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Quality Of Life Among Children Deprived From Family Care In Residential Institutions In El-Beheira Governorate- Egypt

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Abstract:*Around the world, more than eight millions of girls and boys grow up for long periods of their lives not in their own families but in residential institutions. Children are placed in residential institutions because they life in a harsh social conditions due to death of one or both parents, parent's illness, adverse economic circumstances, unknown parenthood, cracked family, parent's imprisonment and family inability to provide proper care. Quality of life concern the satisfaction of individual's needs and demands, which are necessary for his satisfaction with life. Hence, this study was conducted to identify the quality of life among children deprived from family care in residential institutions in El-Beheira governorate.A descriptive research design was used to conduct this study. It had been carried out in all 10 residential institutions for care of children deprived from family care affiliated to the Ministry of Solidarity and Social Justice in El-Beheira governorate , Egypt. The present study subjects included all residents, boys and girls in the previously mentioned residential institutions aged from 6 to17 years and free from any mental or physical disabilities .They were 214 children (92 males and 122 females).Three tools were used in this study (quality of life among children deprived from family care in residential institutions in El-Beheira governorate). Tool I: Residential children's demographic characteristics. Tool II: KINDL ^{R} quality of life questionnaire. Tool III: Satisfaction with life scale (SWLS). Approvals were obtained for conducting the study at the specified settings. The study was conducted in a period of4 months (from May to September 2016). Data was collected by the researcher then appropriate descriptive and analytical statistics were carried out such as arithmetic mean, standard deviation, Chi square and Monte Carlo tests of significance.The main findings obtained from the study revealed that more than half (57.0%) of the institutionalized children were females compared to 43.0% were males. More than one third (36.9%) of them aged from 6 to 12 years, while 63.1% aged from 12 to 17 years with a mean of 13.41 ± 3.29.More than one third (37.9%) of the studied children were in primary education, almost two fifths (39.7%) in preparatory education, and 22.4% in secondary education.Almost two thirds (64%) of the children lived in institutions in urban areas.Regarding their quality of life , more than half (57%) of the studied children had fair QOL, while 41.1% of them had good QOL, and few percent (1.9%) of them had poor QOL. Almost one quarter (25.7%) of the studied children were dissatisfied with their life, while 8.9% of them were extremely dissatisfied with their life a mean of 22.53± 8.80.Based upon the results of the current study, it could be concluded that more than half of the institutionalized children in El-Beheira governorate had fair quality of life and more than one third of them were dissatisfied with their life. In light of the present study findings, it is recommended to assign trained health care providers to provide continuous care for the institutionalized children and their caregivers and make referral when needed.*

Keywords:*children deprived from family care, quality of life, , residential institutions*

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I. Introduction

Family is one of the main socializing institutions of the society and important to the children's development and protection. Within family, they can feel cared and grow up protected from neglect, abuse, and violence. Also, they acquire the social norms and values, develop their sense of belonging, identity and origin and become socially adjusted to form relations with other members of the society. In addition, they can develop physically fit, emotionally resilient and intellectually capable [(1)].

Around the world, millions of girls and boys grow up for long periods of their lives not in their own families, but under the control and supervision of care authorities or justice systems. [(2)]

According tothe International Save the Children Alliance, over 8 million boys and girls around the world live in institutional care. The institutions they live in have different names, including orphanages, children's homes, care homes, juvenile detention facilities, reform schools, etc. All of these institutions govern the daily life, personal development and future chances of a very large number of children [(3)]

Children are placed in residential care because they have lost their parents and have no extended or surrogate family to go to (a problem that is expanding due to AIDS, especially in sub-Saharan Africa). Others are institutionalized because of physical or mental disability, or psychiatric or other severe illnesses and many have been given up by parents due to lack of money or support services. According to Save the Children Alliance, the government data in Egypt indicates that 46,000 children reside in various types of care institutions and according to the Ministry of Social Solidarity (2011) there were 9082 children living in residential institutions for care of children deprived from family care[(4-7)].

The residential institutions for care of children deprived from family care are defined by the Ministry of Social Solidarity as residential, didactic, developmental homes specialized in the care of children deprived of family care of both sexes who not less than the age of six years and until the age of 18 years or until the stability at work or marriage for females. Children are deprived from their natural family care and therefore institutionalized because they life in a harsh social conditions due to death of one or both parents, parent's illness, adverse economic circumstances, unknown parenthood, cracked family, parent's imprisonment and family inability to provide proper care [(8-10)].

Institutionalized children are suffering from complex mix of social, perceptual, physical, intellectual, and emotional deprivation. Moreover, they are usually experiencing physical, behavioral, social, and emotional maltreatment and neglect. As a result, they are more likely to have behavioral and emotional problems, also likely to be suspended or expelled from school, and to receive mental health servicescompared with children in parent care [(10)].A study conducted in Romania (2009) revealed that, institutionalized children were more physically stunted than children raised at home or in foster families. Also, they had significantly lower IQ scores and brain activity levels, they were more likely to have social abnormalities such as disturbances and delays in social development [(11)].

Studies about children reared in residential institutions in Egypt showed that, children living with their families had positive features of psychological structures and are better able to achieve identity compared by children deprived of family care and resident in care institutions. Moreover, sever anxiety, maladaptive cognitive schema, aggression, and depression are common problems among children in residential institutions [(12-15)].World Health Organization (WHO) defines Quality of Life (QOL) as "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". QOL include the perception and judgment of one's own life from the individual's own subjective perspective, as well as one's subjective well-being, or affective mood [(16,17)].

The quality of life for children living in residential institutions may be adversely affected due to reduced potential to form secure, long-lasting attachments, overcrowding, lack of privacy, reduced or no possibility to maintain contact with family members and friends, stigmatization associated with institutionalization, limited choices to select friends specially from outside the institution, and lack of preparation for future life after leaving the institution [(3)].A study conducted in Norway (2015) revealed that adolescents living in residential youth care having poorer QOL compared to the general population on the life domains, physical and emotional well-being, self-esteem, and relationship with friends [(18)].

