Archives of Educational Studies
Volume 2, No. 2, 2022, 144-164
https://ares.pk/

Comparative Analysis of Educational Needs and Residential Care Services for the Destitute Children in Private and Public Welfare Homes Peshawar, Khyber Pakhtunkhwa, Pakistan

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Abstract

In Pakistan, deficient literature on residential care and educational services for destitute children raises concerns because child social protection is mostly ensured by families, and in the absence of families, these are provided by either public or private organizations. The objective of the study was to compare public and private residential care and educational services for destitute children in residential care homes. The symmetry of residential care services with indigenous familial services was analysed by using a convergent mixed-method research approach The Quantitative data was collected through a questionnaire from 274 children and qualitative data interviews were conducted with 5 staff members of the residential care institutes in Peshawar, Pakistan. The study found that public and private residential services are unique. Also, the service provided in the residential care institute was rated similar by children to their home setting, but staff members describe it as high quality. Hence, it was concluded that public and private organizations were providing similar kinds of services which were symmetrical to poor families' provisions. A more holistic comparison of different types of residential care with indigenous familial services may provide more insight into the problem.

Keywords: *Mixed-Method, Social Protection, Destitute children, Public, Private, Residential care, educational services*

Introduction

Worldwide estimates show that 2.7 million children are living in residential care facilities. Meanwhile, 15 out of 100,000 children live in residential care only in South Asia (Cappa et al., 2022; Petrowski et al., 2022). This estimate may be the tip of the iceberg because developing countries lack effective reporting and protection mechanisms (Khalid & Hassan, 2020; Rehmatullah, 2002). Thus, nearly 7 million orphans live in residential care. Majority in the age group 7-15 years with more male dominancy (Abdullah et al., 2015; Alam & Sajid, 2021; Ali & Muynck, 2005; Bukht et al., 2020; Feroz et al., 2020; Mishra & Sondhi, 2018; Sellers et al., 2020). However, the actual statistics will be different due to under-reporting. Major reports suggest a range of 2 million to 8 million (Browne, 2009) but this lack reliable updated data.

The rapid increase in destitute children leads to high enrolment in residential care. It is the outcome of structural factors in societies to either push or full children into residential care. Poverty and large family size are the dominant push factors (Pillay, 2016). Similarly, the pull factors include food, education, health and recreation opportunities in residential care settings (Naqshbandi et al., 2012). In addition to that, some minor factors are neglect of parents and stigma (Pillay, 2016). Studies support that destitute children see residential care services as an opportunity to end their disadvantaged adult role and deprivation (Mishra & Sondhi, 2018; Sellers et al., 2020). Meanwhile, children who got no access to residential care are found the trap by gangs, drugs, beggary and poverty (Hassan et al., 2020; OECD, 2019; UNICEF, 2021; World Bank, 2020). Various measures are suggested by researchers for the prevention of children from deprivation. It includes reducing push and pull factors, as well as provision of quality residential, care services (Dybicz, 2005).

The quality of residential care is associated with evidence-based service designing but most residential care lacks evidence-based practices. Almost 88% of stakeholders report their model of practice evidence base while each organization have put into practice its own services model (Dozier et al.,

2012; Khalid, 2014). As a result, their services are wrestling with the delivery of evidence-based residential care services (James et al., 2015).

addition to that UN CRC stressed right-based services for a child and prioritized basic physical needs fulfilment such as shelter, food, education, and recreation. In response to that major organizations arranged full-time homes for children. However, children were reported to feel insecure in it. This may hamper their development (Sellers et al., 2020). This situation becomes worse when disabled children were mixed-reared with normal. However, studies in Peshawar found that 64% of children were satisfied with the overall accommodation of residential care homes (Abdullah et al., 2015; Akram et al., 2015).

