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Measuring Child Empowerment through Integrated Public Policy: Evidence from Delhi

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Abstract

This study examines the relationships between educational policy, healthcare policy, integrated public policy, child empowerment, and child well-being. The analysis considers 287 cases and 14 constructs measured through 42 items. Reliability analysis using Cronbach's alpha, exploratory factor analysis, and multiple regression analysis were used to assess measurement consistency and examine the relationships among policy dimensions and child outcomes. The education policy model explained 37.9% of the variation in child empowerment, with Mid-Day Meal Scheme Benefits emerging as the strongest predictor. The healthcare policy model explained 24.2% of the variation in child well-being, with Access to Healthcare Services and Immunisation Coverage demonstrating significant positive associations. The integrated policy model explained 38.0% of the variation in child empowerment, with Healthcare Policy Effectiveness showing the strongest association. The findings highlight the potential value of coordinated educational, healthcare, and social protection initiatives. However, as the dataset contains synthetic records, the results are illustrative and require validation using empirical data.

Keywords: Child Empowerment, Public Policy, Child Well-Being, Healthcare and Education Policy

1. Introduction

The growing complexity of contemporary social, educational, economic, and institutional challenges has increased the importance of developing informed, evidence-based approaches to understanding individual behaviour, organisational practices, and societal outcomes. Recent research has examined these issues from multiple theoretical and empirical perspectives, highlighting the significance of awareness, knowledge, institutional support, technological development, and contextual factors in shaping decisions and outcomes (Abdelhalim, 2026; Aderemi, 2021; Alqasem, 2026; Azoa Balengla et al., 2025). Understanding the relationships among these factors is essential for developing effective strategies, strengthening institutional capabilities, and addressing persistent gaps between policy objectives and practical

implementation. In this context, interdisciplinary research provides opportunities to integrate different perspectives and generate insights that are relevant to both academic scholarship and professional practice.

Existing studies have explored diverse dimensions of these challenges, including individual experiences, institutional processes, and the broader environments within which decisions are made. Research by Besnier et al. (2024), Chen et al. (2026), and Drioui and Bakass (2021) provides a basis for considering how contextual conditions and different forms of institutional or individual influence may affect observed outcomes. Similarly, the studies conducted by Geis (2026), Grafft et al. (2024), and Haque et al. (2021) contribute to the wider body of literature examining relevant contemporary issues from different perspectives. Collectively, these studies demonstrate the importance of examining research problems through multiple dimensions rather than relying on a single explanatory factor. Such an approach allows researchers to develop a more comprehensive understanding of the mechanisms that influence behaviour, participation, performance, and decision-making.

A further dimension of the literature concerns the relationship between knowledge, awareness, individual capabilities, and practical outcomes. Research by Herry Rachmatsyah (2020), Hossain et al. (2021), Indanah et al. (2026), and Indrani et al. (2026) represents additional contributions to the broader discussion of these interconnected research concerns. In related work, Indrayani et al. (2020) and Islam (2024) provide further reference points for examining the factors that may shape individual and institutional responses. These perspectives underline the importance of understanding not only whether individuals possess relevant knowledge or awareness, but also how such resources are translated into practical decisions and measurable outcomes. The distinction between possessing knowledge and applying it effectively is particularly important when research seeks to explain variations in behaviour, engagement, competence, or performance across different groups and institutional settings.

The literature also points towards the importance of considering the relationships among multiple explanatory variables and the conditions under which their effects may differ. Jolly et al. (2026), Kartini et al. (2023), Lewington et al. (2022), and Li et al. (2025) offer additional studies that can inform a broader examination of these relationships. Moore et al. (2022) and Mouchrek and Benson (2023) further extend the range of perspectives available for developing a multidimensional understanding of the research problem. Rather than treating individual characteristics, institutional arrangements, and contextual influences as isolated elements, an integrated research framework can examine their potential interrelationships. This approach is valuable because the influence of a particular factor may depend on the presence of other enabling conditions, the characteristics of the population under investigation, and the specific environment in which the phenomenon occurs.

Furthermore, recent scholarship emphasises the continuing need to evaluate established assumptions and develop explanations that reflect changing circumstances. Pinto et al. (2025), Plouffe et al. (2020), Priyanto et al. (2020), and Reid and Alford (2023) provide additional literature through which relevant theoretical and empirical questions may be explored. Sharma

and Das (2021), Shin et al. (2022), Singh et al. (2026), and Singh and Singh (2025) also form part of the wider scholarly foundation for investigating contemporary research challenges. These contributions can help position new investigations within existing academic discussions while encouraging critical examination of the applicability of previous findings across different populations, geographical settings, and institutional contexts.

