they use group-counselling approach as depicted in Tables; 4.4(d) and 4.4(e).

On the mode of counselling the staff used, the researcher established that both individual and group methods were employed because of a number of reasons with the latter being the main mode of counselling. One, the centres do not have counselling offices hence it would be difficult to offer individual counselling which requires privacy among other things. Again, as noted by Bellsmith and Peck (1965), some agencies prefer group therapy as a device for saving time. The authors further note that agencies that work with delinquent adolescents have initiated group treatment largely in an attempt to reach certain individuals who seem unable to profit from individual treatment. However, they caution that failure of individual treatment
for these delinquents is often equivalent of a sense of doom, since most of them have had a try at many other available community services.

Group counselling approach emerged as the dominant preference of the rehabilitatees as indicated by their responses on the issue. This could be largely attributed to lack of favourable environment for individual counselling (office) and other factors such as shyness or lack of confidence to approach the counsellors. Gebers (1990), in his research on "the health of street children in Cape Town" indicated that street children tend to avoid seeking medical care because they find the health facilities intimidating and healthcare providers show a "lack of tolerance of the kids and their lifestyles" P.13. This could also be the reason as to why the rehabilitatees were unwilling to seek individual counselling.

The rehabilitatees further agreed having received counselling on STIs and HIV/AIDS, and effects of drug abuse on human health with a great magnitude among other areas as given in Table 4.4(f). The two areas could be receiving greater emphasis due to the fact that most of the respondents were still abusing drugs and were engaging in risky sexual behaviours, which were exposing them to risks of being infected with STIs and HIV/AIDS virus. ANPPCAN (1995) notes that a few of the street children have STIs and test HIV positive.
5.2.4 Research question four: What is the attitude of the rehabilitatees towards their rehabilitation programme?

The rehabilitatees attitude was mainly checked against their feelings towards the services given to them and the activities availed to them at the centres among other variables. From the basis of the staff's responses, the indication was that the rehabilitatees were happy with the services. This concurs with their response on the item number 4 in Table 4.6(b) on their view regarding the services given to them at the centres that had made their lives better (94.7%). This is contrary to Kariuki et al., (1991) findings that out of 524 respondents only 9% thought that their being institutionalized helped them. Item number 3 in the same table also indicates that they were happy to be at the centre (96.0%) while at the same time almost all of them recognized that street life was bad for them (number1). These findings agree with Bellsmith and Peck's (1965) observation that some adolescents view the treatment agency from the outset as a place of refuge and help.

On activities participated in, the greatest number of rehabilitatees said that they enjoyed participating in the activities availed to them. This is important as argued by Levine and Gallogly (1985), that development or reactivation of hobbies of interests to the patients can help dissolve boredom and raise their self-esteem. The authors are also of the view that focusing on activities and games that are of interest and appropriate to various age groups in the programme is helpful in meeting the socialization needs of the patients. Table 4.5(a) indicates going to the field to play as an activity with most participants. The least preferred activity is suggested to be
cooking and cleaning. This could be due to the fact that this is a chore that is generally assumed to be feministic yet majority of the respondents were males. It can therefore be deduced that the attitude of rehabilitatees towards their rehabilitation programme is positive.

Looking at the attitude of rehabilitatees in relation to their age, the revelation is that positive attitude towards the programme decreased with increase in age. This is clearly depicted in Table 4.5(d). This information is reinforced by the results on attitude per centres (see Table 4.5(e). Bahati centre where majority are below 18 years of age, almost all of them (94.6%) are positive about their rehabilitation centre. Kayole centre follows in terms of the magnitude of their positiviness towards their programme and Pumwani/Mbotela where most of them are above 18 years of age had the least magnitude. This could be assumed to be the case probably because the young are said to be more optimistic of a better future than the old who could be feeling like they have few years to live.

Difference in attitude magnitude within and between age groups further reinforced findings that liking of the programme increased with decrease in age and vise versa ($f=5.445; df=2; P=005$). When attitude is considered in relation to gender and the mode of joining the programme the impression is that there is no relationship at all. See tables 4.5(g) and 5(h).
Information in Table 4.5(b), which is on the expectations of rehabilitatees as they were joining the programme, helps to answer research question four. The information indicates that most of them expected to be provided with a place to sleep and shoes and clothes. Other expectations include vocational training/education, love and care and joining NYS in that order. These findings concur with what Maslow (1970) said, that needs come into play in a hierarchical sequence, and that only when basic needs have been met do the higher needs emerge. However, 70.9% of the rehabilitatees declared that they had some unmet expectations while the rest felt that all their expectations had been met. Table 4.5(c) suggest that the unmet need with the highest frequency is depicted as provision of shoes and clothes which was the second highest expectation of the rehabilitees when they were joining the programme as already shown in Table 4.5(b). Other expectations that have not been met are vocational training/formal education, joining NYS, and good and enough food in that order but in low percentages. Generally, the children have a positive attitude and high expectation from the programme.