Residential care homes follow food menu, according to their resources (Tahir et al., 2015). The majority of Children show satisfaction with the food (Abdullah et al., 2015). Overall studies are mixed as some state that the fixed menu of food is hard to justify for a balanced diet (Feroz et al., 2020) and children show malnourishment (Lassi et al., 2011; Sanou et al., 2008). Whereas, other suggest that the dietary intake of these children are good as compared to their counterpart in the street and community (Bukht et al., 2020). Educational services in residential care homes vary according to the type of organization. Major residential homes claim to have their school system for children but are found to be more focused on religious education (Feroz et al., 2020; Tahir et al., 2015). Few residential care homes send their children to outside public and private schools. In contrast to the claims of quality education, researchers found low-quality education and harsh treatment of destitute children in their schools (Alam & Sajid, 2021).

Nearly all residential care homes provide any form of recreational services to children (Abdullah et al., 2015; Mishra & Sondhi, 2018). Their recreational services are dependent on sponsorships from donors and the availability of funds (Feroz et al., 2020). Indoor games are most frequently founded, as in Pakistan, residential care homes prohibit children from outdoor games, because of protection issues. Similarly, the children of residential care homes are diverse kind. The wworldwide trend in residential care shows the dominancy of orphans and AIDS-affected children in Africa with NGOs sponsored homes (Sanou et al., 2008). Europe has poor and homeless children

with publicly supported foster homes (Kamerman & Gabel, 2006). Indian sub-continent shows the dominance of orphans within faith-based organization homes (Dutta, 2016). Major children in China and Russia are poor and orphans living within indigenous model homes. Among all these practices for destitute children, studies consider the Chinese model to be more effective of all (Hong et al., 2015).

Since the UN conventions on child rights, the quality of residential care is associated with universal right-based institutional care (Frances, 2011). Countries also failed to formulate residential care services based on universal child rights conventions (Kamerman & Gabel, 2006). However, studies raise questions about quality of this approach. In contrast, evidence suggests training and qualified staff is key to quality services but this is hardly found in this kind of service (Davidson, 2010). In some situations, only one caregiving staff is available for children to take care of (Feroz et al., 2020). The vague and misfit residential care services pushed children back to family support (Dutta, 2016). In response to these issues, even the United Nation call for alternative care services (Huefner, 2018).

Since Pakistan's ratification of UN child rights conventions and optional protocols till now the government lack effective protection services for destitute children. (Society for the Protection of the Rights of the Child, 2012; UNICEF & Government of Pakistan, 2017). Hence, a mixture of public and private residential care services existed for destitute children. Government-run sweet homes and welfare homes as residential care for destitute children. Civil society organizations have their own care homes in different parts of the country (Sayeed, 2004; Shujaat, 2015). After the 18-devolution amendment, all the power and responsibilities of child protection shifted to provinces. In this regard, Khyber Pakhtunkhwa province passed the child protection and welfare commission act 2010. After the implementation of this act social welfare ministry developed protection units at the district level and a model home in Peshawar, Mardan named *Zamong Kor* (Our House).

In the growing situation of destitute children in Pakistan. Experts believe that in Pakistan, due to structural and policy issues public and private residential care services for children are not as effective and of average quality (Alam & Sajid, 2021). According to studies Public care homes have untrained

and under staff (Shujaat, 2015). This put younger children at more risk of abuse by staff and children (Mahmood et al., 2020). Private care services attempt to provide comparatively satisfactory services (Akram et al., 2015) but lack sustainability. Thus, a lack of empirical study on comparative analysis of public and private residential care services may compromise global child protection efforts as well the regional services (Towe et al., 2009). Also compromised the rights of children to safe family or community support and less exposure to institutionalization (Longfield, 2020).

The purpose of this inquiry is to compare public and private residential care and educational services with indigenous family provisions to conclude for suitability of child protection services in an i2ndigenous cultural context. We chose a convergent mixed-method research design in contrast to early studies. This will provide a comprehensive understanding of the problem within context (Lund, 2012). Addressing this problem will provide the opportunity for public and private residential care providers to understand the importance and collaborating role of indigenous cultural patterns in child protection services and to redesign their intervention and policies to enhance social protection for destitute children.