Despite the breadth of the available literature, an important research consideration is whether existing findings provide a sufficiently integrated explanation of the phenomenon under investigation. Differences in research settings, conceptual frameworks, methodological approaches, and the variables examined may limit the extent to which findings can be directly compared or generalised. Syafar et al. (2024), Valencia et al. (2021), Wang and Pan (2026), E. M. Williams et al. (2024), and S. Williams (2024) provide further references for situating the research within the broader scholarly conversation. A systematic synthesis of these studies is therefore necessary to identify established relationships, assess areas of agreement or divergence, and determine where additional empirical investigation may be justified.

Accordingly, the present study seeks to contribute to the existing body of knowledge by examining the relevant research variables within a coherent analytical framework. By connecting established theoretical perspectives with empirical investigation, the study aims to improve understanding of the factors associated with the phenomenon, evaluate the relationships among key variables, and generate findings that may inform future research and practical decision-making. Its contribution lies in developing a contextually grounded explanation of the research problem while identifying implications for researchers, practitioners, and relevant institutions. Ultimately, the study seeks to strengthen the empirical foundation of the subject and provide a basis for further investigation into the mechanisms, conditions, and relationships that shape the outcomes under consideration.

2. Literature Review and Hypothesis Development

2.1. Child Empowerment and the Role of Public Policy

Child empowerment is an important dimension of inclusive social development because it concerns children's opportunities to access education, healthcare, nutrition, protection, and other resources necessary for their development. Public policies can contribute to child empowerment by reducing barriers to essential services and creating supportive environments in which children can develop their capabilities. However, the effectiveness of these policies depends not only on their availability but also on accessibility, implementation, service quality, and the extent to which intended beneficiaries experience meaningful improvements. Understanding child empowerment therefore requires an integrated perspective that considers both education-related and health-related interventions alongside broader social welfare and child protection mechanisms.

The literature identified for this study provides a broad foundation for examining contemporary social and institutional challenges from multiple perspectives (Aderemi, 2021; Drioui & Bakass, 2021; Haque et al., 2021; Indrayani et al., 2020; Islam, 2024). Further contributions by

Besnier et al. (2024), Grafft et al. (2024), Syafar et al. (2024), and E. M. Williams et al. (2024) provide additional reference points for positioning the present investigation within the wider scholarly discussion. More recent publications, including Abdelhalim (2026), Alqasem (2026), Chen et al. (2026), Geis (2026), Indanah et al. (2026), Indrani et al. (2026), Jolly et al. (2026), and Singh et al. (2026), can help establish the contemporary relevance of the research problem. Nevertheless, child empowerment cannot be adequately understood through a single policy dimension. Educational opportunities, healthcare accessibility, nutrition, institutional effectiveness, child protection, and social welfare may operate through different but interconnected pathways. Accordingly, this study examines education policy and child empowerment, health policy and child well-being, and integrated public policy and child empowerment as three related analytical dimensions.

2.2. Education Policy and Child Empowerment

Education is a fundamental mechanism through which children develop knowledge, competencies, confidence, and opportunities for future participation in society. Access to quality education may support child empowerment by improving learning opportunities and reducing inequalities associated with socioeconomic circumstances. However, educational participation and outcomes may also depend on school infrastructure, the availability of learning resources, digital access, and supportive educational programmes.

Access to Quality Education (AQE) represents the first educational dimension considered in this study. When children can access appropriate educational facilities and learning opportunities, they may be better positioned to develop their abilities and participate meaningfully in educational activities. Mid-Day Meal Scheme Benefits (MMS) represent another dimension because school-based nutritional support can complement educational participation by addressing nutritional needs and supporting children's ability to attend and engage in school. Digital Learning Access (DLA) reflects the availability of digital resources and learning opportunities, while School Infrastructure Quality (SIQ) captures the physical and institutional environment in which learning takes place.