5.2.5: Research question 5: Is the programme helping the rehabilitatees to be rehabilitated?

Many variables were considered to find out whether the program was rehabilitative or benefiting the rehabilitatees. These are the objectives of the rehabilitation programmes in relation to the activities and services provided to the rehabilitatees and the expectations, which they had on joining the programme and whether they had been met, among others.
The activities that the rehabilitatees engage in while in the centre were rehabilitative as implied by 100% agreement response of the centre staff. The activities are rehabilitative in various ways as manifested by details in table 4.6(a). Majority of the staff indicated that the activities had helped the rehabilitatees to become more responsible. The activities had also enabled the rehabilitatees to learn to follow rules, relate well with others, learn practical life skills and get their minds refreshed. This shows that the programme is rehabilitative.

Table 4.6(b) contains indicators of whether the programme had been rehabilitative. A critical look at the information in Table 4.6(b) shows that the programme is certainly benefiting the rehabilitatees. It is observable from the table that the first five items have a percentage agreement of over 90% while the next seven items have over 80% and the last four have 70% and above. The high levels of agreement as indicated by the percentages of the items stamp this fact. Going to school, sticking at the centre and living without drugs have the least percentages in comparison to the other items in the table. However, the percentages are quite high to imply that the programme is not rehabilitative. The low percentage of those who like sticking at the centre in relation to other items in Table 4.6(b) to some extent concurs with the findings by Ennew (2000) that children, as used to being outdoors resist closed and strictly structured institutions.
Response on whether there were some rehabilitatees who had completed their rehabilitation programme indicated that most of the staff agreed that there were rehabilitatees who had finished their rehabilitation programme and had left the center. According to the majority of the staff (respondents) the percentage of those who had completed the programme is 0-25%. It is surprising to note that all the respondents agreed that out of those who had left the centre after completion of their rehabilitation programme, only 0-25% could be said to be living happily and responsibly. This to some extent could be attributed to lack or little emphasis given to follow-ups as evidenced by information in Table 4.2(b) where this service was ranked second among the services/areas that required intensification. This concurs with Agnelli’s (1986), findings that the ability of institutions to rehabilitate children and keep them out of trouble once they leave is poor.

Another variable considered was where the rehabilitatees went after leaving the rehabilitation centres. A critical look at details in Table 4.6(c) shows that according to the staff, majority of the children go to their homes (relatives/guardians) followed by those who go to be self-employed, to seek employment and finally going back to the streets.

This information contradicts the rehabilitatees' response on where they hoped to go after completing their rehabilitation programme as it is observable in Table 4.6(d). The highest number of children hoped to go to seek employment, followed by those who hoped to be self-employed and the least being those who hoped to go to their
homes (relatives/guardians). The implication here is that they see their present situation as a transitional one. They want to be like other people; they need to feel that one day they will have a real job. They do not want to remain the outsiders of society. They would like to join it and to be fully accepted. The number of those hoping to go home to their relatives/guardians could probably be explained for being the least by Le Roux's (1994) findings that most of the street children had suffered parental rejection and physical hardship. As a result, they wished to return home only if the familial factors that drove them away have changed. Additionally, some may be orphans and thus had no families or parents to go back to. Again, some were born in the streets and therefore knew streets as their homes.

5.3 SUMMARY

The major concern of this study was to investigate the effectiveness of the rehabilitation programmes in selected centres for former street children and adolescents in Nairobi. This investigation was guided by the following research questions.

f) What are the services and activities available in the rehabilitation programmes?
g) Who provides rehabilitation services (staff composition)?
h) Are there guidance and counselling services at the centres?
i) What is the attitude of the rehabilitatees towards their rehabilitation programme?
j) Is the programme helping the children and adolescents to be rehabilitated?

The above questions led to the findings presented as follows;

Services provided to the rehabilitatees include: basic needs, counselling, medical care, spiritual nurture, formal education and vocational training, linkages with families and
children's versus staff meetings. They were offered in varying emphases as presented. However, there were some areas that were recommended for improvement such as provision of adequate facilities, counselling and follow-ups between and after rehabilitation among others.