Theoretical Framework

A more agreed definition in the children's context is any type of temporary living arrangement either in institutions or group homes where children are looked after by a paid caregiving staff (Groza & Bunkers, 2017; Nhep, 2021). Thus, under this definition, our study includes all short and long-term services such as residential schools, orphanages, and institutions but excludes all foster care services either provided by families or kins. We use United Nations Child Right Convention as a theoretical framework. In child welfare services CRC is a suitable framework to operationalize child wellbeing (Wulczyn et al., 2021). Though, only a child physical need-based approach was adopted. For this article 27, 29, 30 and 31 of the UN CRC were operationalized. Thus, four core items were identified and operationalized.

Table 1

Variable for the study

Dependent Variables	Intervening Variables	Independent Variables
Residential Care Service	Guardian Occupation	Food
		Shelter
	Child Enrolment Causes	Education
		Recreation
		Caregiving

Materials and Methods

To compare residential care services designed for children we adopted a convergent mixed-method design under the triangulation. This method provides a holistic insight into complex welfare problems (Creswell, 2014; Lund, 2012). In addition, the convergent nature of the method provides context for the equal representation of service providers and users (Creswell & Clark, 2017; Gunasekare, 2015).

First, we conducted a pilot study in the universe of the study. It is the capital city of Peshawar in the province of Khyber Pakhtunkhwa in Pakistan. Six residential care homes were identified to be included in the study because of the proximity and permanent residential care services providers. Then utilized a non-nested sampling technique and each residential care home was divided into children and staff members. through concurrent sampling methodology, allocated a separate sample for each qualitative and quantitative data (Schoonenboom & Johnson, 2017; Teddlie & Yu, 2007).

For the quantitative part of the study, 288 out of 1024 children were estimated statistically by the Yamane formula (Yamane, 1967). Sample distributed through proportionate methods among the residential care institutes. The researchers then visited each residential care institute and printed questionnaires were filled in from randomly selected participants. However, only 274 children participate in the study. Collected Quantitative data were analysed statistically. Two hypotheses were proposed: (i). Private residential care services are more effective than public; (ii). Residential care service for destitute children is like their familial services. These hypotheses were tested through the chi-square tests.

A sample of six staff members was selected with the help of a purposive sampling technique. Interviews were conducted with five participants in their offices. The rest of one residential care home was shut down during the period of this study. An interview guide was used during the interview process and audio was tapped through the recorder. Qualitative interviews were transcribed and analysed for themes with the assistance of QDA Miner Lite software. Written consent was obtained from each residential care institute and verbal from each participant. Results were triangulated to answer for research question accordingly.

Results

All children who lived in the residential care homes were male as no female child was reported in the study. Age-wise comparison show public and private residential care institutes' differences (Table 2: Public N=74, 9-13, Private N=78, 14-18). Children also vary by family background (Table 2; Public N=56 Nuclear, Private N=79 Joint). A significant number of children belong to nuclear families in both residential care institutes (Table 2: Public 43.4%, Private 56.6%). Children guardian occupation for labourers stands highest at 40 % for public residential care institutes and 60.0% for private, meanwhile, the employees' children ratio is slightly higher in private 78.3% as compared to 21.7% (Table 2). The significant reason for admission to residential care was orphanhood and poor families (Table2: Orphanhood; Public N=63 Private N=129, Poor family; Public N=35 Private N=36) but private residential care homes show enrolment of N=6 drug addicts' children as well.

Table 2

Demographic characteristics of Children participants

		Public residential care institute		Private residential care institute	
		Count	N %	Count	N %
Age	3-8	2	4.9%	39	95.1%
	9-13	74	56.1%	58	43.9%
	14-18	23	22.8%	78	77.2%
Family type	Nuclear	56	43.4%	73	56.6%
	Joint	38	32.5%	79	67.5%

		Public residential care institute		Private residential care institute	
		Count	N %	Count	N %
	Extended	5	17.9%	23	82.1%
Guardian occupation	Unemployed	35	47.9%	38	52.1%
	Laborer	40	40.0%	60	60.0%
	Employee	13	21.7%	47	78.3%
	own business	11	26.8%	30	73.2%
Reason of admission	Drug abuse	0	.0%	6	100.0%
	Delinquency	1	20.0%	4	80.0%
	Poor family	35	49.3%	36	50.7%
	Orphan hood	63	32.8%	129	67.2%

Residential care institutes wise comparison of services

To evaluate the first hypothesis, we compared residential care institutes according to their Food, shelter, education, recreation, and caregiving ratings by children and then cross-check it with qualitative results.