Children deprived from family care represent a highly vulnerable, sensitive and risky group that need multidisciplinary research and intervention.Accordingly, community health nurses can learn more about this important population group and assess the positive and negative factors that can affect their health and quality of life and use this information to help them grow up physically and emotionally healthy. Furthermore, community health nurses can alert the health professionals, businessleaders, religiousgroups, and voluntary organizations to residential care children's and adolescents' needs and the strategies that can improve their health [(14,19)].

Few studies were conducted in Egypt to assess the quality of life of the children living in residential care. Thus, this study was conducted to identify the quality of life among children deprived from family care in residential institutions in El-Beheira governorate, Egypt.

II. Material and methods

Study design: Descriptive design was adopted to carry out this study.

Study Location: The study was carried out in all 10 governmental and non-governmental residential institutions for care of children deprived from family care affiliated to the Ministry of Solidarity and Social Justice in El-Beheira governorate. Those institutions provide care for children grew up in a harsh social condition that prevents them from the care of their natural families, because of orphanhood or cracked family or family inability to provide proper care**.**

Study duration: Data was collected by the researcher over a period of 4 months (from May to September 2016).

Subjects:

All residents, boys, and girls in the previously mentioned residential institutions aged from 6 to17 years and free from any mental or physical disabilities were included in the study. They were 214 children (92 males and 122 females)

Tools:

Three tools were used in the process of data collection. These tools included the following:-**Tool (I):Residential children health profile structured interview schedule** This tool was developed by the researcher after reviewing recent literature in order to collect required data. It was included the following parts:-

Part I: Demographic characteristics of institutionalized children: It included the sex, age, number of siblings, level of education, reason for admission, age on admission, period of residence, relatives visit, presence of siblings in institution and services provided by the institution.

Tool (II):KINDL^R quality of life questionnaire:

The KINDL ^{R} is a generic instrument for assessing health-related quality of life in children and adolescents aged 4 years and older [(20)]. The original version of the KINDL quality of life questionnaire was developed by Bullinger et al in 1994 in German-language and in 1998 Sieberer& Bullinger revised it and developed the KINDL^R which is available in many languages. It provides likert - scale items associated with six dimensions: physical wellbeing, emotional wellbeing, self-esteem, family, friends, and everyday functioning (school or nursery school /kindergarten). Three versions of the KINDL^R questionnaire are available as self-report measures for different age groups and used in the study:

- Kiddy-KINDL^R for children aged 4 to 6 years.
- Kid-KINDL^R for children aged 7 to 13 years.
- Kiddo-KINDL^R for adolescents aged 14 to 17 years.

The Kiddy-KINDL^R consists of twelve items, two for each dimension and its response categories cover 3 levels as follows; 1 = never, 2 = sometimes, 3 = very often.

The Kid-KINDL^R and Kiddo-KINDL^R provide 24 likert - scale items, four for each dimension and its response categories cover 5 levels as follows;1 = never, 2 = rarely, 3 = sometimes, 4 = often, 5 = all the time.

The items and sub-scales of the KINDL^R questionnaire were calculated such that a higher score corresponds to a higher health-related quality of life and the value of the following questionnaire items were reversed: 1,2, and 4 for children aged less than 7 years and 1,2,3,6,7,8,15,16,20,23, and 24 for children aged from 7-17 years .

- The scores of KINDL ^{R} questionnaire for children less than 7 years were summed, the total score ranged from 12 to 36 and the following cut-off points used as benchmarks:

Score	Interpretation
<18 (< 50 %)	Poor quality of life
18-27 (50 %-75%)	Fair quality of life
>27 (>75%)	Good quality of life

The scores of KINDL ^{R} questionnaire for children aged 7-17 years were summed, the total score ranged from 24 to 120 and the following cut-off points used as benchmarks:

Score	Interpretation
< 60 (< 50 %)	Poor quality of life
60-90 (50 %-75%)	Fair quality of life
> 90 (>75%)	Good quality of life

Arabic translated version of KINDL ^{R} quality of life questionnaire was adopted from tool used in a research study that was conducted in Faculty of Nursing, Alexandria University by Ramadan S2010 [(149)], the Kid-KINDLR and Kiddo-KINDLR version were merged together and used as a one questionnaire for children aged from 7 to17 years because the questions of both versions have the same meaning when translated into Arabic language.

Tool (III): Satisfaction with life scale(SWLS): Satisfaction With Life Scale (SWLS) was developed by Diener E, et al (1985) [21] to assess satisfaction with the respondent's life as a whole. A 5-items scale designed to measure global cognitive judgments of one's life satisfaction. Participants indicate how much they agree or disagree with each of the 5 items using a 7- point Likert scale that ranges from 1 strongly disagree to 7 strongly agree.

- The scores of SWLS were summed , the total score ranged from 25 to 35 and the following cut-off points used as benchmarks:

31 - 35 Extremely satisfied.26 - 30 Satisfied.21 - 25 Slightly satisfied.
20 Neutral .15 - 19 Slightly dissatisfied.10 - 14 Dissatisfied.5 - 9 Extremely dissatisfied.

- In this study, the slightly agree and slightly disagree responses were added to agree and disagree respectively (to be a 5- point Likert scale) also, the total number of studied children who were categorized as slightly satisfied and slightly dissatisfied was added to those who were categorized as satisfied and dissatisfied respectively and the following cut-off points used as benchmarks (31 - 35 Extremely satisfied, 21 - 30 Satisfied, 20 Neutral, 10 -19 Dissatisfied, 5 - 9 Extremely dissatisfied)for more clarification of study results.

