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Support Systems for Children with Disability in Alternative Care System in Ibadan Metropolis, Nigeria

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ABSTRACT

Nigeria maintains residential homes as a form of alternative care for children with disability (CWD) despite its reversal in developed nations. This cross-sectional study profiled the nature of care for CWDs in alternative residential homes (ARHs) in Ibadan, Nigeria. The study administered 131 copies of a standardized questionnaire to CWDs, while eight interviews were conducted among staff of residential homes and regulatory bodies. The male (54.2%) population dominated the homes. Satisfaction in healthcare services (61%) and in quality of feeding (73%) were reported, while 32% CWDs expressed willingness to leave the residential homes for reasons of inadequate support structures. There was no significant relationship between respondents' duration of stay and the likelihood of recommending residential homes as the best model for supporting CWD ($P<0.05$). Residential homes provided in-group solidarity and basic survival needs for CWDs, but lacked formal mechanisms for reporting and responding to abuses. Social workers can play a pivotal role in public sensitization to challenge the placing of CWDs in deficient ARHs and can also be at the forefront of advocating for social welfare programmes for parents of CWDs to enable the children to grow within their natural family settings.

Keywords: Alternative care, residential homes, disability, children with disability, Nigeria

Introduction

Historically, there was an increasing need for social services to support the course of persons living with disabilities (Mackelprang & Salsgiver, 1996). However, social workers have gained insight into the unmet needs of persons with disabilities related to social and economic activities to ensure a good quality of life (Kreitzer, et al, 2023; Oketunji & Oketunji, 2016). Precluded

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access to social and economic participation can prevent the family members from becoming economically active and from social inclusion in society (United Nations Human Rights Council- UNHRC, 2017; SABPP Fact Sheet, 2017). The World Report on Disability established that disability would be a greater concern, in the years ahead, due to its rising prevalence (SABPP Fact Sheet, 2017). This reality requires the interventions of social workers in the care of disabled persons (Amadasun, 2020). Guided by models of care and social work approaches, UNICEF launched disability inclusion policy and strategy to create a framework for a fully inclusive world for children with disability (CWD) (Berman-Bieler, et al, 2023; Asamoah, et al, 2021). The focus has six targets to include full and meaningful participation of persons with disabilities; improvement of disability-inclusive services, programmes, and workplaces; access to assistive technology; access to comprehensive community care and support services disability-inclusive action in humanitarian, emergency, and fragile contexts; and prevention of stigma and discrimination. In consequence, social work research has emphasized the need to refocus on capacity within socially defined disabilities to foster a clearer understanding of children with disabilities (Bishop-Fitzpatrick, et al, 2020).

The core area of support for children with disability leverages social workers' advocacy skills and commitment that project the imperativeness of inclusive policies and practice which would emphasize family-based and community-based care for children with disabilities (Bishop-Fitzpatrick, et al, 2020; Hayes & Bulat, 2017). Globally, there are millions of CWDs living in institutions or residential care. One estimate puts the total at about eight million (UNICEF, 2009), while it was acknowledged that many placements are with unregistered children’s homes that lacked oversight from the State Social Work Service or the courts, hence inaccurate figure (Csáky, 2009). Dissatisfaction was also raised on the lack of precise figures on the number of unregistered homes, the number of residents, the reasons for admission, or the average length of stay. Poverty is recognized as the main driver of child institutionalization in most countries (UNICEF, 2005; World Bank, 2009). Using social work approaches and principles, there exist support gaps for CWDs in the institutionalized support systems which include social, economic and educational aspects (WHO, 2023).

In Nigeria, disability in children may be viewed as a curse, yet people still discriminate against persons with disabilities, even within the family. The resultant culture has denied these Nigerians their rights to the dignity of the human person and to the development of their full potential to participate in developmental activities and programmes. Such situations have made the International Community seek to reverse the trend by the adoption, among other instruments, of the United Nations’ CRPD. Hence, proliferation in the number of children’s homes in Africa in recent years, many of which are privately run and therefore poorly regulated (UNICEF, 2008). Consequently, reports indicated the urgent need to address the unacceptably high rate of the institutional placement of children, with and without disabilities (UNICEF, 2011), coupled with inadequate social services in Nigeria (Amadasun, 2020; Chukwu, & Idemili-Aronu, 2019).

Onalu, et al, (2023) maintain that people with disabilities (PWDs) are consistently challenged in educational institutions. However, teachers and guardians of physically challenged children are encouraged to give consideration to social workers to impart skills that would enable them to tackle social, informational, and psychological problems (Oketunji & Oketunji, 2016). Information-seeking skills were found important for CWDs (Salami, 2018) in Nigeria to enhance their intellectual functioning. A study by Musoko, et al, (2014) found harmful characteristics of children in institutional care, including separation, confinement, de-personalization, overcrowding, instability, caregiver responsiveness, repetitive routines, and insufficient resources, regardless of institution size.

Contrarily, children who were moved from an institution into a family-based environment demonstrated signs of improvement in their intellectual functioning and attachment patterns, reduced signs of emotional withdrawal, and reduced prevalence of mental health conditions (Barriga, et al, 2017). Against this backdrop, it is significantly essential to explore the support systems and acceptance of CWD in alternative/residential care systems, in Nigeria with Ibadan metropolis as a case study.

