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Navigating the Triad of Needs: Emotional Security, Healthcare, and Educational Realities of Children in Alternative Residential Care in Rural India

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Abstract - ***Purpose:*** The paper explores lived experiences, institutional provisions, and developmental vulnerabilities of children in rural Child Care Institutions (CCI) in India. Based on a conceptual triad of Emotional Security, Health and Well-being, Education and Skills, and Independent Adulthood, the study examines the role of institutional processes in mediating or limiting child developmental pathways in statutory child-protection paradigms. ***Design/methodology/approach:*** The research design is an inductive, single-site descriptive case study design with a total census cohort (N=20) in a rural sub-district of Maharashtra, India. Triangulation of empirical data was done through administrative artifact audits (custody orders, school logs, and health registries), non-participant naturalistic observations, and semi-structured in-depth interviews with resident children (n=10, ages 10-17) and staff involved in caregiving (n=4). Thematic analysis was used to analyze qualitative materials using a six-phase framework of Braun and Clarke. ***Findings:*** Contrary to the belief that institutionalized youth are double-orphans, 100% of the cohort have living biological relatives, 65.0% of them live in single-parent or grandparent-headed families, and 100% of them come back to their homes on school breaks. Educational poverty has been the most common factor resulting in institutional entry (80.0% as opposed to familial abandonment). Although CCIs can offer basic physical security and school enrollment, there are still critical deficits in the triad: high caregiver-to-child ratios lead to emotional depersonalization; living conditions are characterized by nutritional and WASH shortages; and passive schooling is not enough to enter adult life as a digital native and proficient in the English language. ***Practical implications:*** The research findings can be applied as practical interventions at statutory nodes: increasing direct-to-family educational sponsorships under Mission Vatsalya to avoid unwarranted separation; institutionalizing certified trauma-informed caregiving (TIC) to reduce burnout among caregivers; making mandatory Primary Health Centre (PHC) pediatric audits; and organizing after-care interventions with mentorship and health insurance (PM-JAY) to avoid post-18 transition shocks. ***Social implications:*** By framing institutionalization as an informal poverty-reduction strategy of marginalized rural kin networks, this study shifts policy priorities away from institutional expansion of custodial agencies in favour of family preservation, deinstitutionalization, and capability-based child welfare. ***Originality/value:*** The article provides an empirically supported multi-stage structural research framework operationalizing Capability Approach, Attachment Theory, and Bioecological Systems Theory developed by Bowlby and Bronfenbrenner, respectively, to assess alternative residential care in the under-researched rural Indian environments.

Key Words: Alternative Care, Child Care Institutions (CCIs), Mission Vatsalya, Emotional Well-being, Healthcare, Educational Inclusion, Juvenile Justice, India

Paper type: Research paper

1. INTRODUCTION AND BACKGROUND

1.1 Global Landscape of Alternative Care

Alternative care includes formal and informal care arrangements for children who are unable to live with their biological families or with their habitual caregivers, including kinship care, foster care, family-based care, and residential care. The current international policy principle is that family separation should be avoided unless necessary and that family-based care should be the primary form of care and institutional placement as a last resort, which is enshrined in the United Nations Convention on the Rights of the Child (UNCRC) and the United Nations Guidelines for the Alternative Care of Children (2009).

According to UNICEF data, in 2025, about 2 million children were in residential care worldwide. In a previous UNICEF analysis of 142 countries, it was estimated that there were 2.7 million children aged 0-17 years of age in institutional care in 2017. These data points are not a longitudinal trend, but reflect changing measurement protocols due to changes in methodological protocols and classification parameters across reporting periods. Most importantly, global statistics show that not all children in residential facilities are orphans; a good number have their parents or other extended family members, but are limited by poverty, disability, social outcasting, or acute absence of communal support channels. As a result, the trend in international policy has been towards deinstitutionalization, family preservation, and enhancement of community-based care infrastructures.

1.2 The Indian Child Protection Paradigm: Mission Vatsalya and the JJ (Juvenile Justice) Act

The law of child protection in India is based on the Juvenile Justice (Care and Protection of Children) Act, 2015 (amended in 2021) and administered by the Ministry of Women and Child Development (MWCD). Important operational and judicial hubs are Child Welfare Committees (CWCs), Juvenile Justice

Boards (JJBs), District Child Protection Units (DCPUs), and registered Child Care Institutions (CCIs).

The main flagship scheme that realizes this mandate is Mission Vatsalya, which directly encourages family-based, non-institutional options, e.g., sponsorship, foster care, and kinship care, but institutionalization is the last resort. Indian Government and Press Information Bureau (PIB) official programme data on Financial Year (FY) 202425 indicate such a paradigm shift. In Financial Year (FY) 202425, 2,47,777 children were supported under Mission Vatsalya, including 76,882 children under institutional care in 2,559 Child Care Institutions and 1,70,895 children under non-institutional family-based care services like sponsorship, foster care, and kinship services. Supporting an aggressive policy change to models of family-strengthening and deinstitutionalization, non-institutional care increased assistance by 40.23% compared to FY 2023–24. This child protection ecosystem is further supported by the 24-7 Child Helpline 1098, which is linked to the Emergency Response Support System (ERSS-112), and the single-place Mission Vatsalya Portal for end-to-end digital tracking, institutional management, and case management.