Method

I- Administrative process

- Official letters from Faculty of Nursing, University of Alexandria were directed to the directorate of Social Solidarityin El-Beheiragovernorate to inform them about the study objectives and to seek their permission to conduct the study in the previous settings affiliated to this directorate.
- Meeting was held with the Deputy Minister of Social Solidarity and the directorate agent of social solidarity in El-Beheira governorate to inform them about the study objectives and to take their permission to conduct the study in the previous settings.
- Approval letters were directed from directorate of social solidarity in El-Beheira governorate to the directors of selected institutions via the researcher.
- Meetings were held with the directors of the selected institutions to explain the aim of the study, set the date and time of data collection, assure them that collected data will be used only for the study purpose, and to gain their approval and cooperation during data collection.

II- Development of study tools

- Tool (I) was developed by the researcher after reviewing recent literature in order to collect the required data from the studied children. Tool (I) was revised by Jury composed of (five) experts in the field of Community Health Nursing for content validity and their recommended modifications were done accordingly.Tool (II) and (III) were tested for reliability by test and retest.

The Pilot study was carried out on a sample of 25 (13 female &12 male) institutionalized children, the data obtained from the pilot study were analyzed. Based on the findings of the pilot study, some questions were clarified and few others added.

Data collection : The data was collected individually from the children in their institutions after a brief explanation of the purpose and the nature of the research. The children were asked for an oral consent for participation in the study. Structured interview was conducted individually using tool I, II, and III at the previously mentioned settings with each child at suitable time in order to collect the study data.

Statistical analysis: After data collection, the collected data was coded and analyzed using the statistical package of social science (SPSS) version 20.Variables were analyzed using the descriptive statistics which included: percentages, frequencies, range (minimum and maximum), arithmetic mean, and standard deviation (SD).The level of significance selected for this study was $p \leq 0.05$.Chi square test (X2) ,Monte Carlo P-value (MCP) was used to test significance

Ethical considerations: Permission was obtained to collect the data from the previous settings. Written informed consent obtained from the director of each institution included in the study after explanation of the aim of the study and assure them that collected data will be used only for the study purpose. Each director of residential institutions informed about the date and the time of data collection. Confidentiality and anonymity of individual response was guaranteed through using a code numbers instead of names.

III. Results

Table (I) shows the distribution of the studied institutionalized children according to their demographic characteristics. The table reveals that, more than half (57.0%) of the studied children were females compared to

43.0% were males. Also, their age ranged from 6 to 17 years with a mean of 13.41± 3.29, out of them more than one third (36.9%) aged from 6 to 12 years, while 63.1% aged from 12 to 17 years. In addition, the present table portrays that 40.7% of the studied children had siblings, out of them more than one third (36.8 %) had four siblings or more, with a mean of 3.02 ± 1.75 andmore than two fifths of them (42.5%) had siblings in the institution, out of them 97.3% had 1-2 siblings, with a mean of 1.35 ±.54. Regarding thepresent level of education, more than one third (37.9%) of the studied children were in primary education, almost two fifths (39.7%) in preparatory education, and 22.4% in secondary education. Also, the table shows that almost two thirds (64%) of the children lived in institutions in urban areas, while the rest (36%) were in rural areas.With respect to reasons of institutionalization, more than half (54.7%) of the studied children were placed in the institution due to unknown parentage, followed by 13.5%, 13.1% due to parental separation and family inability to provide financial care respectively, while (9.8%, 4.7%, and 2.8%) were placed due to death of father or mother or both respectively, and 1.4% of them due to father or mother imprisonment. On the other hand, nearly two thirds (65.9%) of the children were institutionalized at age less than 6 years, while (17. 8%, 16.3%) were at age ranged from 6 to 11 years and 11 to16 years respectively, with a mean of 4.96 ± 4.76. Regarding the duration of institutionalization, nearly half of the studied children (47.2%) were living in the institution for a period of 10 -17 years, almost quarter (23.8%) were living a period of 5-10 years, while (27.1%, 1.9 %) were living a period of 1-5 years and less than 1 year respectively, with a mean of 8.56 ± 4.96.

Table (I): Distribution of the studied institutionalized children according to their demographic characteristics.

Demographic characteristics	**No.** **N =214**	**%**
Sex		
- Male	92	43.0
- Female	122	57.0
Age (in years)		
- 6-12	79	36.9
- 12-17	135	63.1
Mean ±SD = 13.41± 3.29		
Having siblings		
- No	127	59.3
- Yes	87	40.7
Number of siblings [n=87]		
- 1-3	55	63.2
- 4-7	32	36.8
Mean ±SD = 3.02± 1.75		
Having siblings in the institution [n=87]		
- No	50	57.5
- Yes	37	42.5
Number of siblings in institution [n = 37]		
- 1-2	36	97.3
- 3-4	1	2.7
Mean ±SD = 1.35±.54		
The present level of education		
- Primary	81	37.9
- Preparatory	85	39.7
- Secondary	48	22.4
Place of Institution residence		
- Urban	137	64.0
- Rural	77	36.0
Reasons of institutionalization		
- Death of both parents	6	2.8
- Death of mother	10	4.7
- Death of father	21	9.8
- Unknown parentage	117	54.7
- Family inability to provide financial care	28	13.1
- Parental separation	29	13.5
- Imprisoned father/mother	3	1.4
Age of institutionalization		
- < 6 years	141	65.9
- 6 – 11 years	38	17.8
- 11-16 years	35	16.3
Mean ±SD = 4.96 ± 4.76		
Duration of institutionalization		

-	<1 year	4	1.9
-	1- 5 years	58	27.1
-	5-10 years	51	23.8
-	10 -17 years	101	47.2
Mean ±SD = 8.56 ± 4.96			

Quality of life of the studied institutionalized children.

