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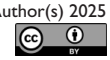
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Hearing the voices of girls in residential care in Pakistan: Exploring perceived influences on mental health and wellbeing

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Abstract

Children across the globe face multiple and intersecting challenges, which impact their mental health and wellbeing. Some groups are more profoundly affected because of marginalization and vulnerability, including those who reside in countries of low resources and who are living in care. This paper focuses on care experienced girls in Pakistan, and their views on structural and systemic factors that shape their mental health and wellbeing. Drawing upon data from three focus groups, we used reflexive thematic analysis to report three core findings of (1) limitations of mental health awareness, (2) gender discrimination and harassment and (3) limited opportunities and hopes for the future. Positioning these findings with a children's and women's rights framework, we make recommendations for supporting the futures of care experienced girls in Pakistan and Majority World countries.

Keywords

care experience, young people, female, mental health, majority world, qualitative

Introduction

Children are growing up in a complex world and are exposed to uncertainty, stressors, adversity and loss that are part of the 'ecosystem of growth' (McGorry et al., 2024). Increasing pressures comparative to previous generations are associated with higher levels of mental health needs, typically underpinned by structural and systemic factors such as socioeconomic disadvantage and inequalities (Collishaw and Sellers, 2020). Children living in resource-constrained settings,

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predominantly in Majority World Countries (MWC), represent 90% of the global child population (United Nations, 2023), and are exposed to multiple risk factors (Erskine et al., 2017). However, they have limited access to appropriate mental health and social care support compared to their better-resourced counterparts (Zhou et al., 2020).

Certain child populations – such as those living in out-of-home care – are exposed to multiple and cumulative risk factors that compound their safety and mental health (Tarren-Sweeney, 2017). These are more pronounced in residential settings, which are variably defined as children's or care homes, orphanages or institutions (depending on reasons for admission to care and available structures and referred to as 'residential care' throughout this paper). This is because of the additional risk of re-traumatization through sexual exploitation, maltreatment, violence and disrupted attachment relationships, especially among girls (Kavemann et al., 2018; Sherr et al., 2017).

Approximately five million children live in residential care globally, with the highest numbers in South Asia (Desmond et al., 2020). In MWC, over-reliance on residential care is due to many factors. This includes gaps in protection legislation and governance, limited evidence-based guidelines, sociocultural contextualization, and alternative family-based placements such as kinship, foster or adoption care (Chege and Ucembe, 2020; Crea et al., 2018). Caregivers often lack professionalization and training, while looking after many vulnerable children (Khalid et al., 2023). The main reasons for admission are maltreatment and loss of parents (Roche, 2019). Roche also noted, however, that unlike high-resource countries, children can be placed in residential care because their families lack financial resources and/or to access education. These risk factors pre- and post-placement have been shown to be associated with high rates of developmental and mental health needs (Ali et al., 2020; Escuetta et al., 2014). Children in residential care particularly struggle in developing and maintaining identity, sense of belonging and agency (Roche, 2019). Residential settings, particularly orphanages, have been perceived as stigmatizing, highly structured and controlling, with children relying on each other for emotional support without contributing to decision-making on their lives (Khoo et al., 2015). Yet, their concerns or disclosures of maltreatment are often not taken seriously (Child et al., 2014).

Increased recognition of the importance of hearing children's voices (Thomas and Winter, 2024) has led to some important child-centred studies. However, their findings are largely not yet implemented in practice. Notably, UNICEF recently proposed that, while children's rights are crucial, a more explicit focus on supporting the voices of girls is necessary. This is because girls are commonly denied opportunities to make informed choices about their lives, or engage in skills training, or access healthcare (Rumble et al., 2024). Rumble et al. reported that girls are more likely than their male peers to experience stigma, retribution and/or violence. Girls, for example, are often dually oppressed and marginalized through socialized norms that compromise agency and opportunities for education or employment (Bunyan, 2021), for example through early marriage (Dutta, 2017). Evidence suggests that this is profound for girls in care, and girls perceive themselves as vulnerable to cruelty from staff and peers, and disempowered because of gender norms (Robertson, 2014; Vicinguerra, 2019). Where positive experiences have been reported, these include peer networks ('sisterhood' for girls), educational opportunities and material advantages (Roche, 2019).