Materials and Methods

The Study Setting: Ibadan Context

This study was conducted in Ibadan metropolis. Ibadan, the capital of Oyo State, has a projected population of 3,232,016 as estimated in 2014 by the National Population Office. It is located in the southwestern Nigeria, 128km inland northeast of Lagos and 530km southwest of Abuja, the Federal capital territory. It is also a prominent transit point between the coastal region and the areas in the hinterland of the country. Ibadan had been the center of administration of the old Region since the days of the British Colonial rule, and at the time of Nigeria’s independence in 1960. There are eleven Local Government Areas (LGAs) in Ibadan Metropolis which consist of five urban and six semi-urban LGAs. Each of the LGAs is also further divided into a minimum of ten political wards. The city is a major center for the economy in the state. Ibadan houses the largest research centers in Nigeria including International Institute of Tropical Agriculture (IITA) and many others. Oyo State has 686 primary healthcare (PHC) centers with 24 medical officers, 243 nurses, and 1088 community health extension workers (Nigeria Tribune, Dec. 7, 2017) totaled 1355 the number of health care providers in PHC in Oyo State.

The growing rate of CWD on the street, begging at various motor parks motivated this study in Ibadan. An online search conducted to identify available residential homes for CWDs in Ibadan showed only fourteen residential homes in the metropolis, while seven were of alternative homes care for CWD. The Oyo State Ministry of Women Affairs and Social Development plays a supervisory role in maintaining care standards in the alternative residential homes.

Study design and field process

This study, conducted among CWDs in alternative residential homes (ARHs), adopted an explorative research design with a mix of quantitative and qualitative approaches and was geared toward adequately capturing the care system available for CWDs in ARHs. Copies of a questionnaire were administered to CWDs who were residing in the ARH system, while in-depth interviews were conducted with the managers and other stakeholders in the residential care system.

Data collection for this study was preceded by a two-day training for two research assistants engaged to conduct interviews. The interviewers had skills in social research and had previous experience in studies of disability. The training focused strictly on the context, the instruments for data collection, the concept of disability and various kinds, means of identifying the participants at the ARHs, and ethical issues including how to seek informed consent. Interviewers were made to role-play the data collection procedures and followed it up with a pretest in a similar home which was not included in the main study. The pretest enabled the researchers to adjust the instruments and methods, based on the lessons learnt. A semi-structured questionnaire was interviewer-administered to 131 CWDs living in ARHs and who were intelligible to respond to the questionnaire. An in-depth interview was also conducted with staff, social workers, managers, and government representatives who directly work with children in residential care. Of the fourteen registered ARHs in Ibadan metropolis, seven were purposively selected. The selected residential homes were Jesus Kids orphanage home, Liepo Cheshire disability home, Ibadan School for the Deaf, Juvenile Correctional Home Ibadan, Rehabilitation Centre Ibadan, Christian Mission for the Deaf, and Home School for the Handicap, Ibadan. Also, CWDs were only purposively selected in the ARHs based on availability and ability to respond to the questions. Assistive devices were used to interview those participants who were deaf, and dumb. Eight in-depth interviews (IDIs) sessions were conducted among one stakeholder each from Oyo State Ministry of Women Affairs, National Association of Persons with Disability, and six staff from the homes.

Ethical procedures

Consent of the CWDs and that of the management of the homes was sought from the management using a consent form. Respondents were assured of confidentiality and anonymity of personality involved, hence, the privacy and identity of the respondents remain protected and kept confidential. This was achieved by not seeking to know the names of the respondents. They were rather identified using a coding technique and no reference was made to any information that can give away participants' identities. Participation in this study was devoid of force and coercion hence, the study was carefully conducted without causing any harm to the participants. Finally, the respondents who felt uncomfortable in the process of the interview were allowed to disengage from the interview.

Data management and Analysis

The data collected were cleaned, coded, entered into the computer, and analyzed using descriptive and inferential statistics aided by the Statistical Package for the Social Sciences (SPSS version 21). Copies of the questionnaire used for data collection and the results output were kept in a safe where no other person than the researchers can access. The descriptive statistics were presented using frequency and percentages, while cross-tabulations were used in inferential statistics. The decision for significance was placed at $P>0.05$ at a 95% accuracy level. Qualitative data were recorded at the interview spot, while the audio files were later transcribed verbatim. The transcriptions were carefully analysed starting from the coding of thoughts, while nodes were developed into themes, which allowed for thematic discourse.

Results

Socio-demographic Data of the Respondents

Table 1 presents the sociodemographic characteristics of the CWDs. The Table shows that the majority (77.9%) of the respondents were in the age range of 15-19 years, while the mean age for respondents was 16 years. Slightly above average (54%) were males. About 77% of the respondents practiced Christianity, one quarter (17.6%) reportedly practiced Islam, while 5% were reportedly followers of indigenous religion. For educational attainment, more than half (55.7%) and 16% of the respondents had Senior Secondary School Certificate, and Junior Secondary School Certificate respectively. Table 1 also shows that about 6% had no formal education, while vocational training was reported by 7% of the respondents.