In the category of food, the N=51 of private residential care institute children rated their food as exceptionally good. In addition, 36.4% of public residential care institute children considered their food good in comparison to 46.3% of private but for the bad category, only public stood at 18.2% as compared to 4.6% in private (Table 3). Test results showed the significance of this association (Table 3; χ^2= 17.256, *P=0. 002*). Good was a widely held response toward accommodation 43.4% for public and 34.9% for private children. A slight difference appeared for bad ratings 13.1% for private as compared to only 3.0% for public. Chi-square tests showed this relationship significant (Table 3; χ^2 = 10.236, *P=0.037*). The comparison for the education services did not appear statistically significant (Table 3; χ^2 = 2.824, *P>0.05*). In the comparison of the recreational services, the public stood at 31.3% in the

normal category and private at 57.7% in the good category. This result found statistically significant as test statistic indicated (χ^2 = 45.975, *P<0.05*). Further, both public and private residential care institute showed higher ratings for the overall good well-being of children (Table 3; Public 71.7% vs. Private 45.7%). In addition, it was found overall well-being particularly good 27.4% of private residential care institutes as compared to public 5.1%. Therefore, the test results also favored these differences (Table 3; χ^2 = 28.177, *P<0.05*) and thus did not support the stated hypothesis.

Table 3

Quantitative comparative analysis of public and private services

Rating type		Public residential care institute		Private residential care institute		χ^2	df	P-Va
		Count	Row N %	Count	Row N %			
Food	Very good	20	20.2%	51	29.1%	17.256	4	.002
	Good	36	36.4%	81	46.3%			
	Normal	22	22.2%	28	16.0%			
	Bad	18	18.2%	8	4.6%			
	Very bad	3	3.0%	7	4.0%			
Accommodation	Very good	34	34.3%	50	28.6%	10.236	4	.037
	Good	43	43.4%	61	34.9%			
	Normal	13	13.1%	33	18.9%			
	Bad	3	3.0%	23	13.1%			
	Very bad	6	6.1%	8	4.6%			
Education	Very much	51	51.5%	99	56.6%	2.824	4	.588
	Somehow	27	27.3%	44	25.1%			
	Normal	14	14.1%	15	8.6%			
	Unsatisfied	5	5.1%	13	7.4%			
	Very much unsatisfied	2	2.0%	4	2.3%			
Recreation	Very good	18	18.2%	46	26.3%	45.975	4	.000
	Good	27	27.3%	101	57.7%			
	Normal	31	31.3%	17	9.7%			
	Bad	15	15.2%	8	4.6%			
	Very bad	8	8.1%	3	1.7%			
Overall Wellbeing	Very Good	5	5.1%	48	27.4%	28.177	4	.000
	Good	71	71.7%	80	45.7%			
	Normal	18	18.2%	30	17.1%			
	Bad	5	5.1%	10	5.7%			
	Very Bad	0	.0%	7	4.0%			

Table 4

Qualitative comparison of institutional services

Category	Quotes
Public residential care institute description of services	*"Our institution provides full-time high-quality accommodation with all kinds of services, which a family may provide to a child including, quality and timely meals, having bedrooms for children, clothes, school uniforms, and education and so on. Every two children are provided one room for living. They have drinkable water and a toilet"*
Private residential care institute description of services	*"We provided them with every kind of service, mean including every child that getting; what in their home can get that here. A standardise diet, a standard education, medical facilities, and recreational facilities, what have their needs are fulfilled by the residential care institute. Upper-middle-class family-like services are provided to children here"*

Qualitative results verified the mixed difference between public and private services. The services provided full-time residential care which includes the fulfilment of children's all physical needs. Also, both residential care institutes considered their services effective and categorise them as good quality (Table 4).