1.3 Research Gap and Study Objectives

Although macro-level policy frames such as Mission Vatsalya focus on non-institutional options and institutional minimum conditions, there is a dearth of empirical studies that capture the micro-level facts of rural Indian Child Care Institutions. The current scholarly sources focus mainly on urban care homes or use aggregated administrative indicators, and do not incorporate the first-person voices of children, the operational limits of caregivers, and the general child-protection statutes. Most importantly, no unified structural frameworks investigate the interaction between early emotional security, physiological health, and capability-based education in preparing institutionalized youth to live outside of care.

In a bid to deal with such empirical and theoretical gaps, this research undertakes four objectives, which are:

1. To analyze the demographic backgrounds, family patterns, and the main socioeconomic circumstances that lead to the institutional entry of the children in rural CCIs, in particular, assessing the frequency of poverty-induced admission as opposed to absolute orphanhood.
2. To elicit and subdivide the first-hand participatory reactions of institutionalized kids in the developmental domains of emotional safety, healthcare, cleanliness, and educational ambitions.
3. To analyze the experiences of caregivers, staffing, and budgetary allocations resulting in operational differences between the statutory requirements and the day-to-day care delivery.
4. In order to develop a theoretically based structural process model that connects emotional security to health and capability acquisition with independent adulthood, provide actionable policy options aligned with the Juvenile Justice and Mission Vatsalya statutory architectures of India.

In order to achieve these goals, this paper adopts an inductive, single-site, descriptive case design, located in a rural sub-district of Maharashtra, India (N=20), and triangulates qualitative in-depth interviews with children and caregivers, observational field notes, and institutional administrative records. Basing the study on the Bioecological Systems Theory by Bronfenbrenner, the Attachment Theory of Bowlby, and the Capability Approach of Sen, the study explains the systemic level of barriers that work at the levels of institutional microsystems and statutory macrosystems. It is hoped that this paper will offer a translational roadmap to policy-makers, District Child Protection Units (DCPUs), and child-welfare practitioners to transform institutional care into an active practice of custodial stewardship instead of capacity-building youth empowerment. The rest of this paper is structured as follows: Sec. 2 examines the literature of the triad on a multidimensional level; Sec. 3 describes the research design and cohort characteristics; Sec. 4 discusses the conceptual framework, the research hypotheses, and the empirical results; Sec. 5 summarizes the theory discussion; Sec. 6 presents the action plan and the operational solution map; Sec. 7 explains the conclusion, limitations of the study, and research directions.

2. LITERATURE REVIEW: THE THREE ESSENTIAL DIMENSIONS

2.1 Emotional Needs and Psychosocial Functioning

There is a natural obstacle to developing safe primary attachments in institutional settings. In a meta-analysis of studies on attachment among institutionalized populations, Pears et al. (2015) found that secure attachment was only shown by about 18 percent of institutionalized children, whereas disorganized and insecure attachments were much more common among children raised by their families. Castle et al. (2013) supported the fact that institutional deprivation causes developmental delays, but strong adaptations occur in response to improvements in care environments.

In India, empirical studies highlight severe psychosocial susceptibilities. A cross-sectional study of 292 institutionalized children in Visakhapatnam reported that 16.78% of the children had clinically diagnosable emotional and behavioral issues, primarily peer conflict, conduct problems, and emotional withdrawal. Tertiary child psychiatric evaluations (e.g., the Swatantra Clinic) also point to high mental-health morbidity in children admitted to their services due to challenging conditions. At the qualitative level, Levey (2017) emphasized the impact of early trauma and caregiver turnover in rural South Indian homes on the ability to regulate emotions; therefore, trauma-informed caregiver training is urgently needed. The recent results of the study by Grover, Rastogi, and Chakraborty (2026) in Delhi are based on the idea that institutional employees will have difficulties managing emotional dysregulation and peer friction because of structural under-resourcing.

On the other hand, resiliency is a deep defensive process. Mishra and Sondhi (2018) found that institutional care, in spite of its shortcomings, can offset deep-seated trauma in the community before admission by building structure, a sense of determination, and future aspirations. According to recent comparative studies conducted by Cherewick et al. (2023) in 360 rural and urban institutionalized children showed that there was a strong negative correlation between resilience and depression, with the rural samples showing an even greater protective buffer when personal resilience was fostered. The systemic interventions that Trubey et al. (2024) and Ramos Miguel et al. (2024) study show that psychological interventions can produce significant short-term decreases in internalizing behaviors; long-term emotional stability cannot be achieved without long-term and embedded institutional support.

2.2 Healthcare, Nutrition, and Environmental Living Conditions

Access to healthcare, nutritional adequacy, and environmental sanitation regulate the physiological well-being of institutionalized children. Nutritional vulnerabilities are widespread as portrayed through physical health evaluations

across Indian CCIs. In their study of 100 institutionalized children in South India, Ganguly et al. (2019) found that 80% of boys and 68% of girls had an unhealthy Body Mass Index (BMI), and that 78% of the children had comorbidities and a lack of health awareness. Thapar et al. (2019) and Lang et al. (2015) found severe chronic stunting, anemia, and psychological distress in populations with specialized populations, e.g., children who were orphaned due to HIV/AIDS in coastal South India.