Table 1: Socio-demographic Characteristics of Respondents

Variable	Frequency (n=131)	Percentage (100%)
Age	**(Mean age = 16.7)**	
5-9 years	7	5.3
10-14 years	22	16.8
15-19 years	102	77.9
Gender		
Male	71	54.2
Female	60	45.8
Religious Affiliation		
Christianity	101	77.1
Islam	23	17.6
Traditional	7	5.3
Ethnic group		
Yoruba	85	64.9
Igbo	31	23.7
Hausa/Fulani	14	10.7
Ebira	1	0.8
Education		
No schooling	8	6.1
Primary education	20	15.3
JSS1-JSS3	21	16.0
SS1-SS3	73	55.7
Vocational Training	9	6.8

JSS= Junior Secondary School; SSS= Senior Secondary School

Facilitators of Admission of CWDs into ARHs

Data generated from both the CWDs and the management delved into facilitators of admission into ARHs. Table 2 indicates the respondents' self-perceived disability. Almost 19% of the CWDs considered themselves not disabled, while the majority (81%) considered themselves as having at least one form of disability. Half (50%) of the CWDs suffered from infant paralysis caused by poliomyelitis (polio), while 14.5% reportedly suffered from blindness, whereas 32.8% of the CWDs were deaf and dumb. Emotional disability was reported by 2% of the CWDs.

Analysis of pathways of CWDs to residential homes indicates that the referral of children to ARH was a product of a network of close and known relationships. For instance, more than half (59.5%) of the CWDs in ARHs were referred by biological parents, followed by neighbours (15%), and self (3.1%), while only 1.5% of CWDs were referred by the Nigerian Police, and siblings each. Also, 4.6% of CWDs were referred to the ARHs by a Magistrate court order. Table 2 also presents minimal experiences of discrimination among CWDs in ARHs. For instance, majority (75.6%) noted that they had never experienced discrimination, while 79.4% were positive about residential home. Table 2 also considered reasons for admission, indicating that about 69% were admitted into ARH due to their disability status. Specifically, 21.4% were admitted because they were deaf, while 31.3% were admitted for their blindness, followed by 22.9% who were admitted without any specifics on the nature of their disability. Others are shown in Table 2.

Table 2: Disability experiences, and facilitators of referral (N=131)

Perceived disability status	**Frequency**	**Percentage**
Yes	106	80.9
No	25	19.1
Type of Disability		
Poliomyelitis	66	50.4
Blind	19	14.5
Deaf and dumb	43	32.8
Emotional	3	2.3
Referral system		
Neighbour	20	15.3
Parents	78	59.5
Heard Information by self	4	3.1
about the place	19	14.5
Family Friends	2	1.5
Police	6	4.6
Court	2	1.5
Siblings		
Reason for Admission into ARH		
Deafness	28	21.4
Blindness	41	31.3
Age and qualification	1	0.8
Ill health	19	14.5
Uneducable	2	1.5
Disability	30	22.9
Don’t know	10	7.6
Experienced Discrimination		
Yes	32	24.4
No	99	75.6
Feelings about ARHs		
Very Positive	58	44.3
Positive	46	35.1
Indifferent	5	3.8
Negative	19	14.5
Very Negative	3	2.3

Narratives of indepth interviews (IDIs) provide further insight into the workings of the ARHs and reasons for children’s admission. Managers and administrators of ARHs stated that the institutions were established to meet direct and indirect needs of CWDs and that of parents/guardians respectively. For the CWDs, residency and care were taken care of, while the parents/guardians were relieved of stress and social stigmatization which may prevent the wellbeing of the CWDs. Clearly, communal and relief services for CWDs and their parents resonate as major reasons for admitting CWDs to residential homes:

> The purpose of this organisation is to relieve the burden of parents. We admit children with disability to take care of them. Instead of parents to lock up such child at home; the child is admitted into our residency programme for care. This allows parents to attend to their daily life or any other things. We only get children through parents and guardian (**Administration Assistance/NGO/residential home**)

Prior to admission, the referral is expected to fulfill administrative requirements which include obtaining and filling out the admission form, provision of medical certification of disability, ensuring consent from 3 guarantors, and demonstrating ability to pay a token fee. The payment was considered ‘token’, since the parents may not be able to pay all that is required to take care of a child with a disability. Age is another administrative criterion considered for admission in some homes, as observed by a matron “Parents of CWD obtain the admission form, then we conduct interview with the parents after filling the form. For us, we don’t admit a child whose age is less than fourteen years **(Matron/NGO/residential home).**

Despite the general condition, a CWD may not gain entrance into some ARHs if all conditions are not met. Narratives indicate that some ARHs have a two-pronged imagery: to their clients, the residential homes are service providers, while on the other hand, they are voluntary and not-for-profit organizations that depend on societal donations for survival. Managers of ARHs explained the economic importance of the ‘token’ that parents of CWDs pay and how it is subsidized:

> Yes, we collect token, as we all know that to raise a normal child, it takes a community and to raise this kind of a child, it takes the whole city. The ‘tokens’ that we receive from parents/guardians only cater for just 30% of the running cost of this organization. The remaining 70% running cost to cater for these children are realized through advocacy and soliciting from individuals and corporate donations **(Administration Assistance/NGO/residential home**).