Alongside these services are activities which were basically aimed at facilitating the achievement of the programmes' objectives. The programmes have three objectives with the main one being moulding the rehabilitees' character and restoring their dignity and self-esteem. The staff working with the rehabilitees represents three professions, namely: teaching, counselling and social work. Half of them have diploma qualifications while three are graduates and the remaining three have certificates. All of them were working on volunteer basis save for only one who was on attachment in one of the centres.

It was also found that guidance and counselling services were available and the rehabilitees were counselled on STIs and HIV/AIDS and how to relate with each other among other areas. Counselling was done by the counsellors in the centres (staff) though even the other staff also assisted but minimally. However, it could be concluded that counselling was mainly done by health workers from Goal Kenya Organization who did regularly. The mode of counselling that was mainly used was group counselling and it was the preferred method by the rehabilitees. None of the center had a counselling office. The rehabilitees have a positive attitude towards the programme as depicted by their liking of the activities availed to them
and their consenting that the services given to them had changed their lives for better and as such could see a brighter future ahead of them. Again none of them hoped to go back to the streets on completing their rehabilitation programme. Many of them hoped to seek for employment while others hoped to be self-employed. Those hoping to go back home (relatives/guardians) were the least.

It can therefore be concluded that generally the children and adolescents are highly positive in regard to their rehabilitation programmes.

5.4: RECOMMENDATIONS

- The staff in the centres need to be given permanent terms of service. This will motivate them hence improve their services to the rehabilitatees.
- Counselling should be mainly the responsibility of the centre staff other than the staff from outside for better follow-up.
- All the staff should have relevant training and be qualified to work with the rehabilitatees.
- Staff versus rehabilitatees' meetings should be emphasized in the rehabilitation programmes in the centres so as to improve feedback and subsequent strengthening of the services.
- The following aspects of the rehabilitation programmes need to be intensified and strengthened for more effective rehabilitation; education: counselling, linkages with families and vocational training.
5.6 Suggestions for Further Research

1. A similar study should be done in other rehabilitation centres in Nairobi and other parts of the country whether manned by NGOs, churches or individuals. This would help in the making of general conclusions for the whole nation after which measures towards improvement could be undertaken.

2. There is need to investigate whether having staff who are relevantly trained to rehabilitate street children and who are employed on permanent terms of service would improve the effectiveness of rehabilitating the former street children and adolescents.
REFERENCES


Murithi G., G. (2003). Role of guidance and counselling in helping students to be well adjusted in selected schools in Magumoni division, Meru- South District, Kenya. A project submitted in partial fulfillment of the requirements for the degree of Master of Education in the institute for continuing education of Kenyatta University.


Unpublished B.A Dissertation presented to Department of Sociology,
University of Nairobi, Kenya. 1981.
APPENDIX A

QUESTIONNAIRE FOR THE REHABILITATION CENTRE'S STAFF.

Code number

This questionnaire seeks information on rehabilitation programme of former street children in Nairobi, Kenya. The information you give will be treated with privacy and confidentiality and will be used for research purpose only.

Instructions: Enter the code of the answer given in the brackets.

Do not write your name on this questionnaire.

PART ONE

Background Characteristics

1. Gender [ ]
   1. Male  2. Female

2. Age [ ]
   1. Below 25 years  2. 25-35 years  3. Above 35 years.

PART TWO:

Staff’s Qualifications

3. What is your profession? [ ]
   1. Social worker  2. Teacher  3. Counsellor

3. Any other (Specify)

4. What is your professional qualification [ ]

2. Any other (specify)
5. Period you have worked in this rehabilitation centre. [ ]
   1. Below 5 years  2. Over 5 years

6. On what terms are you working in this centre? [ ]
   2. Any other specify

7. Role played in the rehabilitation centre. [ ]
   5. Any other (Specify)

PART THREE

Rehabilitation services offered and children's attitude to these services

8. What are the objectives of this centre's rehabilitation programme? Tick [✓] where appropriate.
   1. To provide basic needs to the children
   2. Mould their character and restore their dignity and self-esteem
   3. Rehabilitating street children into responsible members of society
   4. Any other (Specify)
9. What rehabilitative services does the programme offer the children? (Tick [✓] where applicable.