More importantly, cognitive performance is directly controlled by physical health. Kamath, Venkatappa, and Sparshadeep (2017) established a direct relationship between malnutrition among institutionalized children and cognitive delays and learning disabilities. Institutional environmental hygiene is also a very important determinant. Maharaj et al. (2019), in an international scoping review, showed that a lack of water, sanitation, and hygiene infrastructure (WASH), overcrowded dorms, and knowledge gaps among caregivers play a role in preventable infectious diseases in CCIs. Moreover, as Alves, Casanova, and Sanches-Ferreira (2025) pointed out, institutional exclusion is especially high among children with disabilities because of the lack of specialized therapeutic centers and healthcare indicators that are customized to address the needs of children with disabilities.

2.3 Educational Realities, Skill Acquisition, and Life Transition

Education is the major means of helping institutionalized children exit marginalization by the generation they belong to. A systematic review by Garcia-Molsosa, Collet-Sabé, and Montserrat (2021) and McCormick, McCafferty, and Hayes (2026) found that academic achievement in residential settings is determined by institutional expectations, a consistent educational context, parental engagement, and individual student aspirations.

Household secondary data analyses undertaken in India show that orphaned children are always trailing behind their non-orphan counterparts in academics. According to caregiver qualitative research, institutional placement guarantees basic school enrolment, but financial limitations do not allow CCIs to offer special tutoring, remedial learning, and vocational training. The QANCC standardized Questionnaires to Assess the (Fulfilment of) Needs of Children in Care, standardized by Modi, Kalra, and Roy (2021/2022), demonstrated that educational and interpersonal aspirations are often not met when the institutions did not have individual support mechanisms.

3. RESEARCH METHODOLOGY

3.1 Empirical Case Study: Rural Institutional Realities in Maharashtra

In order to anchor the macro literature to micro-level lived experiences, this paper will rely on the primary empirical findings of a rural Child Care Institution in the Ahmednagar/Shirdi rural belt in the state of Maharashtra in India.

3.1.1 Research Design and Sampling Framework

This paper took an inductive single-site descriptive case study approach centered on a rural Child Care Institution (CCI) under-resourced and understaffed in the Ahmednagar/Shirdi administrative belt of Maharashtra, India. The sampling was a total census method, which included all of the active participants in the facility (N=20). The cohort comprised 10 girls (55.0%) and 10 boys (55.0%) with a mean age of 12.75 years (SD=3.01, range: 6–18 years, median: 13 years). In addition, qualitative data were gathered from 4 adult institutional informants (n = 4), comprising three full-time administrative care staff/wardens and one 29-year-old resident caretaker who was raised in the facility and currently assists in daily floor caregiving and supervision while pursuing higher educational rehabilitation.

3.1.2 Data Collection and Methodological Triangulation

To achieve qualitative credibility and reduce the influence of a single informant, the empirical data were triangulated in three methodological streams: audits of administrative documents (intake ledgers, Child Welfare Committee custody orders, health registries, school enrollment logs) to chart socioeconomic and familial profile; semi-structured in-depth interviews with resident children (n=10, ages 10-17) and caregivers (n=4) about daily routines, emotional stressors, and institutional capacities; and non-participant naturalistic observations of living quarters, study space, meal preparation, and daily interpersonal interactions.

3.1.3 Qualitative Analysis Protocol

Thematic analysis was used to analyze textual data collected through interviews and field notes based on the six-phase model of thematic analysis presented by Braun and Clarke (2006). All qualitative data were repeatedly reread to familiarize the researchers with the data and systematically divided into initial semantic codes (e.g., resource scarcity, craving affection, digital divide) and grouped into overriding themes that were aligned with the conceptual triad.

3.1.4 Ethical Safeguards and Vulnerability Protocols

Owing to the inherent vulnerability of children in residential care, strict ethical procedures were observed at all stages of the research: administrative approval was given by the governing board of the care home and the social welfare department before entering the field; adult caregivers and superintendents gave written informed consent; all minors gave verbal and written consent in their native language (Marathi/Hindi) under express conditions of voluntary and penalty-free participation; and full anonymity was ensured through the replacement of all personal names, individual identifiers, and exact geographical localities with standardized pseudonyms.

3.2 Cohort Characteristics and Demographic Profile

As summarized in Table 2, the resident cohort (N = 20) exhibits an almost balanced gender distribution (50.0% girls, 50.0% boys) with a mean age of 12.75 years (SD = 3.01, range: 6–18 years). Notably, 100% of the children possess surviving biological kin, with nearly two-thirds (65.0%, n = 13) originating from single-parent or grandparent-headed households engaged in precarious informal daily-wage labor. Consequently, institutional placement for four-fifths (80.0%, n = 16) of the children is directly precipitated by resource-driven educational poverty rather than total orphanhood or abandonment, with 100% (20/20) of the residents returning home to their families during school vacation periods.

Table -2: Socio-Demographic and Familial Characteristics of the Institutional Cohort (N = 20).