Table (II) shows the distribution of the studied institutionalized children according to kindle subscales (for children aged less than 7 years). Regarding physical wellbeing, all children (100 %) never suffered from feeling of illness. While 33.3% of them were sometimes suffering from headache or tummy-ache, and two thirds (66.7%) never suffered from it. Concerning emotional well-being, all children (100 %) aged less than 7 years were having feeling of fun and laughed a lot. One third (33.3%) of the children were sometimes suffering from boredom, while 66.7% of them never suffered from it. As regards self- esteem, two thirds (66.7%) of children aged less than 7 years were very often felt pleased with themselves, while 33.3% of them were sometimes having that feeling**.** Also, two thirds (66.7%) of children were very often proud of themselves, while 33.3% of them were sometimes having that feeling.

In relation to Family, two thirds (66.7%) of children aged less than 7 years were very often getting on well with their caregivers in the institution, while 33.3% of them were sometimes getting on well with them. Moreover, two thirds (66.7%) of children were very often felt fine at the institution, while 33.3% of them were sometimes having that feeling. Regarding friends, two thirds (66.7%) of children aged less than 7 years were very often playing with their friends, while 33.3% of them were sometimes doing that. Also, two thirds (66.7%) of children were very often getting along well with their friends, while 33.3% of them were sometimes getting along well with them. The same table also indicates that, half of the children (50%) were very often or sometimes coping well with the assignments set in school respectively. Moreover, 100% of the children were very often finding school interesting.

Table (II): Distribution of the studied institutionalized children according to kindle subscales (for children aged less than 7 years)

Demographic characteristics	No. N =214	%
Sex		
- Male	92	43.0
- Female	122	57.0
Age (in years)		
- 6-12	79	36.9
- 12-17	135	63.1
Mean ±SD = 13.41± 3.29		
Having siblings		
- No	127	59.3
- Yes	87	40.7
Number of siblings [n=87]		
- 1-3	55	63.2
- 4-7	32	36.8
Mean ±SD = 3.02± 1.75		
Having siblings in the institution [n=87]		
- No	50	57.5
- Yes	37	42.5
Number of siblings in institution [n = 37]		
- 1-2	36	97.3
- 3-4	1	2.7
Mean ±SD = 1.35±.54		

The present level of education		
- Primary	81	37.9
- Preparatory	85	39.7
- Secondary	48	22.4
Place of Institution residence		
- Urban	137	64.0
- Rural	77	36.0
Reasons of institutionalization		
- Death of both parents	6	2.8
- Death of mother	10	4.7
- Death of father	21	9.8
- Unknown parentage	117	54.7
- Family inability to provide financial care	28	13.1
- Parental separation	29	13.5
- Imprisoned father/mother	3	1.4
Age of institutionalization		
- < 6 years	141	65.9
- 6 – 11 years	38	17.8
- 11-16 years	35	16.3
Mean ±SD = 4.96 ± 4.76		
Duration of institutionalization		
- <1 year	4	1.9
- 1- 5 years	58	27.1
- 5-10 years	51	23.8
- 10 -17 years	101	47.2
Mean ±SD = 8.56 ± 4.96		

Table (III) shows the distribution of the studied institutionalized children according to kindle subscales (for children aged 7-17 years). Regarding physical wellbeing, less than two thirds (63.5%) of children never suffered from feeling of illness, followed by 21.2% sometimes suffering from it, and 9.6% of them rarely suffered from it. Half (50.0%) of the children never suffered from headache or tummy-ache, while almost one quarter (25.5%) were sometimes suffering from it, and 9.6% ,6.3% of them were often or all the time suffering from it respectively. Moreover, 67.3% of the children were never having tiredness or worn out, while more than one eighth (13.5%) of them were sometimes having it, and 5.8% were often having that feeling. On the other hand, one eighth (12.5%) of the children had never felt strong and full of energy, while more than one third (34.1%, 34.6%) were sometimes or all the time having that feeling respectively.

In relation to emotional wellbeing, more than half (51.9%) of the children were all the time having fun and laughed a lot, while 24.0%, followed by16.8% were sometimes or often doing that respectively, and 5.8% of them were never doing. Meanwhile, more than one quarter (28.8%) of the children were sometimes suffering from boredom, while 15.9% were often having that feeling, and more than one third (36.5%) were never having that feeling. Moreover, more than one fifth (23.1%, 21.2%) of children were sometimes suffering from loneliness and feeling scared or unsure of themselves respectively, and more than half (53.8%, 51.9%) of them were never having that feelings respectively .

As regards self esteem, (14.4% , 4.8%) of the children were never or rarely having feeling of pride of themselves respectively**,** while more than one quarter (28.8%) were sometimes having that feeling, and 36.1% were all the time having it. (32.7% , 11.5%) of the children were never or rarely having feeling of being on the top of the world respectively, while less than one quarter (22.6%) of them were sometimes having that feeling , and 18.3% of the children were all the time having it. Almost one tenth (9.1%) of the children were never or rarely having feeling of pleasure with themselves, while less than one third (29.3%) were sometimes having it ,and 44.2% of them were all the time having it. Moreover, 17.3% of the children reported that they never having lots of good ideas, while less than two fifths (38.9%) were sometimes having it, and less than one quarter (24%) of them were all the time having it.

Concerning family, more than half (51.4, 55.3%) of children aged from7 to 17 years were all the time getting on well with their care givers in the institution and felt fine at institution respectively, while 4.8 % and 10 .1% of them were never getting on well with their care givers or felt fine at institution respectively .One tenth (10.1%) of the children were often quarreling at institution, while 45.2% of them were never do. Moreover, slightly more than one tenth (10.6%) of the children were all the time felt restricted by care givers, and more than half (54.8%) of them were never felt restricted by care givers.