Self-assessment and Perceived quality of Services for CWDs in ARHs

The perceived quality of services received by CWD in ARH was documented. The only services considered were regularity of feeding and perceived quality of education received by CWDs in ARHs in Ibadan metropolis. Specifically, for regularity of daily feeding pattern, a number of times fed daily was considered a measure. In that instance, majority (73.3%) of CWD were fed at least three times in the previous day before the survey, whereas 22.1% and 4.6% were fed twice and once daily respectively. On perceived quality of education received in the ARH, only 19.1% of the CWDs perceived it as adequate, 55% perceived it as good, while 24.4% CWD wanted improvement. However, 1.5% perceived the quality of educational services received as poor. In this study, CWD considered the following factors as important in their self-assessment and perception of quality of education received: the teachers were disciplined (29.8%), availability of good learning facilities (23.7%), and better treatment in ARH aided concentration and performance (17.5%). Other factors are: inadequate supplies of materials needed (8.4%), ARH not conducive like parents' home (8.4%) and observation/presence of dilapidated building (6.1%). Overall, 6.1% of the CWD gave no reason.

Health-Seeking Behaviour of CWDs in ARHs

Respondents were asked to reflect on their last illness episode. They were made to recall the period of last illness episode, the sources of treatment for their ailments, the duration of illness delay before treatment was sought, and sources of treatment sought. In all the 131 CWDs surveyed, 25.2% each, respectively expressed that they were ill in less than a month before the survey, and less than three months before the survey. Others were ill, in less than six-month prior to the survey (9.9%), slightly less than a year prior to the survey (6.1%), and more than a year prior to the survey (8.4%). About a quarter (25.2%) CWDs could not recall the time of their last illness episode.

During the last illness episode reported by CWDs, their health needs were met through three major healthcare services utilized, including treatment, assistive and rehabilitative measures. Treatment involved the use of oral drugs, injections and intravenous vaccination. Assistive involves the application of certain gadgets appropriate for aiding the CWDs' condition, while rehabilitation involves counseling CWDs on the appropriate actions to take in case of future occurrence. Hence, about half (49.6%) CWDs received general treatment of illness, 9.2% CWDs received assistive devices to improve health condition, while only 2.3% CWDs received rehabilitative therapy. No response was indicated by 38.9% CWDs as service type received during the last illness episode.

The delay period/duration of illness before treatment was sought and ranged from less than a week to less than six months. Illnesses were delayed for less than a week for 30.5% CWDs, less than a month for 26.7% CWDs, and less than three months for 16% CWDs. Also, illnesses were delayed for less than six months (10.7%). Other CWDs (16%) were not able to recall the duration of the delay. Overall, CWDs indicated that treatments were sought from pharmacists/chemists (12.2%), clinics/hospitals (70.2%), herbal homes (9.2%), spiritual homes (3.8%) and self-treatment/medication (3.1%). Two (1.5%) CWDs did not indicate their sources of treatment.

Support Services and Comfort in ARHs

When the respondents were asked to assess the extent of satisfaction with the support services available to them in ARHs, varied responses were received. Support services available to CWDs include healthcare services, educational services, safety services, transportation services, recreation and social services, and assistive devices. In all, Figure 1 indicates that slightly less than half (43.5%) were reportedly very comfortable with the healthcare services at their disposal, while 16.1% were reportedly uncomfortable. In education, only 3.1% of respondents did rate their extent of comfort, while about one-fifth of it were comfortable. One-fifth were very comfortable with their safety and security services, while slightly above one-quarter could not decide on whether they were comfortable with the available transport system or not. About half (44.3%) of the CWDs enjoyed the leisure and recreational services. In all, 50.3% were reportedly comfortable with staff support, while 45% were comfortable with available assistive devices.

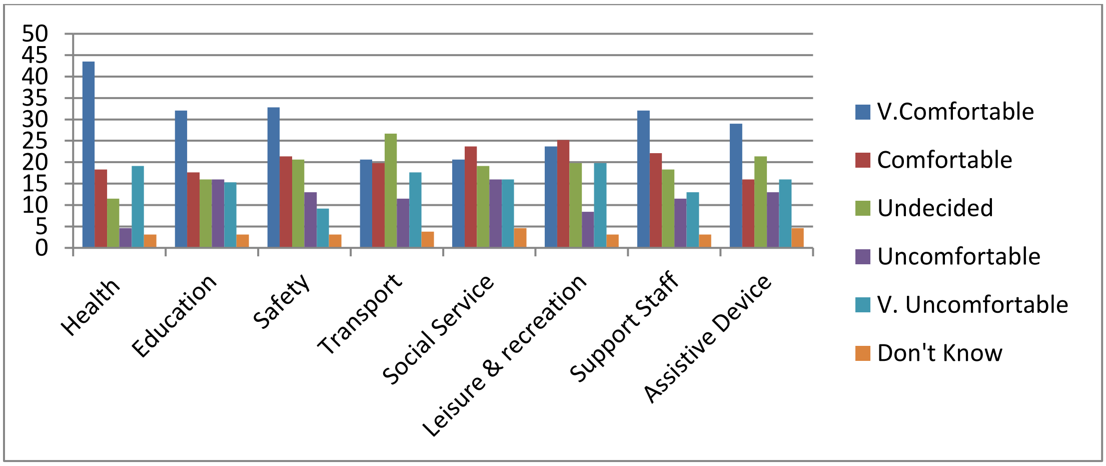

Figure 1: Support services available for CWDs in Alternative homes

Figure 2 indicates caregivers' extent of support activities to CWDs in ARHs. Majority (85%) of the CWDs reported having responsive caregivers, 28.2% reported that their caregivers show a great deal of interest in their welfare, followed by 20% CWDs who expressed that their caregivers only provided quite a bit of welfare. Very few (18.3%) maintained that no time was created for them, while slightly above a quarter (27.5%) CWDs reported that their birthday was never celebrated. Also, 21.4% CWDs were not motivated academically, while 24.4% did not have a caregiver to discuss personal issues with.