Demographic / Variable	Cohort Distribution & Statistical Metrics
Gender Distribution	Girls: 10 (50.0%), Boys: 10 (50.0%)
Age Distribution	Mean: 12.75 years (SD = 3.01), Range: 6 to 18 years
Primary Stated Reason for Admission	• Educational Purpose: 16 (80.0%) • Family Hardship/Crisis: 2 (10.0%) • Behavioral Modification/Discipline: 2 (10.0%)
Home Visitation Pattern	100% (20/20) visit family during school vacations
Parental / Kinship Typology	• Grandparent / Single-Parent Headed: 13 (65.0%) • Intact Nuclear Households: 7 (35.0%)
Occupational Background of Parents	Daily wage: Housekeeping, Wood-cutting, Driver, Marginal Farming, Hotel Service, Tailoring

4. CONCEPTUAL MODEL, HYPOTHESES DEVELOPMENT, AND EMPIRICAL FINDINGS

4.1 The Triad Conceptual Framework

To evaluate how institutional living shapes childhood trajectories, this paper synthesizes empirical observations into a sequential conceptual model (Fig. 1):



Fig -1: The Sequential Process Model of the Institutional Developmental Triad.

To understand the systemic interplay across this developmental progression, the framework is grounded in Bronfenbrenner's Bioecological Systems Theory, Bowlby's Attachment Theory, and Sen's Capability Approach:

- **Emotional Security (Microsystemic Dynamics and Attachment):** On the institutional microsystem level, children are exposed to the daily interactions in the group dormitories with high child-to-caregiver ratios that hinder individual attention. The major neurodevelopmental basis required to regulate stress is stable, responsive caregiving and psychosocial safety. Within the context of Attachment Theory, the lack of stable, sensitive parental role models leads to emotional dissociation and emotional disturbance, thus emotional safety is the invaluable foundation of a normal development.
- **Health and Well-being (Ecological Sustenance and Bodily Integrity):** Bodily development and cognitive ability are preserved by healthy eating habits, regular check-ups with medical professionals and living in a clean environment. The ecological perspective has physiological health that mediates the correlation between emotional and cognitive readiness to be ensured that chronic nutritional deficiency or uncontrolled diseases do not interfere with the development.
- **Education and Skills (Capability Deprivation vs. Functionings):** Institute education cannot be measured as an output of custodial inputs only because of the availability of passive school attendance records or limited supply lists, as suggested by the Capability Approach of Amartya Sen. True developmental well-being demands a transformation of educational materials into meaningful human skills, such as basic literacy, speaking English fluency, digital literacy, and workplace skills, which enable youth to choose their own life trajectories.
- **Independent Adulthood (Macrosystemic Transition and Social Integration):** The general idea of harmonizing these three fields is the getting of institutionalized youth ready to live outside care. The exosystemic and macrosystemic systems, such as the Juvenile Justice system, the District Child Protection Units (DCPUs) and the Mission Vatsalya after-care guidelines should have the ability to make the care-leavers emotionally stable, physically strong and marketable in order to become self-reliant and socially integrated adults.

4.2 Conceptual Model and Hypotheses Formulation

The conceptualization of the proposed model to analyze the effects of alternative residential care on long-term developmental trajectories systematically is a multi-stage, mediated structural pipeline. This model assumes that child transition into independent adulthood is not a result of independent custodial interventions, but comes as a result of a chain of developmental processes: Emotional Security → Health and Well-being → Education and Capabilities → Independent Adulthood, with direct protective buffering pathways (Fig. 2; Table 1).

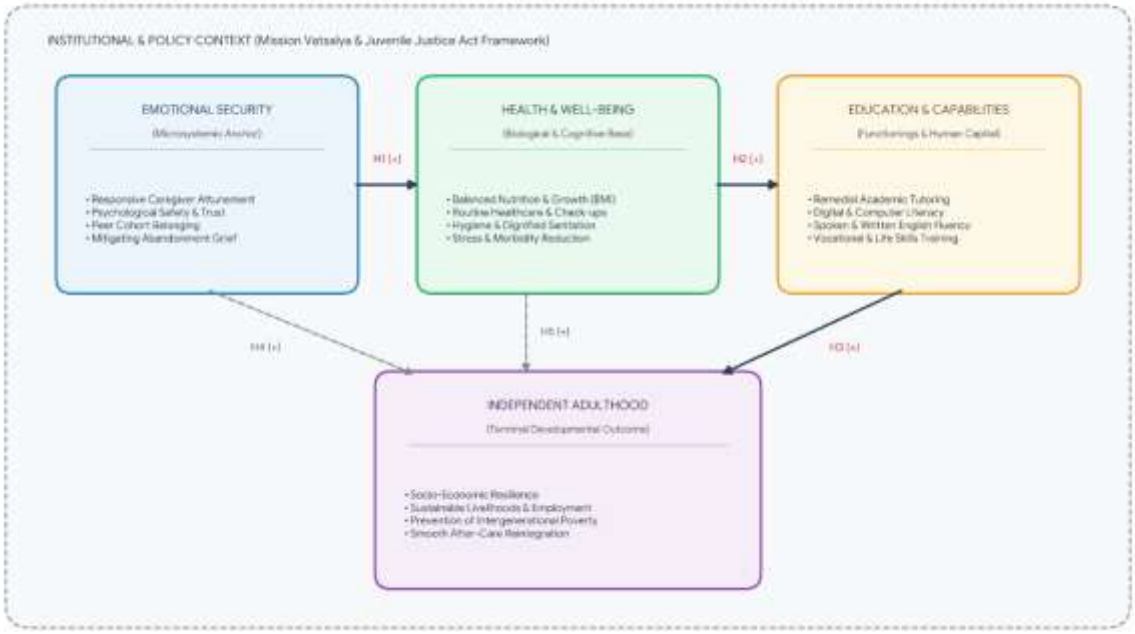


Fig -2: Structural Equation Model of the Triad Hypotheses and Transition Paths (H_1–H_5).