This evidence-base indicates that girls living in MWC residential care face three compounded layers of vulnerability, (i) being care-experienced, (ii) female and (iii) living in a resource-constrained setting. If quality of care and life opportunities are to improve then a gender transformative approach is necessary (UNICEF, 2021). This means that policies, initiatives and programmes need to challenge gender norms and power imbalances that favour men and boys (Rumble et al., 2024). Rumble et al. further argued that it is important to ensure that when designing policies and interventions there should be an active effort to redistribute power to women and girls and to hear

their voices. It is important to understand how girls experience their lives in conjunction with the three layers of vulnerability from their perspective. In this study, we focus on a child female population in Pakistan, because of established macro-factors related to poverty, illiteracy, familial structure, culture and gender norms, and the risk of violence against females from early childhood (Ali et al., 2020; Mahmood et al., 2020). We, therefore, ask the following research questions to explore these intersecting layers from girls' personal perspectives, as follows:

(a) How do girls in residential care in Pakistan experience growing up?

(b) What beliefs do they hold about the factors influencing their mental health and wellbeing?

Method

A qualitative approach was adopted, as this provides a mechanism for listening to populations that do not always have a platform for their voices to be heard and is well suited for exploring child mental health (O'Reilly and Parker, 2014). This approach was underpinned by a macro-social-constructionist epistemology, as this is useful for explicating a deeper insight into human experience and for exploring the perspectives of children (Fraser et al., 2004). This is valuable when examining mental health and social issues where there is a limited evidence-base.

Context, participants and ethics

In Pakistan, 45% of the population are children, of whom 22.7% are adolescents aged 10–19 years (UNICEF, 2020). Within the country, there are a raft of socio-economic and gender inequalities, with children from urban areas faring better in nutrition, education and healthcare access comparative to those in rural areas, who are more likely to experience economic exploitation, early marriage and malnutrition, with limited educational opportunities (UNICEF, 2017). Indeed, UNICEF (2017) reported that approximately 18% of girls in Pakistan are married before the age of 18 years, with 4% married before 15 years. Statutory or non-governmental residential care is a common option for children who have familial difficulties or are orphaned (Mahmood et al., 2020).

Participants for this study were recruited from a large care home with 175 female residents. This was provided by a charitable foundation conducted in the Skardu area of the northern Gilgit-Baltistan region of Pakistan, which has a population of approximately 214,484 (Pakistan Bureau of Statistics, 2024). Staff consisted of one female manager and five caregivers, who were assisted by five 'senior' girls with daily activities, including education. To recruit through the care home, the research team coordinated with a non-governmental organization (NGO) that acted as host and gatekeeper to the study. In total, 30 girls aged 14–18 years consented to participate, following convenience sampling. We refer to them as children by adopting a broad developmental definition.

We had an understanding of and sensitivity to the layers of vulnerability which provided a foundation for ethical practice. Our close working relationships with the host NGO gatekeepers supported the data collection in ethical ways. Governance oversight and approval was provided by the University of Leicester Research Ethics Committee. The local and general cultural knowledge of the lead researcher was facilitative in approaching the domains of the study. Caregivers with statutory responsibility provided informed consent for those younger than 16 years. Participants aged 14–16 years gave additional verbal assent, while those over 16 years provided independent consent in advance. On the day of data collection, all participants accessed a safe space to ask questions about the study and were provided a further opportunity to withdraw should they wish to.