Regarding friends, less than half (48.6%) of children were all the time playing and doing things together with their friends, followed by more than one quarter (28.8%) of them were sometimes doing that, and (4.8%, 4.3%) were never or rarely doing that respectively . Slightly more than half (52.9%, 50.5%) of children were all the time having success and getting along well with their friends respectively, while less than one quarter (23.1%, 24%) of them were sometimes having success and getting along well with their friends, while (7.7% , 4.3%) of them were never having success and getting along well with their friends respectively. Moreover,(14.9%, 6.3%) of the children were all the time or often felt different from other children, while 20.2% were sometimes having that feeling, and 51.9% of them were never having it.

As regards school, more than one quarter of the children (26.4%, 32.7%) of the children were never doing school work easily or enjoying their lessons respectively, while, less than one quarter (24.5%, 21.6%) were sometimes doing school work easily and enjoying their lessons respectively, and (34.6%, 33.2%) of them were all the time doing school work easily and enjoying their lessons respectively. Meanwhile, (23.1%, 6.7%) of the children were all the time or often worrying about their future respectively, while more than one fifth (21.6%) were sometimes worrying about it, and 40.9 % of them were never worrying about it. Additionally, more than two fifths (43.3%) of the children were all the time worrying about bad marks, while 23.1% were sometimes worrying about it, and less than one quarter (22.6%) of them were never worrying about it.

Table (III): Distribution of the studied institutionalized children according to kindle subscales (for children aged 7 -17 years).

Quality of life domains n=208	Never		Rarely		Sometimes		Often		All the time	
	No.	%	No.	%	No.	%	No.	%	No.	%
Physical wellbeing										
1. Felt ill	132	63.5	20	9.6	44	21.2	6	2.9	6	2.9
2. Had headache or tummy-ache	104	50.0	18	8.7	53	25.5	20	9.6	13	6.3
3. Was tired and worn-out	140	67.3	20	9.6	28	13.5	12	5.8	8	3.8
4. Felt strong and full of energy	26	12.5	7	3.4	71	34.1	32	15.4	72	34.6
Emotional well-being										
5. Had fun and laughed a lot	12	5.8	3	1.4	50	24	35	16.8	108	51.9
6. Was bored	76	36.5	29	13.9	60	28.8	33	15.9	10	4.8
7. Felt alone	112	53.8	20	9.6	48	23.1	15	7.2	13	6.3
8. Was scared or unsure of myself	108	51.9	29	13.9	44	21.2	10	4.8	17	8.2
Self-esteem										
9. Was proud of self	30	14.4	10	4.8	60	28.8	33	15.9	75	36.1
10. Felt on top of the world	68	32.7	24	11.5	47	22.6	31	14.9	38	18.3
11. Felt pleased with self	19	9.1	4	1.9	61	29.3	32	15.4	92	44.2
12. Had lots of good ideas	36	17.3	14	6.7	81	38.9	27	13	50	24
Family										
13. Got on well with care givers	10	4.8	3	1.4	62	29.8	26	12.5	107	51.4
14. Felt fine at institution	21	10.1	3	1.4	5	24.0	19	9.1	115	55.3
15. Quarreled at institution	94	45.2	19	9.1	65	31.3	21	10.1	9	4.3
16. Felt restricted by care givers	114	54.8	17	8.2	43	20.7	12	5.8	22	10.6
Friends										
17. Played and did things together with friend	10	4.8	9	4.3	60	28.8	28	13.5	101	48.6
18. Was a "success" with friends and other kids liked me	16	7. 7	1	0.5	48	23.1	33	15.9	110	52.9
19. Got along well with friends	9	4.3	5	2.4	50	24.0	39	18.8	105	50.5
20. Felt different from other children	108	51.9	14	6.7	42	20.2	13	6.3	31	14.9

School											
21.	Doing school work was easy	55	26.4	7	3.4	51	24.5	23	11.1	72	34.6
22.	Enjoyed my lessons	68	32.7	5	2.4	45	21.6	21	10.1	69	33.2
23.	Worried about future	85	40.9	16	7.7	45	21.6	14	6.7	48	23.1
24.	Worried about bad marks or grades	47	22.6	8	3.8	48	23.1	15	7.2	90	43.3

Table (IV) illustrates the distribution of the studied institutionalized children according to their total QOL score. Regarding physical wellbeing, 65.9% of the studied children had good physical wellbeing, while less than one third (30.3%) of them had fair physical wellbeing and 3.8% had poor physical wellbeing. Concerning emotional well-being, less than two thirds (57.2 %) of studied children had good emotional well-being, while about two fifths (39.9%) of them had fair emotional well-being, and 2.9%of them had poor emotional well-being. As regards self- esteem, 17.3% of the studied children had poor self esteem, while about one third (33.2%) of them had good self esteem, and 49.5 % had fair self esteem.

Regarding family, less than two thirds (58.4%) of the studied children had good relation with their caregivers in the institution, while 33.6% of them had fair relation, and poor relation with caregivers was among 7.9% of them. In relation to friends, 60.3% of studied children had good relation with their friends, while slightly more than one third (34.1%) of them had fair relation, and 5.6% of them had poor good relation with their friend. Concerning school, 22.4%of studied children had poor school functioning, while slightly more than half (52.3%) of them had fair school functioning, and almost one quarter (25.2%) of them had good school functioning. Regarding the total quality of life score, more than half (57%) of the studied children had fair QOL, while 41.1% of them had good QOL, and few percent (1.9%) of them had poor QOL.