Primary Mediated Sequential Pipeline

Hypothesis 1: Emotional Security Positively Influences Health and Well-being

Theoretical Rationale & Problem Identification: Children are often exposed to communal depersonalization, grief of parental separation, and excessive child to caregiver ratio by the institutional settings. Continuous stimulation of the hypothalamic-pituitary-adrenal (HPA) axis when in distress increases allostatic load, which hinders physiological growth, immune resistance, and digestive-nutritional absorption. Neuroendocrine stress is decreased through responsive caregiving attunement, psychological safety, and positive peer acceptance, which creates the biological stability needed to promote physical recovery and daily immune defense.

Empirical Triangulation: Qualitative narratives from institutionalized children highlighted this physiological-emotional connection: *"I want someone to help me when I feel stressed or unwell"* and *"I want someone to comfort me when I am sad"*.

Policy & Operational Solution: CCIs need to move towards trauma-informed caregiving protocols and not custodial shelter management, as part of Mission Vatsalya. District Child Protection Units (DCPUs) must require accredited training in early trauma resolution, distress de-escalation, and non-punitive emotional control of the staff working at the residential facility and introduce a weekly counseling check-in.

H_1: *Emotional Security exerts a significant positive effect on Health and Well-being in institutionalized youth.*

Hypothesis 2: Health and Well-being Positively Influences Education and Capabilities

Theoretical Rationale & Problem Identification: Physiological wellness forms one of the biological foundations of cognitive processing. Chronic micronutrient deficiencies, low Body Mass Index (BMI), and avoidable somatic infections directly hinder the functioning of synaptic plasticity, working memory, and the ability to sustain classroom attention. Meeting physiological preconditions, such as balanced macronutrient diets, clean drinking water, personal sanitation (WASH), and regular vaccination, leads to less absenteeism and cognitive endurance to achieve mastery of demanding curricula.

Empirical Triangulation: Clinical evaluations in India show that low BMI is present in up to 80 percent of institutionalized boys and 68 percent of girls, with nutritional deficiencies being associated with cognitive delays (Ganguly et al., 2019; Kamath et al., 2017). This is corroborated by direct child appeals: *"I want healthy and hygienic food"* and *"I want help with my studies"*.

Policy & Operational Solution: Develop obligatory institutional links between CCIs and local Primary Health Centres (PHCs) for two-monthly pediatric screenings, regular hemoglobin/BMI screening, and uniform nutritional menus which are approved by state dietary standards.

H_2: *Health and Well-being exerts a significant positive effect on Education and Capability acquisition.*

Hypothesis 3: Education and Capabilities Positively Predict Independent Adulthood

Theoretical Rationale & Problem Identification: According to the Capability Approach as proposed by Sen, passive enrolment in standardized rural schooling does not result in competitive socioeconomic functioning. Marginalization is reproduced in the modern labor markets through educational poverty. The process of turning schooling into a practical human capacity, namely functional computer literacy, oral English communication, financial literacy, and certified technical skills, would provide care-leavers with the practical capital to obtain viable jobs and to withstand economic exploitation.

Empirical Triangulation: In the empirical cohort (N = 20), 80.0% of admissions were driven by families seeking educational escape from generational poverty, with children emphasizing: *"I want to learn English speaking and writing"* and *"I want to learn computers and basic digital skills"*.

Policy & Operational Solution: Modernize institutional infrastructure through public-private relationships (CSR initiatives) to equip CCIs with effective digital learning labs, high-speed internet, and individualized remedial tutoring, as

well as formal connection to National Skill Development Corporation (NSDC) vocational pipelines.

H3: *Education and Capabilities exert a significant positive effect on successful transition into Independent Adulthood.*

Hypothesis 4: Emotional Security Directly Enhances Independent Adulthood

Theoretical Rationale & Problem Identification: The sudden end of state care at legal majority (age 18) is often accompanied by acute existential crisis, loneliness, and homelessness. Care-leavers who absorb positive relational paradigms in the course of institutionalization have better psychological resilience, self-efficacy, and adaptive coping styles in the face of post-discharge adversity.

Empirical Triangulation: Child elicitations emphasize lasting human connection: *"I want love and care"* and *"I want someone to listen to me"*. Cherewick et al. (2023) demonstrated that psychological resilience serves as an enduring buffer against depression among vulnerable youth.

Policy & Operational Solution: Implement structured after-care transition frameworks under Section 46 of the Juvenile Justice Act, 2015. Extend individualized mentor networks, peer alumni support groups, and community transitional guidance up to age 21 to prevent psychological abandonment post-discharge.