Comparison of residential services with children's familial services

The second hypothesis; Residential care services for destitute children are like their familial services was tested. A chi-square test was applied on the self-rating data of children. It indicated that the stated hypothesis stood true (χ^2 =92.569, df =5, P= *.00<0.05)*. Additionally, descriptive statistics indicated that the observed values for similarity of home and residential services were among the highest (Table 5: same as home observed 121, expected 68.5).

Table 5

Rating of institutions' services by children

Rating	Observed N	Expected N	Residual
Good from your home	84	68.5	15.5
Same as your home	121	68.5	52.5
Not like your home	40	68.5	-28.5
Your home is better than this	29	68.5	-39.5
Total	274		

Qualitative results from interviews with staff members did not support the quantitative findings. Rather, it suggested that the services provided by the residential care institutes were of the best quality in comparison to destitute children's familial services. The respondents provided that most children belonged to poor families and could not afford this kind of service. They were of the view that destitute children are very much satisfied with the residential care services as they never stay long at home (Table 6).

Table 6

Comparison of residential services with local family services by residential care institute staff

Dimension	**Quotes**
The quality of accommodation provided to children in institutions is much higher than those families provide to them	*"Our institution provides a full-time high-quality accommodation with all kinds of services, which a family may afford"*
Services for children provided here are of upper-class family level	*"Upper-middle-class family-like services are provided to children here"*
The children are very much satisfied with services as compared to their living in families	*"When we send these children home for many days they return after 2 days with the intent that their homes have no such kind of facilities that are available for them here"*

Discussion

The results of this study highlighted several factors. First, there were gender disparities in residential care services for destitute children. Therefore, it provided that female children have very low access to residential care services which was founded in the early literature on child protection programs (Abdullah et al., 2015), however, Mishra & Sondhi (2018) study disagreed by finding out more female than male children. Second, this study demonstrated that most of the children in these residential care institutes were orphans. It is the verification of findings of earlier scholars who named residential care homes in Pakistan as orphan homes (Akram et al., 2015; Alam & Sajid, 2021; Castillo et al., 2012; Feroz et al., 2020; Mahmood et al., 2020). Moreover, it is believed that the number of street and drug-addicted children are very high in cities (Society for the Protection of the Rights of the Child, 2012) but only private residential care institutes included some drug-addicted children. The more marginalized street children and addicted who are more in need of such kinds of services were absent. This may be due to the possible poor enrolment mechanism.

The major age category in this study is 9-13 years which is in line with the major trend in early studies (Whetten et al., 2009). In addition to that family stands, as the first actor in children enrolment and the institutional staff's role in searching for an enrolment of destitute children were negligible. This may be due to the possible lower age group or may be due to the dominant role family play in children's lives in this cultural context. This study supports that a major portion of these children belongs to nuclear families. Thus, there may be an association between children's enrolment in a residential care home and family type which need further exploration. It may be due to the low capacity of families in face of poverty to support their children. It was found that the decline of extended family and kins support pushed destitute children to depend on residential care services (Dybicz, 2005).

The findings of this study are providing mixed support to the stated hypothesis. One residential care institute was performing better in one category so the other was doing well in another category. Therefore, this is not in line with the stated supposition. However, private residential care institutes showed slightly higher quality in food and education. It is because private

institute have either their own private school or they send children to a standardise private school. However, it is low significant association. Former research indicated a slightly better quality of food and educational services in private residential care (Feroz et al., 2020; Tahir et al., 2015). The public residential care institutes showed better ratings in accommodation, recreation, and caregiving. This finding also supports by some studies (Abdullah et al., 2015) but some disagree and report that children are provided low-quality services that put them at risk (Mahmood et al., 2020).

The qualitative result also supports these findings and did not report any major difference in the services of public and private residential care institutes. Despite these findings of the current research, past studies suggested private residential care is better quality (Kamerman & Gabel, 2006; Ryan et al., 2009) and better satisfy children's needs (Akram et al., 2015). Although, the possible factor in the correspondence of services in this study may be the adoption of a universal approach to child protection by the organization. Policies of the government and private residential care institutes are highly influenced by the universal convention on child rights. Thus, they see the success of child protection services in an adaptation of universal models and conventions in designing their services (Pulla et al., 2018).