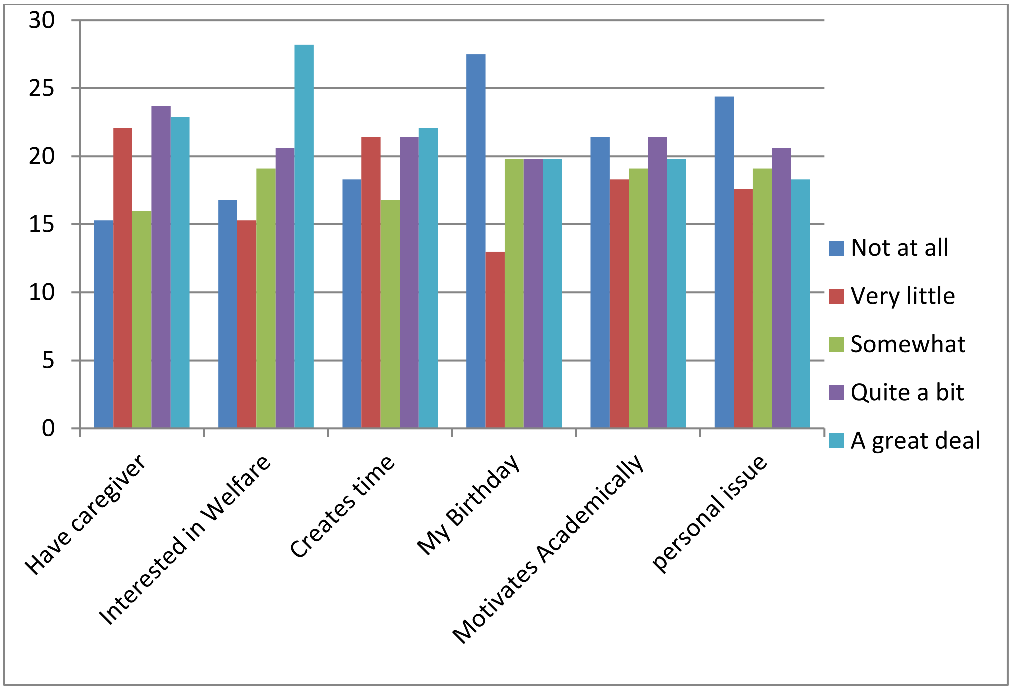

Figure 2: Activities of Caregivers to Children in Alternative homes

Duration of Stay, Experience of Discrimination, and Types of Disability

Table 3 shows the CWDs' duration of stay and experiences of discrimination in ARH. Majority (65.6%) of the CWDs who reportedly had experienced discrimination were those within their first four years (1-4 years) of admission, while 25% of CWDs had spent 5-8years. The large majority (72.7%) who had never experienced discrimination were within 1-4 years of admission, while only 2% were in 1-4 years and above, category. There was a significant reduction when the duration of stay increased from 9-12 years to 8% and a marginal increase to 15% when the duration of stay was between 13years+. However, there was no significant relationship between experience of discrimination and duration of stay in the residential home (P-value>0.05), while correlation result (0.178) depicts a weak relationship between the two variables. Table 3 also shows the relationship between CWDs' duration of stay and types of disability. Majority (60%) of the respondents with physical disability had stayed in the ARHs within 1-4 years, while only 4.4% had stayed in the home for 13 years and above. However, there was no significant relationship between experience of discrimination and types of disability, while the relationship is averagely strong.

Table 3: Cross-tabulation on duration of stay, experience of discrimination, and types of disability

Experience	**Duration of stay in ARH**				**Total**
	1-4 years	**5-8 years**	**9-12 years**	**13 years+**	
Discrimination	21 (65.6%)	8 (25.0%)	1 (3.1%)	2 (6.2%)	32
No Discrimination	72 (72.7%)	16 (16.2%)	9 (9.1%)	2 (2.0%)	99
Total	93 (71.0%)	24 (18.3%)	10 (7.6%)	4 (3.1%)	131
Chi-square value: 4.555; Significant level = 0.05; Df= 3; P-value = 0 .290 Correlation: 0. 539					
Disability	**1-4 years**	**5-8 years**	**9-12 years**	**13 years+**	**Total**
Physical	27 (60.0%)	10 (22.2%)	6 (13.3%)	2 (4.4%)	32
Not Physical	66 (76.7%)	14 (16.3%)	4 (4.7%)	2 (2.3%)	99
Total	93 (71.0%)	24 (18.3%)	10 (7.6%)	4 (3.1%)	131
Chi-square value: 5.088; significant level = 0.05; Df= 3 P-value = 0. 290 Correlation: 0.539 (averagely strong)					