Table (IV): Distribution of the studied institutionalized children according to their total QOL score

Quality of life domains	**Quality of life score [N = 214]**					
	Poor < 50 %		**Fair** 50 % - 75%		**Good** > 75%	
	No.	**%**	**No.**	**%**	**No.**	**%**
- Physical wellbeing	8	3.8	63	30.3	137	65.9
- Emotional well-being	6	2.9	83	39.9	119	57.2
- Self-esteem	37	17.3	106	49.5	71	33.2
- Family	17	7.9	72	33.6	125	58.4
- Friends	12	5.6	73	34.1	129	60.3
- School	48	22.4	112	52.3	54	25.2
Total QOL score	**4**	**1.9**	**122**	**57.0**	**88**	**41.1**

Table (V) shows the distribution of the studied institutionalized children according to their total score of life satisfaction. Almost one quarter (25.7%) of the studied children were dissatisfied with their life, while 8.9% of them were extremely dissatisfied and 4.2 % of them were neutral (neither satisfied nor dissatisfied). On the other hand, 40.2% of the children were satisfied with their life, 21.0% were extremely satisfied, with a mean of 22.53± 8.80.

Table (V): Distribution of the studied institutionalized children according to their total score of life satisfaction.

Life satisfaction total score	**No. N=214**	**%**
- Extremely satisfied (31 – 35)	45	21.0

-	Satisfied (21 – 30)	86	40.2
-	Neutral (2 0)	9	4.2
-	Dissatisfied (10 – 19)	55	25.7
-	Extremely dissatisfied (5 – 9)	19	8.9
Max- Min = 35.00-5.00			
Mean ± SD = 22.53± 8.80			

Relation between demographic characteristics and their quality of life.

Table (VI)presents the relation between demographic characteristics of the studied institutionalized children and their quality of life. The table shows that, half (50.0%) of the studied males had good QOL, compared to 34.4% of females. By contrast, 63.1% of females had fair QOL, compared to 48.9% of males. No statistically significant relation was observed between the studied children's sex and their quality of life (^{MC}**P**=. 068).

Furthermore, 64.6% of the studied children aged from 6 to 12 years had good quality of life, compared to less than three quarters (70.4%) of the children aged from 12 to 17 years had fair QOL. A statistically significant relation was observed between children's age and theirquality of life (^{MC}**P** = <0.0001). Concerning the level of education, 65.4% of the children who were in primary education had good QOL, compared to 22.4% of the children in preparatory and one third (33.3%) of the children in secondary education. A statistically significant relation was observed between children's level of education andtheir quality of life (^{MC}**P** = <0.0001).While, no statistically significant relation was observed between the place of institution residence and the studied children's quality of life (^{MC}**P** =. 955).

Moreover, no statistically significant relation was observed between the reason of institutionalization and the studied children's quality of life (^{MC}**P** = .575). More than half (57.9%) of the children who were institutionalized at age ranged between 6 to 11 years had good QOL, while 60.3 % of children who were institutionalized at age less than 6 years and 65.7% of children who were institutionalized at age 11years or more had fair QOL. A statistically significant relation was observed between children's age of institutionalization and theirquality of life (^{MC}**P** =.037).

Table (VI): Relation between demographic characteristics of the studied institutionalized children and their quality of life.

Demographic characteristics	**Quality of life [N=214]**						**Test of significance**
	Poor		**Fair**		**Good**		
	No.	**%**	**No.**	**%**	**No.**	**%**	
Sex							
- Male	1	1.1	45	48.9	46	50.0	^{MC}**P** =.068
- Female	3	2.5	77	63.1	42	34.4	
Age (in years)							
- 6-12	1	1.3	27	34.2	51	64.6	^{MC}**P**<0.0001*
- 12-17	3	2.2	95	70.4	37	27.4	
Level of education							
- Primary	1	1.2	27	33.3	53	65.4	^{MC}**P**<0.0001*
- Preparatory	1	1.2	65	76.5	19	22.4	
- Secondary	2	4.2	30	62.5	16	33.3	
Place of institutionresidence							
- Urban	3	2.2	77	56.2	57	41.6	^{MC}**P** =.955
- Rural	1	1.3	45	58.4	31	40.3	

Reasons of institutionalization							
- Orphanhood	0	0.0	19	51.4	18	48.6	^{MC}**P** =.575
- Unknown parentage	2	1.7	71	60.7	44	37.6	
- Family inability to provide care	2	3.3	32	53.3	26	43.3	
Age of institutionalization							
- < 6	1	0.7	85	60.3	55	39.0	^{MC}**P** =.037*
- 6-11	2	5.3	14	36.8	22	57.9	
- 11 or more	1	2.9	23	65.7	11	31.4	

^{MC}**P**: Monte Carlo pvalue * Significant at P ≤ 0.05

Table (VII) illustrates the relation between demographic characteristics of the studied institutionalized children and their life satisfaction.More than one third (35.6%) of the studied children who aged between 12-17years were extremely dissatisfied with their life , compared to 8.9% of the children who aged 6-12 years. A statistically significant relation was observed between studied children's age and their life satisfaction (X^2 = 41.164, P <0.0001). Moreover, More than one third (37.5%) of the studied children who were in secondary education were dissatisfied with their life, compared nearly one eighth (12.3%) of the children who were in primary education. A statistically significant relation was observed between studied children's level of education and their life satisfaction (^{MC}P<0.0001).

Additionally, 46.7% of the studied children who lived in institutions in urban areas were satisfied with their life compared to 28.6% of the children who lived in institutions in rural. A statistically significant relation was observed between the place of institution residence and the studied children's life satisfaction (X^2 = 18.083, while P= .001). On the other hand, no statistically significant relations were observed between either the reason or the age of institutionalization and studied children's life satisfaction (^{MC}P =.141 and .099 respectively).

Concerning the relation between duration of institutionalization and life satisfaction, the table shows that more than half (56.9%) of the studied children who were institutionalized for a period ranged from1 to5 years were satisfied with their life, while three quarters (75.0%) of the children who were institutionalized for less than 1 year were dissatisfied with their life. A statistically significant relation was observed between studied children's duration of institutionalization and their SWL (^{MC}P = .001)

Table (VII): Relation between demographic characteristics of the studied institutionalized children and their life satisfaction.