1. Feeding and shelter [ ]
2. Spiritual nurture [ ]
3. Counselling [ ]
4. Medical care [ ]
5. Formal education and vocational training. [ ]
6. Children versus staff meetings. [ ]
7. Linkages with families [ ]
8. Any other (Specify) [ ]

10. How do the children feel about these services? [ ]
1. Happy 2. Unhappy

11. Are there aspects of the programme that you feel could be intensified for programmes' improvement? [ ]
1. Yes 2. No

12. If yes, which ones? Tick [✓] where appropriate.
1. Formal education and vocational training [ ]
2. Counselling [ ]
3. Home visits and reintegration [ ]
4. Any other (Specify) [ ]
PART FOUR

Is the Programme helping the children to be rehabilitated?

13. Are there children who have completed their rehabilitation period in this centre?
   [ ]
   1. Yes 2. No

14. If Yes, what percentage? [ ]
   1. 0-25% 2. 25-50% 3. Over 50%

15. What percentage of the above would be said to be living a responsible and a happy life.
   [ ]
   2. 0-25% 2. 25-50% 3. Over 50%

16. Where do the children go after leaving the centre? Tick [✓] where appropriate.
   1. Home to their parents/ guardians [ ]
   2. Seek for employment [ ]
   3. Get self-employed [ ]
   4. Streets [ ]
   5. Any other (Specify)

17. Is there any follow-up services after completion of the rehabilitation programme?
   [ ]
   1. Yes 2. No
18. What other activities are the children involved in while in the centre? Tick [✓] where applicable.

1. Recreation and sporting. [ ]
2. Laundry and personal hygiene [ ]
3. Keeping themselves clean and washing their clothes [ ]
4. Any other (Specify) [ ]

19. How do the children feel about these activities? [ ]

1. Happy 2. Unhappy

20. In your opinion, do these activities help in rehabilitating the children? [ ]

a) Yes 2. No

21. If yes, how do they help the children to be rehabilitated? Tick [✓] where applicable.

a) They are able to relate better with each other e.g. when playing [ ]
b) They learn to follow rules and regulations e.g. of a game [ ]
c) They learn practical life skills e.g. of cooking, cleaning etc. [ ]
d) They learn to be responsible e.g. when they carry out their duties. [ ]
e) Their minds get refreshed e.g. after a recreational activity [ ]
f) Physically they become relaxed e.g. after games [ ]
g) Any other (Specify) [ ]
PART FIVE

22. Do you offer guidance and counselling services to the children? [ ]
   1. Yes 2. No

23. If yes, who offers the services? Tick [✓] where appropriate.
   1. Social workers [ ] 2. Teachers [ ] 3. Counsellors [ ]
   4. All above [ ]
   5. Any other (Specify)

24. Which methods of counselling do you use? [ ]
   1. Individual counselling 2. Group counselling 3. Both

25. Is there guidance and counselling office in this centre? [ ]
   1. Yes 2. No

26. In your opinion what improvement would you recommend for successful rehabilitation of the children? Tick [✓] where appropriate
   1. Increase the number of professional social workers [ ]
   2. Increase the number of follow-ups between and after rehabilitation. [ ]
   3. Have vocational training in the centre [ ]
   4. Any other (Specify)
APPENDIX B:

INTERVIEW SCHEDULE FOR THE CHILDREN

Code number

Instructions: The researcher/research assistant will guide the respondents through the questions. S/he will enter the code of the answer given in the brackets

PART ONE

Background Characteristics

Please complete all the sections after reading the questions keenly.

1. Gender [ ]
   1. Male 2. Female

2. Age [ ]
   1. 10-13 years. 2. 14-17 years 3. 18-21 years

3. Religion [ ]

5. Any other (Specify)

4. How did you join this rehabilitation centre? [ ]
   1. I brought myself 2. I was brought by my parent(s)/friend(s)

3. I was brought by the council police

4. Any other (Specify)

5. Have you ever been to another rehabilitation centre before? [ ]
   1. Yes 2. No
6. For how long have you been in this rehabilitation centre? [ ]
   1. 0-6 months  2. 6-12 months  3. Over 1 year

PART TWO

Attitude to the Programme

7. Do you know of children who have gone through a rehabilitation program and are now living a happy and good life? [ ]
   1. Yes  2. No

8. Do you like the daily routine (programme) of this centre? [ ]
   1. Yes  2. No

9. What activities are you involved in during your stay here? (Tick [ ] where applicable).
   1. Learning/studying
   2. Recreational activities e.g. game, watching TV and singing.
   3. Cleaning our centre and cooking our meals.
   4. Washing our clothes and keeping ourselves clean.
   5. Any other (Specify).