H4: *Emotional Security directly and positively influences resilient outcomes in Independent Adulthood.*

Hypothesis 5: Health and Well-being Directly Sustains Independent Adulthood

Theoretical Rationale & Problem Identification: Childhood physical health and structural sanitation have long-term longitudinal outcomes in adulthood. Persistent stunting, untreated childhood diseases, and a high frequency of nutritional deficits lower physical tolerance in adulthood and predispose adulthood to morbidity. The long-term maintenance of childhood health is protective of care-leavers against premature medical wage-loss and physical fatigue in the initial years of workforce utilization.

Empirical Triangulation: Institutional living conditions prevent persistent physical disability in later life, and Maharaj et al. (2019) and pediatric morbidity audits show that systematic assessments suggest that institutional living environments are preventative of persistent physical disability.

Policy & Operational Solution: Enroll all youth leaving institutional care into universal state-sponsored health insurance programs (including Ayushman Bharat - PM-JAY) before leaving institutional care, and provide ongoing preventive, mental, and emergency health care coverage through early adult transitions.

H5: *Health and Well-being directly and positively sustains socioeconomic stability in Independent Adulthood.*

Table -1: Summary Matrix of Hypothesized Structural Relationships and Mechanisms.

Path	Structural Relationship	Primary Mechanism	Underlying Challenge	Operational / Policy Solution
H_1	**Emotional Security → Health & Well-being (+)**	Stress reduction, lowered allostatic load, neurodevelopmental stability	High child-to-staff ratios, unaddressed separation grief	Trauma-informed caregiver training; professional psychosocial counseling
H_2	**Health & Well-being → Education & Capabilities (+)**	Cognitive readiness, reduced sickness absenteeism, working memory	Malnutrition, low BMI, substandard WASH conditions	Bi-monthly PHC check-ups; certified nutritional rosters; modern sanitation
H_3	**Education & Capabilities → Independent Adulthood (+)**	Conversion of schooling into marketable digital, linguistic, and job skills	Passive schooling lacking digital access and English fluency	Computer labs via CSR; remedial tutoring; NSDC skill certification
H_4	**Emotional Security → Independent Adulthood (+)**	Internalized psychological resilience and self-worth	Abrupt emotional severance and isolation at age 18	Mentorship programs; structured after-care alumni networks up to age 21
H_5	**Health & Well-being → Independent Adulthood (+)**	Preserved physical vitality preventing premature labor disability	Untreated chronic conditions eroding adult earning potential	Universal PM-JAY health insurance enrollment upon discharge

4.3 Empirical Findings and Thematic Analysis

Theme 1: "Poverty-Driven Institutionalization" vs. True Orphanhood

However, despite the general social belief that institutional residents are the parentless double orphans of the world, 100% of the children at the surveyed institution have biological relatives who are alive (Fig. 3). It is only a shocking 65.0 percent of the children who are the product of single-parent families (often widowed or abandoned mothers taking on menial housekeeping positions) or elderly grandparents (grandmothers who run tea stalls or take on sanitation shifts). The direct cause of institutional admission in 80.0 percent of the children was "Education Purpose," showing the economic inability of their families to provide schooling, uniforms, books, and daily sustenance.



Fig -3: Primary Stated Drivers of Institutional Admission (N = 20).

Moreover, the entire cohort visits their villages of origin during vacation time. This proves the international and Mission Vatsalya claims: institutional care in rural spaces is more an informal boarding school and poverty reduction tool for vulnerable rural families than a permanent abandonment.

Theme 2: The Direct Child Voice - Unmet Needs

Observations of the children in direct participatory expressions indicate that there are deep dichotomies between fundamental physical containment and holistic developmental requirements (Table 3). In addition to basic subsistence, residents expressed desperate desires to climb the economic ladder by learning English, knowing how to use the computer, and receiving academic tutoring because they understand that state education without digital abilities leaves them with little chance of earning a living in the future. At the same time, they highlighted bodily dignity and hygiene, namely, clean drinking water, personal sanitation, and nutritious food, as the critical health preconditions, which, like Maharaj et al. (2019), support the centrality of institutional water, sanitation, and hygiene (WASH) infrastructure. Most heartrendingly, emotional pleas like I want someone to listen to me and I want someone to console me when I feel sad reveal the sterility of the provisioning of children of disproportional child-to-caregiver ratios, and show that material provisioning will never be an appropriate substitute for individualized affection, active listening, and relational safety. The combination of these child accounts with interviews with the caregivers further enlightens the bottlenecks of operation that lead to these unmet needs. Caregivers complained of severe time crises and emotional fatigue due to administrative overload, daily meal preparation, and disciplinary workload, and left little bandwidth to conduct individualized psychological counseling, as one senior warden noted: it was almost impossible to console a crying or lonely child at night with only two duty staff, no matter how willing they were. With these human resource limitations, stringent budgetary allocations can barely afford basic groceries, uniforms, and textbooks, making paid English teachers, computer labs, and specialized remedial classes beyond the financial means of many, except through regular acts of charity.

Table -3: Triangulated Matrix of Participatory Child Voices, Expressed Needs, and Empirical Literature.