Data collection

Three focus groups were conducted over a period of 2 months, with ten girls participating in each group ($n = 30$). Discussions were conducted in Urdu by an independent researcher, who had previously spent a few weeks to familiarize herself with the local community, education and care system. The focus group recordings were then translated into English by **Hafzah Shah**. The moderator steered open-ended conversations around a flexible and general research agenda, encouraging participant-led topics of discussion. The topic guide explored participants' everyday life in the care home, school and community; interpersonal relationships with peers, teachers and caregiver; experiences of the care environment; and experiences of positive mental health or problems, including associated protective and risk factors. Adopting an open style of questioning promoted an ethos of control and comfort (Adler et al., 2019) for the participants. It was important they experienced a sense of safety and agency in conveying their personal stories and experiences. Focus groups are especially useful for garnering perspectives, as peer group support can facilitate the exploration of culture, self-perception and social identity (Jackson and Sherriff, 2013).

Reflexivity and positionality

Throughout the study the team have reflected on the intersectional nature of our positions and privilege. Those of the team located at least part time in the Minority World recognize our privilege and seek to address these structural inequalities in our work. Four of the five authors are female and thus at the level of gender share insights in relation to the power dynamics and female-specific concerns raised by the participants. The male author (Panos Vostanis), has clinical experience working in relation to gendered dynamics of mental health and in relation to female trauma in groups from diverse backgrounds, including residential care. Two of the authors have Pakistan heritage (Hafzah Shah & Sajida Hassan), with one author being born and living there currently. This author continues to work with in the field with disadvantaged girls in the context of health and wellbeing (Hafzah Shah). This alignment with the cultural heritage of the participants ensured culturally relevant analysis, but also created an emotional investment in the goals to hear seldom-heard voices. Furthermore, these two authors led the focus group discussions, led the development of the questions, and facilitated recruitment and engagement of participants to ensure cultural sensitivity and alignment. The team itself is diverse, with heritage in the UK, Greece, South Africa and Pakistan, and all have worked with children and young people in the context of mental health and disadvantage.

Data analysis

Due to the exploratory nature of the study and the centring of female children's voices, analysis aimed to identify the broad issues at stake for the participants. To achieve this patterning of data, we employed a reflexive thematic analysis approach. This ensures that meaning is grounded in participants' voices and assures an inductive approach to coding data (Braun and Clarke, 2022). Data were coded and analyzed using the traditional thematic process (Braun and Clarke, 2006), and a data-driven and participant-centred coding framework was created to map the central themes. Themes relevant to the research questions are discussed in this paper.

Findings

Central to the research questions, three themes were developed. First, participants recognized how limited mental health awareness and literacy were in the setting, and that mental good/ill health was connected to being care-experienced. Second, participants reported significant concerns about experiencing gender discrimination and harassment, which impacted their sense of wellbeing. Third, participants believed that they had more limited educational opportunities and attainment than their male counterparts, which affected their hopes for the future. The central unifying concept across the three themes was 'disadvantage'; through a sense, either by implication or direct statements, that growing up in care exacerbated gender discrimination, increased adverse mental health impact, and diminished hope.

Theme one: Mental health and the care experience

Participants widely recognized the volume and depth of support they needed to maintain positive mental health amongst their daily life challenges. They argued that a central issue for girls in Pakistan was limited mental health awareness, especially in relation to female experiences. Research suggests that in Pakistan, lack of mental health awareness and literacy is a fundamental contributor to stigmatization (Tareen and Tareen, 2016), which is barrier for help-seeking (Choudhry et al., 2021). For girls in residential care, the triple stigma of being female, care experienced and having mental health needs was seen as a problematic essence of their social and cultural identity. Notably, they believed that their care status was connected to their mental health, and that this was due to the lack of insight or care from society broadly.