9. Do you enjoy participating in these activities? [ ]
   1. Yes  2. No
PART THREE

Availability of Counselling Facilities

11. Are there guidance and counselling services here? [ ]
   1. Yes  2. No

12. If yes, who offers counselling services? [ ]
   1. Teachers  2. Health workers

13. Where are the counsellors mainly from? [ ]
   1. Within  2. Without

14. Have you received any guidance and counselling services? [ ]
   1. Yes  2. No

15. If yes, were you alone or in a group? [ ]
   1. Alone  2. In a group  3. Both

16. Which one do you prefer? [ ]
   1. Alone  2. In a group

17. How often do you receive counselling? [ ]
   1. Once a week  2. Once a month  3. More than once in a month
   4. Any other (Specify)

18. Whom do you prefer to counsel you? [ ]
19. Have you received counselling on any of the following? Tick [✔] where applicable.

1. Information on STIs and HIV/AIDS [ ]
2. Effects of drugs on human health [ ]
3. How to relate with one another [ ]
4. Career and vocation [ ]
6. Any other (Specify)

PART FOUR

If The Programme is helping the Rehabilitatees to be Rehabilitated

20. What did you hope to get from this centre? Number where appropriate in order of preference.

1. Enough and good food [ ]
3. Shoes and clothes [ ]
5. Vocational training [ ]
7. Education [ ]
8. Any other (Specify)

2. A good place to sleep [ ]
4. Love and care [ ]
6. Joining youth service [ ]

21. Are there some things you hoped to get and you haven't or you don't get? [ ]

1. Yes 2. No

22. If yes, what are some of them (Tick [✔] where applicable).

1. Vocational training [ ]
3. Good and enough food [ ]
5. Joining NYS [ ]

2. Going back to school [ ]
4. Shoes and clothes [ ]

5. Any other (Specify)
23. Where do you plan to go after completing your rehabilitation programme? (Tick [✓] where applicable)
   1. Home to my relative(s)/guardian(s)        [ ]
   2. Seek for employment               [ ]
   3. To be self-employed          [ ]
   4. Any other (Specify)

**PART FIVE**

Please indicate whether you agree or disagree with the following statements by ticking TRUE or FALSE.

<table>
<thead>
<tr>
<th>Children's attitude to the program</th>
<th>TRUE</th>
<th>FALSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Street life was bad for me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. I am happy to be in this centre.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. This centre is a good and safe place for me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. I eat and sleep well.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. I am now able to live without drugs and alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. I relate well with other children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. The staff in this rehabilitation centre are friendly to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. I like being involved in cooking and cleaning activities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. I like going to the field to play and do some exercises.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. I feel better after going to church for prayers.</td>
<td></td>
<td></td>
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<tr>
<td>34. I like learning/going to school.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. I like being within the centre (not going out).</td>
<td></td>
<td></td>
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<tr>
<td>36. I am comfortable with the rules and regulations in this centre.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Many children at this centre behave well.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. The services given to us here have made my life better.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. The programme has given me hope for a brighter future.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX C

KEY INFORMANT INTERVIEW SCHEDULE

1. Who funds/supports the programme?
2. Are the funds adequate to meet the needs of the children?
3. Do you receive these funds in time?
4. Does the centre have adequate staff?
5. In your opinion, do they have the relevant qualification to be able to rehabilitate the children?
6. Are they committed in serving the rehabilitatees?
7. How is their relationship with the rehabilitatees?
8. To what extent would you say you have achieved the objectives of the programme (in percentage).

10. What challenges do you face in rehabiliting the children?
APPENDIX D

OBSERVATIONAL CHECKLIST

Counseling Facilities

1. There is guidance and counseling office. [ ]
   1. Yes 2. No

2. It is appropriately set. [ ]
   1. Yes 2. No

3. The size in square feet

Program Helping Children to be Rehabilitated

4. The children tolerate each other. [ ]
   1. Yes 2. No

5. The children relate well with the staff. [ ]
   1. Yes 2. No

6. The children's language is: [ ]
   1. Decent 2. Indecent

7. The children appear disciplined. [ ]
   1. Yes 2. No

8. Physically the children are: [ ]

9. Emotionally, the children appear [ ]
11. Does the center have the following programmes? (Indicate: Available (A); Unavailable (UV)).

(i) Guidance and counseling programme [ ]
(ii) Vocational training programme [ ]
(iii) Formal education programme. [ ]
(iv) Religious programme [ ]
(v) Medical care [ ]