Extent of Comfortability with Access to Infrastructure services in ARHs

This study also documented the extent to which CWDs are comfortable with access to infrastructure. Infrastructures examined in the study included access to adequate transportation system, social amenities/services and healthcare services. Table 4 shows that overall, more (40.5%) of CWDs were comfortable with the transport services in ARHs with more (48.8%) of deaf and dumb CWDs category reportedly comfortable, followed by 36.4% of polio-caused disabled category. On the contrary, 52.6% of visually impaired CWDs category and 33.3% of emotionally disturbed CWDs category were reportedly uncomfortable with transport system in ARHs. The Chi-square result shows a significant relationship ($P>0.05$) between respondent's personal disability described and extent of comfort when accessing transportation services. Also, there was a strong relationship between types of disability and access to transportation services with the correlation value of 0.973. Table 4 also reveals that 46.5% of deaf and dumb CWDs category, 45.5% of polio-caused disabled category, and 33.3% of emotionally disturbed category were reportedly comfortable with the social services available at their disposal. Contrarily, more (47.4%) of visually impaired children were reportedly uncomfortable with social services than other categories of CWDs in the ARHs. Furthermore, Table 4 shows that there was no significant relationship between types of disability and comfort enjoyed by CWDs ($P>0.05$) and they were not correlated.

Additionally, more than half (61.5%) of the polio-caused disabled children are comfortable with their access to health care services, while 23% of same polio-caused disabled category are uncomfortable with their access to health care services as indicated in Table 4. However, 15% were undecided. Also, more than half (54.5%) of children with blindness were comfortable with their access to health care services than 27% of same category who reportedly were uncomfortable. Majority (66.6%) of CWDs of deaf and dumb category indicated being comfortable with their access to health care than 16.7% who were uncomfortable. The overall result shows a weak relationship between types of disability and access to health care. However, the correlation value of 0.934 shows a strong relationship between types of disability and access to health care services. The Chi-square results (13.659; P-value=0.345) indicate no significant relationship between CWDs' duration of stay and likelihood of recommending the ARHs as the best model for supporting CWDs.

Table 4: Cross Tabulation between Personal Disability, and Comfort in Accessing Transportation, Social Services and Healthcare services

Personal Disability Description	**Extent of comfort accessing transport services**			**Total**
	Comfortable	Uncomfortable	Undecided	
Polio	24 (36.4%)	21 (31.8%)	21 (31.8%)	66
Blindness	8 (42.1%)	10 (52.6%)	1 (5.3%)	19
Deaf and Dumb	21 (48.8%)	6 (14.0%)	16 (37.2%)	43
Emotional	-	1 (33.3%)	2 (66.7%)	3
Total	53 (40.5%)	38 (29.0%)	40 (30.5%)	131
Pearson Chi-Square: 15.380**;** Df: 6**;** Significant level: 0.05; P-value: 0.017; Correlation: 0.973				
Personal Disability Description	**Extent of comfort accessing Social Services**			**Total**
	Comfortable	Uncomfortable	Undecided	
Polio	30 (45.5%)	25 (37.9%)	11 (16.7%)	66
Blindness	7 (36.8%)	9 (47.4%)	3 (15.8%)	19
Deaf and Dumb	20 (46.5%)	8 (18.6%)	15 (34.9%)	43
Emotional	1 (33.3%)	-	2 (66.7%)	3
Total	58	42	31	131
Pearson Chi-square:12.358**;** Df: 6**;** Significant level: 0.05; P-value: 0.054; Correlation: 0.153				
Personal Disability Description	**Extent of comfort accessing Healthcare services**			**Total**
	Comfortable	Uncomfortable	Undecided	
Polio	32 (61.5%)	12 (23.1%)	8 (15.4%)	52
Blindness	6 (54.5%)	3 (27.3%)	2 (18.2%)	11
Deaf and Dumb	4 (66.6%)	1 (16.7%)	1 (16.7%)	6
Total	42	16	11	69
Pearson Chi-square:13.659; Significant level: 0.05; df = 4; P-value:0.345; Correlation:0.934				

Re-integration process of CWDs into independent living

The transition from residential care to independent living can be challenging for young people with disability. While some departures from care may be well planned, others may be sudden or unexpected, leaving young people emotionally and financially ill-equipped to cope with change. Without adequate preparation for leaving, care and support during the aftercare phase, young people with disability may face risks such as long-term unemployment, stigma and discrimination, homelessness and lack of acceptance from society. Administrators observed that the biggest barrier to transitioning children out of care includes the absence of supportive relationships, educational challenges, housing instability and economic challenges.