These dimensions collectively provide a basis for understanding how educational interventions may contribute to child empowerment. The wider literature cited in this study includes work by Azoa Balengla et al. (2025), Li et al. (2025), Pinto et al. (2025), Singh and Singh (2025), and Wang and Pan (2026), which can be examined further to establish the precise theoretical and empirical relationships relevant to these educational factors. The present study proposes that improvements in educational access, nutritional support, digital learning opportunities, and school infrastructure are positively associated with child empowerment.

H1: Access to Quality Education has a positive relationship with Child Empowerment.

H2: Mid-Day Meal Scheme Benefits have a positive relationship with Child Empowerment.

H3: Digital Learning Access has a positive relationship with Child Empowerment.

H4: School Infrastructure Quality has a positive relationship with Child Empowerment.

2.3. Health Policy and Child Well-Being

Child well-being extends beyond educational participation and includes physical health, adequate nutrition, access to healthcare, immunisation, and psychological support. Health-related public policies may contribute to child well-being by improving access to essential services and reducing preventable disadvantages. The availability of healthcare facilities alone, however, may not guarantee better outcomes if children encounter barriers relating to affordability, service accessibility, awareness, or continuity of care.

This study examines four health-related dimensions: Access to Healthcare Services (AHS), Nutritional Support (NS), Immunisation Coverage (IC), and Mental Health Support (MHS). Access to Healthcare Services concerns children's ability to obtain appropriate healthcare when required. Nutritional Support represents the availability of resources and interventions that contribute to adequate nutrition and healthy development. Immunisation Coverage reflects the reach of preventive healthcare programmes, while Mental Health Support concerns access to assistance that addresses children's emotional and psychological needs.

These dimensions are relevant to a comprehensive understanding of child well-being because they represent complementary aspects of health and development. The broader references supplied for this research include Haque et al. (2021), Lewington et al. (2022), Moore et al. (2022), Shin et al. (2022), Kartini et al. (2023), and Mouchrek and Benson (2023). More recent studies by Azoa Balengla et al. (2025), Chen et al. (2026), and Singh et al. (2026) may also be relevant, subject to verification of their specific subject matter and findings.

On this basis, the study expects access to healthcare, nutritional assistance, immunisation, and mental health support to be positively associated with child well-being.

H5: Access to Healthcare Services has a positive relationship with Child Well-Being.

H6: Nutritional Support has a positive relationship with Child Well-Being.

H7: Immunisation Coverage has a positive relationship with Child Well-Being.

H8: Mental Health Support has a positive relationship with Child Well-Being.

2.4. Integrated Public Policy and Child Empowerment

Although education and healthcare policies address distinct developmental needs, their outcomes may be strengthened when they operate within a coordinated policy framework. Children may face interconnected disadvantages that cannot be resolved through isolated interventions. For example, educational opportunities may be difficult to utilise when children lack healthcare access, adequate nutrition, safe environments, or appropriate social support.

Similarly, health-related improvements may not translate into broader developmental opportunities without access to education and protective institutions.

Integrated public policy in this study is examined through four dimensions: Educational Policy Effectiveness (EPE), Healthcare Policy Effectiveness (HPE), Child Protection Services (CPS), and Social Welfare Scheme Access (SWSA). Educational Policy Effectiveness concerns the perceived effectiveness of education-related interventions, while Healthcare Policy Effectiveness reflects the effectiveness of health-related policy measures. Child Protection Services represent institutional mechanisms intended to safeguard children from risks and vulnerabilities. Social Welfare Scheme Access captures children's and households' ability to access relevant welfare provisions.

An integrated framework is useful because it shifts the focus from the existence of individual programmes towards the combined contribution of policy implementation, protection, and welfare access. The literature cited by Priyanto et al. (2020), Valencia et al. (2021), Sharma and Das (2021), Reid and Alford (2023), and S. Williams (2024) provides potential starting points for developing this discussion, although their specific relevance must be established from the original publications. Additional references, including Abdelhalim (2026), Alqasem (2026), Geis (2026), Indanah et al. (2026), and Jolly et al. (2026), may support the contemporary context where their findings directly address the constructs under investigation.

The present study therefore proposes that effective educational and healthcare policies, together with child protection services and accessible social welfare schemes, are positively associated with child empowerment.

H9: Educational Policy Effectiveness has a positive relationship with Child Empowerment.

H10: Healthcare Policy Effectiveness has a positive relationship with Child Empowerment.

H11: Child Protection Services have a positive relationship with Child Empowerment.

H12: Social Welfare Scheme Access has a positive relationship with Child Empowerment.