Domain	Specific Expressed Voices & Needs	Supporting Literature & Empirical References
Educational Needs	• "I want help with my studies." • "I need books, notebooks, and study materials." • "I want to learn English speaking and writing." • "I want to learn computers and basic digital skills." • "I want guidance about my future studies and career." • "I want to participate in sports and educational activities"	• Modi, Kalra, & Roy (2021/2022): Documented unmet educational and interpersonal needs via child-centric QANCC tool in Indian homes. • McCormick, McCafferty, & Hayes (2026): Systematic review identifying institutional support, digital learning, and aspirations as key academic enablers. • Garcia-Molsosa et al. (2021): Outlined structural and care-related barriers directly impacting school functioning and skills acquisition.
Healthcare & Living Conditions	• "I want healthy and hygienic food." • "I want clean drinking water." • "I want proper medical care when I am sick." • "I want regular health check-ups." • "I want clean toilets and clean, comfortable surroundings." • "I want someone to help me when I feel stressed/unwell."	• Ganguly et al. (2019): High prevalence of low BMI (80% boys, 68% girls) and multiple comorbidities in Indian orphanages. • Kamath, Venkatappa, & Sparshadeep (2017): Demonstrated that malnutrition directly impairs neurocognitive and learning outcomes in institutionalized children. • Maharaj et al. (2019): Scoping review linking institutional hygiene/WASH deficits to pediatric morbidity risks.
Emotional & Relational Needs	• "I want love and care." • "I want someone to listen to me." • "I want someone to comfort me when I am sad." • "I want someone to play with me." • "I want to spend time with my friends." • "I want to feel happy and safe."	• Levey (2017): Case evaluations in rural Indian CCIs highlighting early trauma, grief, and the need for responsive caregiving. • Cherewick et al. (2023): Evaluated resilience as a protective buffer against childhood depression across rural and urban institutions. • Grover, Rastogi, & Chakraborty (2026): Identified emotional dysregulation and peer friction stemming from staffing and relational limitations in CCIs.

5. DISCUSSION: SYNTHESIZING THE TRIAD FRAMEWORK

5.1 Emotional Security as the Bedrock

The open expression of the desire of the children to have someone to listen to me, to comfort me when I feel sad, is a demonstration of the mental price of parental separation. Although the institution ensures physical security against the dangers of abject rural poverty, it, in itself, functions on communal timetables which establish relational depersonalization. In line with the attachment paradigms introduced by Bowlby and the empirical evidence conducted by Levey (2017) and Grover et al. (2026), children deprived of a primary, attuned attachment figure feel vulnerable emotionally. This deficit is partially buffered by peer relationships, but peer bonding cannot replace authoritative, unconditional emotional scaffolding that is offered by parental or trained caregiving individuals.

Children cannot be successful in educational or developmental activities without the basis of emotional security. When CCIs are used as custodial institutions only, children will have emotional detachment, behavioral conduct problems, or internalizing anxiety. Constant caregiver relationships and systematic peer relationships are the essential psychological buffer, and inner strength is developed to surmount pre-care trauma and socioeconomic upheaval.

5.2 Health and Nutrition as Cognitive Enablers

Physiological health mediates the transition from emotional safety to educational success. Neurocognitive processing and school attendance are directly depressed by nutritional deprivation (high levels of low BMI and anemia reported across Indian homes). Regular check-ups, clean living environments, and nutritious food are not luxury welfare benefits, but preconditions to thought processes and school activities.

5.3 Education and Skills Leading to Independent Adulthood

Learning in CCIs can not be passive. To end intergenerational poverty, rural institutional settings must bridge the digital divide, offer spoken English training, and offer systematic career guidance. Moreover, institutional support also suddenly decreases as young people attain legal majority (age

18). Youth leaving care face severe housing, employment, and social vulnerabilities in the absence of intentional after-care pathways, vocational competencies, and psychosocial preparedness.

The approach to the support of education based on the capability framework developed by Sen explains why mere school attendance is not enough. Even though all children go to the local rural schools, they express acute anxiety about digital illiteracy and limited English skills. This lack of these fundamental skills in the contemporary Indian labor market results in a sharp capability gap, which exposes care-leavers to downward economic mobility on discharge. The passage to independent adulthood without specific life competencies and institutionalized vocational tracks built in before the age of 18 threatens to recreate the very intergenerational deprivation that led to original institutional placement.

6. POLICY IMPLICATIONS AND RECOMMENDATIONS

Based on the empirical findings and the operational bottlenecks identified across the developmental triad, translating statutory frameworks into impactful residential and community practice requires targeted policy interventions. To bridge the divide between legislative intent and institutional realities, child protection authorities and welfare departments should prioritize four systemic reforms:

- **Scale-Up Family-Preservation Sponsorships under Mission Vatsalya:** Since more than 80% of rural institutional admissions are due to educational poverty in single-parent or grandparent-headed families, central and state governments need to increase direct-to-family educational sponsorships. Enhancing the monthly family maintenance grants would allow the vulnerable children to receive quality education and stay in the biological kin networks.
- **Educational Trauma-Informed Caregiver Training:** Change the institutional caregiving paradigm to professionalized, trauma-informed caregiving. State DCPUs need to make it mandatory to have certified training programs on the psychological development of children, the regulation of their emotions, and management of their behavior without punitive methods.
- **Specific Mental Health and Digital support infrastructure:** All registered CCIs should be connected to local public health centres and child psychologists to conduct screening of mental health quarterly. At the same time, government and business collaboration must be enlisted to provide rural CCIs with secure labs of computers, high-speed internet, and additional English and remedial lessons.
- **Extensive After-Care and Transition Support:** Implement powerful after-care systems within the JJ Act, which include transitional housing vouchers, post-secondary school scholarships, work-related apprenticeships, and mentoring networks into the 21st year.