The analyses of narratives of perception on re-integrating CWDs and young people with disability back into the society after care, show some patterns among the managers of alternative homes. The results indicate that ARHs for CWDs serve different purposes which are broadly classified into three: Private and public residential home for CWDs that provides only educational services and boarding facilities; they play parental roles and run as schools. Second, there are Non-Governmental Organizations that admit CWDs for respite care and long-term care; and third, there are Government-owned facilities that admit CWDs that are abandoned or relinquished by their parents. In the participant's words:

> We render daycare program. The program is for pupils whose parents bring in the morning and then come back to pick in the afternoon. And that daycare program is designed for pupils that are educable and trainable. On the daycare, we have some children that are not educable neither trainable; their parents bring them here, so that we can watch over their child. Also we have hostel programs, of ten-month residence program where such child would have the ability to observe all holidays, and the second one- all year round program, where such child would not go home except during Christmas (**Administration Assistance/NGO/residential home)**

A participant from government residential care noted "We admit all categories of children that are abandoned or orphaned" (**Caregiver /Government/ residential home).** There are three categories of processes that government adopt to reintegrate children and young people with disability back to the society. The first of the processes is adoption. The government gives out some of these children for adoption:

> Government provides shelter, food and education up to the University level for children with disability who are educable. For those who are not educable at a certain age they are sent to government rehabilitation centre for vocational skills. After graduation from the vocational centre, government would set them up and there would be a monitoring team that would follow them up **(Caregiver/Government/residential home)**

Most reintegration processes of CWDs have not been very successful. For females, most of the strategy is to organize marriage for them. For those who have been established or set up for businesses, societal discrimination and stigma against people with disability had crippled their businesses. A case of one of the reintegrated youth with disability was narrated:

> Community should see persons with disability as part of the society. We trained, supported and reintegrated a young person with disability, but in the community where he does his trade, nobody patronized him. He closed down the business and almost committed suicide. Thank God that he was rescued from taking his own life **(Caregiver/Government/residential home)**

Reducing these risks involves working with young people with disability to plan for life aftercare and adulthood- including helping them to determine the most appropriate living environment, financial management and job skills, and ensuring that they have a reliable support system in place. Once a child leaves an alternative home, an administrator advised, “they should be encouraged to keep in contact with their previous caregivers, their friends, still gain access to basic social services and be supported to enjoy educational, vocational and employment opportunities” **(Administration Assistance/NGO/residential home).**

Discussion

While other sociodemographic structures of the respondents in this study are important in the discourse of the nature of support systems for CWDs, the import of religion resonates tangible in ARHs care in Ibadan metropolis. The analysis of the religious affiliations of the CWDs indicates that majority (77%) of the CWDs practiced Christianity as their religion. This may be because most of the ARHs surveyed were either owned or managed by Christian missionaries or the government. Religion may likely play a role in the categories of parents who may be aware of the services provided by the residential homes.

The education of the respondents is another demographic factor worthy of discussion. The level of education impinged some of the challenges faced by CWDs in this study. This may not be applicable to respondents in this study alone but to all individuals with disabilities. In spite the fact that more than half (56%) of the respondents were in the senior secondary school, it is less likely for another 10% of the respondents to proceed to tertiary institution. This assertion is in line with the report from the UIS Fact sheet (2017) which points out that persons with disabilities are more likely to be out-of-school or to leave school before completing primary or secondary education. Several factors may account for this. Most tertiary education providers in Africa lack basic learning facilities to accommodate young people with disability. Public educational infrastructures were also not designed to support the learning of people with disability. One of the relevance of ARH is the ability of the home to provide educational services which was generally lacking in the community schools, although the quality of the services provided also needs attention. For example, practice guidelines could be developed for social workers to support students with disabilities and inconsistent behaviour even when pupils are not willing to seek help (Greer, et al, 2023; Dupper, et al, 2009).

The study explores societal factors influencing children's admission to ARHs, including stigma, discrimination, lack of social services, stress, and cost of care. The reality suggests a dearth of social workers in schools and educational settings hence the increasing need for them to support children with disability to engender sustainable education for children in need (Nnama-Okechukwu, *et al*., 2023). Investigation on reasons why children with disability were admitted into ARHs showed that more than three-quarters (76%) were reportedly admitted due to disability. This is in line with UNICEF, WHO and World Bank’s observations which noted that challenges dealing with stigma and discrimination, as well as the stress of caring for a CWD, have been identified as factors leading to the institutionalization of children (UNICEF, 2005). Support to parents is often unavailable, especially in resource-constrained settings (WHO and World Bank, 2011). The challenge violates the rights of CWDs, as outlined in the global Convention on the Rights of the Child, which guarantees survival, development, protection, and participation in family life (United Nations Human Rights, 1989). Studies have also revealed that institutionalization isolates children from their families and communities and places them at increased risk of neglect, social isolation and abuse (The Worldwide Campaign to End the Institutionalization of Children, 2012; UNICEF, 2011).

It was observed that half (50%) of the respondents suffered from infant paralysis caused by poliomyelitis (polio), while 14.5% reportedly suffered from blindness, whereas 32.8% of the respondents were deaf and dumb. One key observation in the data is that more than half of the disability are preventable. For example, the majority of developed countries eradicated poliomyelitis in the 1980s, as a result of oral polio vaccines developed in the 1950s, but polio continued to be endemic in developing countries. In 2016, 37 cases were reported, from Pakistan, Afghanistan and Nigeria (Lickness, et al, 2020). This figure shows implications for the possibility of eradication of poliomyelitis.