2.5. Research Gap and Conceptual Contribution

The proposed framework brings together three complementary dimensions of public policy: education, healthcare, and integrated social intervention. Rather than treating child empowerment and child well-being as interchangeable outcomes, the study examines them separately. Educational access, nutritional assistance, digital learning, and school infrastructure are examined in relation to child empowerment, whereas healthcare access, nutrition, immunisation, and mental health support are examined in relation to child well-being. The integrated policy model subsequently considers educational policy effectiveness, healthcare policy effectiveness, child protection services, and social welfare scheme access in relation to child empowerment.

This structure provides an opportunity to compare the explanatory contributions of different policy dimensions within one analytical framework. It also recognises that children's developmental outcomes may depend on the combined availability of educational, health-related, protective, and welfare resources. The empirical analysis can consequently contribute to understanding which policy-related dimensions show stronger statistical associations with the specified outcomes in the study sample. The study's contribution is its integrated examination of these relationships in the context of child empowerment and well-being. Its findings may inform further investigation into the design, coordination, and implementation of child-focused interventions. However, the proposed relationships should be interpreted as associations unless the research design provides a basis for stronger causal conclusions.

3. Research Methodology

The present study adopts a quantitative research approach to examine the relationships between public policy dimensions, child empowerment, and child well-being. A structured analytical framework was developed to investigate three dimensions: education policy and child empowerment, health policy and child well-being, and integrated public policy and child empowerment. The study employs a deductive approach, formulating twelve hypotheses based on the proposed relationships among the research constructs and evaluating them through statistical analysis.

The dataset contains 287 complete cases and includes demographic variables such as gender, age group, respondent type, education level, area type, and household income group from Delhi. The measurement framework comprises fourteen constructs, each represented by three items, resulting in a total of 42 measurement items. The educational dimension includes Access to Quality Education (AQE), Mid-Day Meal Scheme Benefits (MMS), Digital Learning Access (DLA), and School Infrastructure Quality (SIQ). The health dimension comprises Access to Healthcare Services (AHS), Nutritional Support (NS), Immunisation Coverage (IC), and Mental Health Support (MHS). The integrated policy dimension includes Educational Policy Effectiveness (EPE), Healthcare Policy Effectiveness (HPE), Child Protection Services (CPS), and Social Welfare Scheme Access (SWSA). Child Empowerment (CEI) and Child Well-Being (CWI) represent the outcome constructs.

The analysis was conducted using R software. Descriptive statistics and frequency distributions were used to summarise the demographic profile. Internal consistency was assessed using Cronbach’s alpha. The suitability of the data for exploratory factor analysis (EFA) was examined using the Kaiser–Meyer–Olkin (KMO) measure and Bartlett’s test of sphericity. EFA was performed using the minimum residual extraction method and oblimin rotation, while parallel analysis was used to guide factor retention.

Multiple linear regression was subsequently applied to examine the hypothesised relationships. The first model assessed the relationships of AQE, MMS, DLA, and SIQ with CEI. The second model examined the relationships of AHS, NS, IC, and MHS with CWI. The third model evaluated the relationships of EPE, HPE, CPS, and SWSA with CEI. Regression coefficients,

standard errors, t-statistics, p-values, R-squared, adjusted R-squared, and F-statistics were considered when interpreting the results. Statistical significance was evaluated at the 5% level.

4. Results

The demographic profile presents the characteristics of 287 respondents from Delhi. Regarding gender, males constituted the majority (55.05%), followed by females (42.51%), while 2.44% selected other or preferred not to disclose. The largest age group was 14–16 years (36.59%), followed by respondents aged 10–13 years (26.83%) and 17–18 years (20.21%). Parents or guardians represented 50.87% of respondents, while adolescents accounted for 32.75% and teachers, community members, or frontline workers constituted 16.38%. In terms of education, higher secondary education was the most common category (33.80%). Most respondents belonged to urban low-income or resettlement localities (70.03%). Regarding monthly household income, the lower-middle income group represented the largest proportion (35.19%), followed by the lowest-income group (28.92%). These characteristics provide context for examining child empowerment and public policy.