Demographic characteristics	**Life satisfaction [N=214]**										**Test of significance**
	Extremely satisfied		**Satisfied**		**Neutral**		**Dissatisfied**		**Extremely dissatisfied**		
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
Age (in years)											
-6-12	31	39.2	37	46.8	1	1.3	7	8.9	3	3.8	**X^2** = 41.164
-12-17	14	10.4	49	36.3	8	5.9	48	35.6	1	11.9	**P**<0.0001*
Level of education											
-Primary	35	43.2	28	34.6	2	2.5	10	12.3	6	7.4	
-Preparatory	5	5.9	39	45.9	3	3.5	27	31.8	11	12.9	^{MC}**P**<0.0001*
-Secondary	5	10.4	19	39.6	4	8.3	18	37.5	2	4.2	
Place of institution residence											
-Urban	18	13.1	64	46.7	8	5.8	36	26.3	11	8.0	**X^2** =18.083
-Rural	27	35.1	22	28.6	1	1.3	19	24.7	8	10.4	**P**=.001*
Reasons of institutionalization											
-Orphanhood	5	13.5	21	56.8	1	2.7	10	27.0	0	0.0	
-Unknown parentage	31	26.5	39	33.3	5	4.3	30	25.6	12	10.3	^{MC}**P**=.141
-Family inability to provide care .	9	15.0	26	43.3	3	5.0	15	25.0	7	11.7	

Age of institutionalization											
- < 6	35	24.8	51	36.2	6	4.3	34	24.1	15	10.6	
- 6-11	8	21.1	13	34.2	2	5.3	13	34.2	2	5.3	^{MC}**P** =.099
- 11 or more	2	5.7	22	62.9	1	2.9	8	22.9	2	5.7	
Duration of institutionalization											
- <1	0	0.0	0	0.0	0	0.0	3	75.0	1	25.0	
- 1<5	14	24.1	33	56.9	1	1.7	8	13.8	2	3.4	^{MC}**P=** 0.0001*
- 5<10	21	41.2	13	25.5	2	3.9	10	19.6	5	9.8	
- ≥ 10	10	9.9	40	39.6	6	5.9	34	33.7	11	10.9	

^{MC}**P**: Monte Carlo p_ value X^2: Chi-Square test * Significant at P ≤ 0.05

IV. Discussion

Residential institutions worldwide are responsible for providing the support and resources for a holistic development in the lives of children who are deprived of family care. Every year, public agencies place a substantial number of children in residential care after child welfare officials have determined that the parents of these children are either unable or unwilling to care for them. Children are placed in residential care facilities when they are not able to enjoy an adequate quality of life at home. Thus, residential institutions must be able to provide them with a decent quality of life in order to promote their physical, cognitive, social, and psychological development [(22)].

Improving the knowledge concerning the institutionalized children and adolescents' quality of life has special relevance in public health because it likely to affect their levels of achievement and considered the foundation for quality of life and health in adulthood [(23)]. So, the current study was conducted to identify the quality of life among children deprived from family care in residential institutions in El-Beheira governorate. The study findings would contribute to a better understanding of perceived health of institutionalized children and can be used in decision making related to health promotion, prevention and follow up for this vulnerable group.

The present study revealed that, more than half of the studied institutionalized children had fair QOL. These findings agreed with Davidson-Arad study(2010) [(24)] which showed that QOL of at risk children in alternative care higher than those who live at their homes. On the other hand, these results contradicted with Carbone et al. (2007) [(25)], Van Damme-Ostapowicz (2007) [(26)] andDamnjanovic, et al. (2012) [(27)] studies which showed that children and adolescents in residential care have significantly poorer QOL compared to children living in normal families.

Quality of life measure is an assessment of a multidimensional construct which involves domains in physical, mental, social, and psychological aspects of well-being and functioning [(28)]. The current study revealed that, about two thirds of the children had good physical wellbeing and less than two thirds of them had good emotional well-being and good relation with their caregivers and friends, which may be attributed to the better ability of residential institutions to meet the children's physical needs compared to their emotional and social needs; the institution can provide shelter, food, and clothes for the children, but unable to create a substitute caring and loving family environment. These results were in line with Abdel Samia study (2014) [(29)] which found that physical QOL was good among nearly three quarters of childrenin orphanages institutions andthe majority of them had good relationship with teachers, workers, and colleagues.

Moreover, the current study revealed that slightly less than one quarterof the children had poor school functioning. This result supported by Berridge (2007) [(30)], Ringle al. (2010) [(31)] studies which found that, children in out-of-home care represent a high-risk group for low educational outcome. Which may be attributed to the difficult circumstances in which the children live prior institutionalization, unavailability of parents encouragement and help in studying, lack of support from institutional care providers, overcrowding in the institution, and repeated absenteeism from school due to stigmatization associated with residential care.

The present study showed that less than one fifth of the institutionalized children had poor self-esteem. These findings disagreed with Mansour study (2010) [(13)]which revealed that more than three quarters of the children had high self esteem and less than quarter of them had moderate self esteem. Which may be attributed to thatmost of the children involved in the current study were adolescents and have better abilities to evaluate their self esteem than school aged children involved in Mansour's study and most of them lived in the institution for long periods of their lives suffering from its stigma.

The results of the study revealed that more than half of the institutionalized children were females and they had lower QOL compared to males, this may be attributed to the higher willingness of females to complain and perceive stress and sense of helplessness than males. This finding also reported by Damnjanovic, et al. (2012) [27] and Berman et al. (2016) [32], and agreed with a study conducted by department of health and children in Ireland (2005) [33] which revealed that females rated their overall HRQOL lower than males.