Major literature on child protection stress on provision of right-based services to children which includes all the granted rights of children in universal conventions to be fulfilled by residential care institutes. (Khalid, 2014; CRC[1], 1989). However, it was found that each residential care homes claim the uniqueness of its services which any other residential care institute may not be able to provide. This study concluded that all their services are one copy applied in all public and private residential care institutes. Some scholars warn about the universal approach for child protection around the world (Dybicz, 2005) which ought to be successful in every cultural context. Children reared in low-quality residential care are at greater risk of abuse and attachment in later life (Greger et al., 2016).

Therefore, findings from children and staff were not aligned, each supported a different perspective. Quantitative findings indicated that

[1] Convention on the Rights of the Child

residential care services were providing a home-like environment to children and qualitative suggested the highest quality of services. It pretended by service providers that residential care services are more effective. Some studies support the finding of qualitative results. Research reported that residential care is better than children's home environment (Whetten et al., 2009). However, this claim is in contradiction with our quantitative findings which report it like child home provisions. Some studies correlate children's high satisfaction with residential care to their poor familial background (Mahmood et al., 2020). They identified that the possible factor for the rating of services as like home is the cause of the poverty level of households. These children have no access to any basic needs in the family. Their families hardly manage to provide them with food. Thus, these destitute children perceived residential care of better quality.

Similarly, residential care services in developing countries such as Pakistan are based on basic need fulfilment and are key to the successful integration of destitute children in societies (Mathiti, 2006). On the other hand, it is well established by some studies that public and private social protection services for children lack a commitment to quality in Pakistan (Khalid, 2014). Studies associate the deferential effects of institutional care with low-quality, resources and untrained staff (Sanou et al., 2008). This suggests that the quality of care in residential care is more important than its setting.

Thus, our results suggest that service providers need to consider the quality and cultural compatibility of residential services. They also need to consider the scholar's approach who did not consider residential care for orphans and destitute children as a priority and an effective solution to a problem. They consider these services maybe not be a successful substitute for the family system (Dozier et al., 2012). It is suggested that children living in the traditional family system may have a better quality of life than those in residential care. They propose that system of residential care is the product of the developed nation. Child protection services based on different cultures did not fit into developing countries' cultural contexts. Thus, there is a need for a locally emerged solution to child protection problems (Jabeen, 2013; Kamerman & Gabel, 2006; Rehmatullah, 2002).

Conclusion

This research in combination with other recent studies on the comparison of public and private residential care and educational services put forward that residential care and educational services provided by residential care institutes and their compatibility with indigenous cultural context is a common question in developing countries like Pakistan. So, it is important to analyse the residential services in association with destitute children's family environment. By assessing the residential care and educational services for destitute children through a mixed method. it is established in this study that such kinds of services, of less accessible, limited, and minimum quality may not be a substitute for those services that a poor family can provide. There must be a mechanism to assess residential care services in comparison to familial services to better care for destitute children. It put forward, the need for assisting children within their families, and residential care services must be the lowest priority for destitute children. Hence, in this study, it was found that residential care and educational services for destitute children have similarities with those families provide and are not of good quality. As well as we found that public and private residential care institutes did not vary in services. However, slight differences were reported which nullify each other. Hence, residential care and educational services must not be based on sole universal convention alone. It might satisfy children's needs but leave no room for improvement of protection services for destitute children.

Prospect research on residential care services' effectiveness and compatibility within local cultural contexts may provide a platform for quality services. Also, qualitative in-depth studies need to uncover the lives of destitute children and their problems during institutional care provided to them by public and private organizations in the local context. This study's qualitative finding may be affected by the possible factor of respondents' social desirability bias due to the small sample size. Further investigation based on a larger sample size may provide precise data about the phenomenon. There is a need for studies to explore the possible link between families' backgrounds and children's perceptions of residential care services.

Declaration of interest

The Authors have no conflict of interest and no funds received for this research.

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