Table 1. Reliability Analysis

Construct	Number of Items	Cronbach's Alpha
AQE	3	0.766
MMS	3	0.767
DLA	3	0.808
SIQ	3	0.752
AHS	3	0.715
NS	3	0.772
IC	3	0.727
MHS	3	0.739
EPE	3	0.772
HPE	3	0.744
CPS	3	0.763
SWSA	3	0.799
CEI	3	0.831
CWI	3	0.852

Table 1 presents the reliability of the 14 constructs measured using Cronbach's alpha, with three items used for each construct. The alpha values range from 0.715 to 0.852, indicating acceptable internal consistency across the measurement scales. Child Well-Being (CWI) records the highest reliability value of 0.852, followed by Child Empowerment (CEI) at 0.831 and Digital Learning Access (DLA) at 0.808. Social Welfare Scheme Access (SWSA) also demonstrates good reliability, with an alpha value of 0.799. Access to Healthcare Services (AHS) records the lowest value of 0.715, although it remains within the commonly accepted range for exploratory research. Overall, the results indicate that the items within each construct demonstrate satisfactory internal consistency for further factor analysis and regression analysis.

Table 2. Summary of Exploratory Factor Analysis

Parameter	Result	Interpretation
Sample size	287	Complete cases analysed
Number of observed items	42	Measurement items analysed
Number of extracted factors	14	Fourteen-factor solution
Extraction method	Minimum Residual (minres)	Factor extraction method
Rotation method	Oblimin	Allows factors to be correlated
KMO measure	0.843	Adequate sampling adequacy
RMSR	0.017	Low residual discrepancy
Tucker–Lewis Index (TLI)	0.995	Favourable fit statistic
RMSEA	0.008	Low estimated approximation error
RMSEA 90% confidence interval	0.000–0.024	Low upper confidence limit
BIC	−1687.734	Information criterion for model comparison
Parallel analysis	14 factors suggested	Supports examining a 14-factor solution

Table 2 presents the results of exploratory factor analysis conducted on 42 measurement items using 287 complete cases. The Kaiser–Meyer–Olkin (KMO) value of 0.843 indicates adequate sampling adequacy for factor analysis. The minimum residual extraction method and oblimin rotation were used, allowing the extracted factors to correlate. Parallel analysis suggested a 14-factor solution, consistent with the study's 14 constructs. The model also demonstrates favourable fit statistics, including an RMSR of 0.017, a Tucker–Lewis Index (TLI) of 0.995, and an RMSEA of 0.008, with a 90% confidence interval ranging from 0.000 to 0.024. The negative BIC value of −1687.734 provides an additional criterion for comparing factor solutions. Overall, these results support examining the 14-factor structure, although the complete factor-loading matrix should also be reviewed.

Table 3: Regression Analysis of Child Empowerment and Integrated Public Policy

	Dependent variable:		
	CEI Education Policy (1)	CWI Health Policy (2)	CEI Integrated Policy (3)
Access to Quality Education	0.181**		
	(0.058)		
Mid-Day Meal Scheme Benefits	0.362***		
	(0.057)		
Digital Learning Access	0.260***		

	(0.058)		
School Infrastructure Quality	0.232***		
	(0.059)		
Access to Healthcare Services		0.341***	
		(0.066)	
Nutritional Support		0.124	
		(0.065)	
Immunisation Coverage		0.322***	
		(0.066)	
Mental Health Support		0.120	
		(0.066)	
Educational Policy Effectiveness			0.196***
			(0.057)
Healthcare Policy Effectiveness			0.315***
			(0.060)
Child Protection Services			0.264***
			(0.058)
Social Welfare Scheme Access			0.257***
			(0.054)
Constant	0.041	0.433	0.091
	(0.249)	(0.289)	(0.236)
Observations	287	287	287
R^2	0.379	0.242	0.380
Adjusted R^2	0.370	0.231	0.372
F Statistic (df = 4; 282)	43.006***	22.534***	43.294***
Note:	*p<0.05; **p<0.01; ***p<0.001		
	*** p < 0.001; ** p < 0.01; * p < 0.05		

Table 4 presents three regression models examining education policy, health policy, and integrated public policy. Model 1 explains 37.9% of the variation in Child Empowerment (CEI), with all four education-related predictors showing positive and statistically significant associations. Mid-Day Meal Scheme Benefits has the largest coefficient (β = 0.362), followed by Digital Learning Access (β = 0.260), School Infrastructure Quality (β = 0.232), and Access to Quality Education (β = 0.181). Model 2 explains 24.2% of the variation in Child Well-Being (CWI). Access to Healthcare Services (β = 0.341) and Immunisation Coverage (β = 0.322) are significant predictors, whereas Nutritional Support and Mental Health Support are not statistically significant at the 5% level. Model 3 explains 38.0% of the variation in CEI, with

Healthcare Policy Effectiveness (β = 0.315) recording the largest coefficient. All four integrated-policy predictors are statistically significant.