The studied institutionalized children's age was ranged from six to seventeen years. Age was an important determinant of QOL among the studied children, the study findings showed a highly statistically significant relation between the children's age and their QOL. It was found that,school age children had higher QOL than adolescents, which may be attributed to that, adolescents' worries about the future after deinstitutionalization negatively affected their QOL. These results were agreed with Van Damme- Ostapowicz (2007) [26], and Berman et al. (2016) [32]. In contrast, it disagreed with Kools et al. (2009) [34] study which showed that age had no significant impact on QOL. Also, a contradictory finding reported by Damnjanovic et al. (2012) [27] who showed that children from residential care valued their QOL lower than adolescents, although this difference was not statistically significant.

Children in primary education reported higher quality of life than those in preparatory or secondary education, which may be attributed to the effect of education in improving the knowledge and rising awareness of the children about their rights and unmet needs. Also, a longer contact with their colleagues in school make them perceive differences between living with a foreign people in an institution and living in a home with a family, leading to low rating of QOL. A contradicting result was found by Ravens-Sieberer'sstudy (2013) [35]which showed that low educational status resulted in low QOL.

The study findings showed that, nearly two thirds of the children were institutionalized at age less than 6 years with a mean of 4.96 ± 4.76 years , more than halfof them with unknown parentage and most of them were living a long period of their lives in the institution with a mean of 8.56 ± 4.96 years. Similar results were provided by Abdel Samia study (2014)[29]([)which reported that, the main reason for placement of children in orphanages institutions was foundling and most of children were institutionalized more than five years. In addition, these findings supported by Kools et al. (2009) [34] who found that most of the children were placed in long-term foster care with a mean of 6.46 ± 4.86 years.

Moreover, the study findings pointed out statistical significant relation between the children's age of institutionalization, duration of institutionalization and their QOL. These results agreed with Kools et al. study (2009) [34] which showed that the total years in foster care and age at first placement were correlated with quality of life.

The quality of one's life and life satisfaction can be judged by the nature and quality of lifestyle. Physical activities are beneficial to improve the quality of lifebecause it decrease the risk for different diseases, help to maintain energy balance and desirable body weight, enhance self-esteem, mental activity, learning, memory, and mood. On the other hand, insomnia is known as one of the factors contributing directly to impaired everyday life function, increases the risk of depression and anxiety and subsequently decreases the quality of life and life satisfaction [36]. In accordance, the current study showed a statistically significant relation between studied institutionalized children's sleeping hours during night, practicing sporting activities and their QOL and their life satisfaction.

Life satisfaction is an important aspect of well-being and functioning in children and adolescents and considered a key indicator for positive development and broad enabling factor that promotes and maintains optimal mental health[37]. In this respect the current study revealed that, more than one third of the studied institutionalized children were either dissatisfied or extremely dissatisfied with their life, and children who were satisfied with their life had better QOL. It may be attributed to that, life satisfaction make children feel that they are physically, socially, and emotionally healthy which subsequently affect their QOL. Conversely to the present findings, a study conducted in Illinois (1999)([38]) by Wilson and Conroy to assess satisfaction of 1,100 children in out-of-home care found that, the children's satisfaction with their living arrangements was high, and on average more than three quarters of the children said that they were 'happy' to 'very happy' with their current living situations.

As evident in the present study, male children reported higher satisfaction with their life than females. This finding supported by the results obtained from studies conducted by Savoye et al. (2015) [36], and Eblish (2016) [39]which showed a significant disadvantage for girls compared to boys in life satisfaction. On the other hand, a contradictory findings were reported by a study conducted in Ireland (2005) [33]

The present study portrayed that adolescents (12-17years) were dissatisfied with their life compared to the younger children and there were a statistically significant relation between the studied institutionalized children's age and their life satisfaction. This findings agreed with Qun Zhao et al. (2009) [40] study which revealed that younger children had higher scores of life satisfaction than the older children.

Moreover, the study showed that more than one third of the studied children who were in secondary education were dissatisfied with their life, compared to nearly one eighth of the children who were in primary

education which may be attributed to that, higher educational level help children to realize the negative aspects of their living in the institution. In addition, children in secondary education are adolescents affected by the drastic changes of the puberty. Additionally, nearly half of the studied children who lived in institutions in urban areas were satisfied with their life compared to less than one third of the children who lived in institutions in rural. A statistically significant relation was observed between the place of institution residence and the studied children's life satisfaction. It can be attributed to that, the availability of different services including recreational services in urban communities help children to satisfy their needs and subsequently become more satisfied with their life.

Concerning the relation between the period of institutionalization and life satisfaction, the current study declared that more than half of the children who were institutionalized for a period ranged from1to5 years were satisfied with their life, while three quarters of the children who were institutionalized for less than 1 year were dissatisfied with their life, may be due to that the newly institutionalized children need long period of time in order to cope well with their new life thus they assess their life satisfaction lower than their peers.

To sum up, all efforts must be done by governmental and nongovernmental organizations, community leaders, institutional workers, school teachers and the community at large in order to make the institutionalized children enjoying a higher quality of life and be more satisfied with their life.

V. Conclusion and recommendations

Based upon the findings of the current study, it could be concluded that more than half of the institutionalized children and adolescents in El-Beheira governorate had fair quality of life (QOL) and satisfied with their life, while more than one third of them were dissatisfied with their life. Institutionalized females had lower quality of life and life satisfaction than males.Institutionalized children's and adolescents' quality of life was inversely affected by their age, level of education, age and duration of institutionalization.

Based on the current study findings the following recommendations are suggested:

- Assign trained health care providers to provide continuous care for the institutionalized children and their caregivers and make referral when needed.
- Develop guidelines for nurse role in residential institutions.
- Develop practice guidelines for infection prevention in residential institutions.
- Psychometric instruments must be developed and utilized by health care providers in order to evaluate and enhance the institutionalized children's quality of life and satisfaction with life.
- Conduct health education campaigns about health promotion and healthy life style for children and adolescents and all personnel in residential institutions.
- Collaboration and coordination with Governmental Organization in order to raise the standard of care provided to children in residential institutions..

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