The referral of children to ARH was a product of a network of close and known relationships. Findings in this present study indicate that more than half of the children (59.5%) in residential homes were referred by biological parents. This is an additional finding to those from other studies where it was stated that a large proportion of children in institutional care have at least one living parent, but who has significant difficulty providing care or is unwilling or unable to do so. For instance, studies such as one conducted in Sri Lanka show that 92 percent of children in private residential institutions had one or both parents living, while more than 40 percent were admitted due to the poverty status of their parents (Bilson & Cox., 2006). Relatedly, in Zimbabwe, where nearly 40 percent of children in orphanages or institutional care have a surviving parent and nearly 60 percent have a contactable relative, poverty was reported as the driving force for placement (Powell et al, 2005).

The study found that nearly three-quarters of respondents in ARHs are fed three times daily, indicating no challenge in feeding, but a third advocate for improved education quality. The study also showed that most ARHs have their private clinic to attend to minor health issues, while a majority (72%) use public clinics/hospitals during illness episodes. However, only 30% sought treatment within a few days of illness. All these constitute part of activities for safety issues and security matters. Qualitative data showed the lack of formal child safeguarding policy across most of the residential homes. This is an indication of the lack of mechanisms for prevention, reporting and responding to child abuse incidences in ARHs. These same experiences were reported in some settings, where CWDs were especially vulnerable to neglect, abuse and limited opportunities for rehabilitation (MDRI, 2007; Rosenthal et. al. 2011; WHO, 2010). Social isolation, powerlessness and stigma faced by CWDs make them vulnerable to violence and exploitation in their own homes and in other environments such as care homes or institutions. The finding in this study validates the previous one that CWDs are three to four times more likely to experience violence than their non-disabled peers (Jones *et al.*, 2012) perhaps owing to the lack of adequate mechanisms for safety and security matters in ARHs. However, pupils in need do not necessarily seek social work services personally which prevents their social inclusiveness, hence demands a proactiveness of social workers (Pfiffner, et al., 2023; Asamoah, et al, 2021). Access to transportation services was identified as a critical need across the different types of disability. However, this need was strongly required among the blind with over 50% reportedly not comfortable with the available transportation services. This same position was maintained in a recent study of visually impaired persons in Ibadan, Nigeria, where the lack of well-organized public transportation suitable to cater for disabled persons was a major barrier to access transportation in Nigeria (Salami, 2018) as occurred in some highly developed countries (Leonardi, et al, 2009). Transportation provides independent access to employment, education, health care services and facilities, and social and recreational activities. Poor access to transportation as reported in this study, has been observed to have a risky potential of exclusion for people with disabilities from services and social contact (Robert et. al., 2005; Venter, et al, 2004). A study in Europe, cited transport as a frequent obstacle to the participation of people with disabilities (Leonardi, et al, 2009), while the lack of transportation was the second most frequent reason for a person with disability being discouraged from seeking work (Loprest & Maag, 2001) in the United States of America.

Less than half of the respondents in this study were comfortable with the available assistive devices. This indicates an important gap in the need for children with disability. Assistive devices have been reported to reduce disability and may substitute or supplement support services thereby reducing the cost of care for people living with disability (Persson et al., 2007). An assistive device is any item, piece of equipment or product, which is used to increase, maintain, or improve the functional capabilities of individuals with disabilities (Assistive Technology Act, 2004). Nigerian studies such as ones on hearing impairments (Olusanya, 2006), and visual impairment (Salami, 2018) suggest that the provision of assistive devices tends to improve function, participation and user satisfaction for persons living with a disability. In the same sense, a study from the United States showed that users of assistive technologies such as mobility aids and equipment for personal care reported less need for support services (Agree & Freedman, 2003).

Nigeria seemed structured to the disadvantage of people with disability and support systems for CWDs are premised on factors of religion and education in Ibadan metropolis, hence the need for culturally sensitive and inclusive approaches in social work interventions. Institutionalized stigmatization and discrimination significantly influence admissions of CWDs, despite poverty and other attributes. Social work practice should challenge systemic issues to prevent unnecessary placement in residential homes.

Furthermore, the notoriety gained by preventable disabilities, such as polio, underlines the significance of community health programmes and policy advocacy. Also, a proactive social work intervention would contribute to the sustainable and inclusive education of CWDs. While the global movement on deinstitutionalisation and reintegration is relevant in Nigeria, a lot still needs to be done to prepare the Nigerian society to accommodate and care for CWDs. The reality emphasizes the necessity of engendering practice guidelines for social workers to assist CWDs and improve the quality of services offered. Lack of formal child safeguarding policies in residential care settings highlights a critical gap, necessitating the integration of safeguarding measures in social work education and training.

Access to transportation services, ease with assistive devices, and the overall need for a holistic approach to support services emphasize the significance of research and policy development in improving the quality of life for CWDs. This paper suggests that social work education should also focus on disability-inclusive practices, emphasizing preemptive and socially competent approaches, and suggests further research on community-based support programs and family-strengthening interventions.

This study was limited to those CWDs in ARHs who could respond to the questionnaire. There were difficulties in data collection from the participants with different disabilities. For instance, children with developmental, mental, and emotional disability; down-syndrome, cerebral palsy, and mental retardation- were unable to logically respond to the questionnaire. Hence, this led to the elimination of children with such disabilities which invariably led to a reduction in the population pool of available respondents. However, courage was summoned to interview those CWDs who could respond at the time of the study.

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