5. Discussion

The findings highlight the importance of education, healthcare, and integrated public policies in understanding child empowerment and child well-being. The education policy model explains 37.9% of the variation in Child Empowerment (CEI), with all four predictors demonstrating positive and statistically significant associations. Mid-Day Meal Scheme Benefits emerged as the strongest predictor, followed by Digital Learning Access, School Infrastructure Quality, and Access to Quality Education. This suggests that educational empowerment may depend not only on access to formal education but also on nutritional assistance, digital learning opportunities, and adequate school facilities. These findings can be discussed in the broader context of inclusive education and child development addressed in previous research (Haque et al., 2021; Sharma & Das, 2021). The health policy model explains 24.2% of the variation in Child Well-Being (CWI). Access to Healthcare Services and Immunisation Coverage demonstrate significant positive associations, highlighting the importance of healthcare accessibility and preventive health interventions. However, Nutritional Support and Mental Health Support are not statistically significant at the 5% level when the other predictors are included. This does not necessarily indicate that these services are unimportant; their independent contributions may depend on overlapping influences or contextual factors. The results underline the value of examining multiple dimensions of child health and development together (Lewington et al., 2022; Moore et al., 2022).

The integrated public policy model explains 38.0% of the variation in Child Empowerment. Healthcare Policy Effectiveness records the strongest association, followed by Child Protection Services, Social Welfare Scheme Access, and Educational Policy Effectiveness. These findings suggest that child empowerment may be associated with coordinated policy support extending beyond educational interventions alone. Effective healthcare systems, protective services, and accessible welfare schemes may collectively contribute to an enabling environment for children (Besnier et al., 2024; Singh & Singh, 2025). Overall, the results support a multidimensional perspective on child empowerment and well-being. Policymakers should consider coordinated educational, healthcare, and social protection initiatives. However, the regression findings establish associations rather than causality, and further research using verified empirical data is necessary to confirm their generalisability.

6. Conclusion

This study examined the relationships between educational policy, healthcare policy, integrated public policy, child empowerment, and child well-being. The findings highlight the importance of considering multiple dimensions of public policy when addressing children's developmental needs. The education policy model explained 37.9% of the variation in Child Empowerment (CEI), with Access to Quality Education, Mid-Day Meal Scheme Benefits, Digital Learning Access, and School Infrastructure Quality demonstrating positive and statistically significant

associations. Among these variables, Mid-Day Meal Scheme Benefits recorded the strongest coefficient, suggesting the potential importance of combining educational opportunities with nutritional support and student welfare initiatives.

The healthcare policy model explained 24.2% of the variation in Child Well-Being (CWI). Access to Healthcare Services and Immunisation Coverage were significant positive predictors, whereas Nutritional Support and Mental Health Support did not achieve statistical significance at the 5% level. These results indicate the need to examine healthcare interventions individually and collectively to understand their relationships with child well-being. The integrated public policy model explained 38.0% of the variation in Child Empowerment. Healthcare Policy Effectiveness emerged as the strongest predictor, followed by Child Protection Services, Social Welfare Scheme Access, and Educational Policy Effectiveness. This finding underscores the relevance of examining education, healthcare, child protection, and social welfare within a coordinated policy framework.

From a practical perspective, policymakers should strengthen school infrastructure, improve digital learning access, maintain effective nutritional programmes, expand healthcare accessibility, and enhance child protection mechanisms. Greater coordination among educational institutions, healthcare providers, and social welfare agencies may help create supportive environments for children. Policy evaluation should also consider differences in household income, locality, and access to public services.

Despite these contributions, the study has limitations. The dataset documentation identifies the records as synthetic, meaning the results should be interpreted as illustrative analytical findings rather than evidence from actual respondents. Future research should use verified empirical data, broader geographical coverage, and longitudinal designs to investigate changes over time. Additional analyses could examine demographic differences, indirect relationships, and interactions among policy dimensions. Overall, the study provides a preliminary analytical framework for examining how educational, healthcare, and integrated public policies relate to child empowerment and well-being.

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