Table -4: Operational Solution Matrix

Hypothesis / Path	Target Construct Area	Core Challenge in Current CCIs	Policy & Operational Solution	Responsible Statutory Node
H_1	Emotional Security → Health & Well-being	High child-to-caregiver ratios; unaddressed attachment disruptions and parental separation grief	• Institutionalize mandatory trauma-informed caregiving (TIC) training for all residential staff. • Establish formal MoUs with District Mental Health Programmes (DMHP) for bi-weekly psychosocial therapy and art/play decompression sessions. • Revise statutory staffing norms to lower child-to-caregiver ratios, relieving house-parents from administrative duties to enable individual emotional bonding.	District Child Protection Unit (DCPU), Child Welfare Committee (CWC), Specialized Mental Health NGOs
H_2	Health & Well-being → Education & Capabilities	High prevalence of subnormal BMI, pediatric anemia, micronutrient deficits, and substandard dormitory WASH facilities	• Mandate quarterly pediatric check-ups via Primary Health Centres (PHCs) tracking BMI, hemoglobin, dental health, and immunization milestones. • Overhaul institutional food rosters to meet ICMR age-specific caloric and protein requirements, supplemented with iron and micronutrient fortification. • Standardize dignified, continuous clean drinking water filtration and private hygiene sanitation infrastructure.	District Health Office (DHO), Primary Health Centres (PHCs), CCI Management
H_3	Education & Capabilities → Independent Adulthood	Passive state-school enrollment lacking digital competencies, spoken English fluency, and practical vocational preparedness	• Bridge the rural digital divide by establishing dedicated broadband-equipped computer laboratories via Corporate Social Responsibility (CSR) partnerships. • Implement remedial tutoring and immersive spoken English modules to build academic confidence. • Create formal apprenticeship and certification pipelines with the National Skill Development Corporation (NSDC) and Industrial Training Institutes (ITIs) for residents aged 14–18.	National Skill Development Corporation (NSDC), State Department of Education, CSR Foundations
H_4	Emotional Security → Independent Adulthood	Abrupt emotional severance, existential crisis, housing instability, and acute social isolation upon reaching legal majority (age 18)	• Establish structured youth mentorship programs pairing adolescents aged 15+ with vetted community mentors and university volunteers. • Form institutional and district-level Care-Leavers Associations funded through Mission Vatsalya after-care provisions to provide peer support and transitional solidarity. • Provide continuous post-discharge counseling through age 21 under Section 46 of the Juvenile Justice Act.	DCPU After-Care Units, District Child Protection Societies, Youth Mentorship Organizations

Hypothesis / Path	Target Construct Area	Core Challenge in Current CCIs	Policy & Operational Solution	Responsible Statutory Node
H_5	Health & Well-being → Independent Adulthood	Unaddressed chronic conditions and lack of medical security leading to premature health-related wage loss and physical vulnerability	• Mandate pre-discharge universal enrollment of all care-leavers into state-sponsored health coverage (*Ayushman Bharat - PM-JAY*). • Issue digital, portable "Transition Health Passports" containing complete immunization logs, laboratory baselines, and ongoing health management plans.	Ministry of Health & Family Welfare, National Health Authority (NHA), State Health Agencies

7. CONCLUSION, LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

In India, the situation with child institutional care is at a crossroads. Although national policies such as the Mission Vatsalya and the Juvenile Justice Act have taken some admirable steps with regard to ensuring that family-based care and institutional standards are given priority, ground realities in rural CCIs show that there are major differences between the statutory aims and lived realities. Institutionalized children show a profound need for emotional attachment, clean surroundings, healthy food, and 21st-century learning facilities. It is necessary to meet these interdependent needs with the integrated triad framework of creating emotional security to unlock health and health to empower educational transformation in order to make institutional care not only a survival shelter, but a stepping stone to a strong, dignified independent adulthood.

Although the present work offers substantial micro-level empirical data on the institutional dynamics of rural life, the following methodological constraints should be considered: first, the single-location study with a localized cohort (N=20) in Maharashtra hampers the generalizability of the study to the broader scope of the state-level care models; second, the cross-sectional design captures only a time snapshot of the present population, which is why longitudinal investigations comparing non-institutional sponsorship beneficiaries in the state of Maharashtra with residential cohorts using cognitive, psychological and academic developmental indicators are critically needed; third, despite the qualitative depth of the study, subtle social desirability biases or unwillingness to criticize the current state of affairs may exist; and lastly, further research should consider multi-state comparative studies in contrasting non-institutional sponsorship beneficiaries in the state of Maharashtra with residential cohort data across cognitive, psychological, and academic developmental indices.

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