> We live here with this reality that we are not wanted. Of course, it is emotionally draining. (Girl 3–FG1)

So, the biggest challenge is that, as a girl, you must manage the care home and the house. It causes mental disturbance. Because girls are more sensitive and emotional in this regard. (Girl 6–FG1)

Girls noted that they felt '*not wanted*' and that this created an adverse emotional response. They believed that the challenges of living within the care home environment and the Pakistan gender norms operating within those institutions caused '*mental disturbance*', in part because '*girls are more sensitive and emotional*'. They considered the influence of residential structures and argued that education should be positioned within a wider psychosocial framework to provide a more nurturing environment. Indeed, the central narrative was that several participants were experiencing a range of emotional challenges, which were not recognized or supported.

> The facilities here are better than the emotional support. The emotional support is not very prominent. That hinders with our mental health a lot. The carers do not even try giving us emotional support, they don't even ask us why we are behaving the way we are. When we are alone, we cry a lot and feel very sad. [participant starts crying] (Girl 5-FG3)

I really want to leave. If we find a more emotionally stimulating environment elsewhere, we would leave but we are only here for the facilities and education. I feel homesick. I want to go home. But I cannot tell anyone that. I cannot talk to anyone, so I go to my room and cry. If we get poor grades, then we are disregarded for the whole year and not given motivation or emotional support. They need to ask us why we performed bad? Maybe we are emotionally vulnerable, they need to ask us. (Girl 7–FG2)

Evidence indicates that well-adjusted children with emotional support perform better in school than those with mental health needs (Agnafors et al., 2021). Interestingly, this relationship was acknowledged by the participants. They experienced emotional problems anchored to their care status and wanting to '*go home*', which frequently resulted in isolation, low mood and the need to '*cry*'. However, they believed that despite this emotional turmoil, caregivers only focused on the behavioural manifestation of emotions and '*poor grades*' rather than underpinning factors. They argued that the lack of '*emotional support*' was itself a hindrance to their '*mental health*'. Notably, they constructed their social identity as '*emotionally vulnerable*' and wished their voices to be heard. Indeed, such failure to support left children feeling '*disregarded*'.

Theme two: Gender discrimination and harassment

As vulnerable girls in Pakistan, participants were often subject to harassment and discrimination. Harassment is broadly defined as verbal comments and sexual gestures which lead to discomfort and unease in the victim (Fernandez, 2016) and is closely linked to gender-based violence (Ahmad et al., 2024). In Pakistan, women and girls who raise concerns regarding harassment, also have fears of being blamed and bringing shame to their culture and family (Ahmed et al., 2021). Such cultural norms can, therefore, encourage a blanket of silence and inaction (Muazzam et al., 2016). Participants grappled with challenges associated with experiencing harassment and limited channels to communicate their discomfort. Notably, harassment was recognized as pervasive and serious.

> Blackmail and harassment are very common. People do not understand how serious it is. We are at risk of it, but nobody does anything. (Girl 2–FG2)

> People think harassment is a joke. We cannot even step outside because of it. (Girl 6–FG2)

Participants believed that, despite the frequency of harassment, it was not taken seriously within society. They argued that, despite the '*risk*' brought to their lives, '*nobody does anything*', which means they spend their days trapped and unable to '*step outside*' of the care home. Indeed, constant harassment was perceived as adversely impacting their mental health and educational outcomes.

> Whether you live at home or care home or live in hostel if you are a girl, you will be harassed. It does not matter. We leave the care home for school, we are harassed. We leave school to get to our care home, we are harassed. It is frequent. Our lives are stressful because of this. Our education suffers because of this. (Girl 5-FG1)

> Harassment effects every girl here. I mean no girl is safe from it. Men here do not care if you are young or old. We are harassed on our way to school. Men just look for excuses to make us uncomfortable. This not only affects our mental state but also our educational life. With experiencing these things on a daily, of course it will affect our education, and we will perform bad, because we keep thinking about this. (Girl 4–FG3)

The severity of harassment was emphasized by some participants, who noted that all girls within the care home were affected ('*every girl here*') and they constructed this experience as being unsafe. They also noted the gender discriminatory aspect of this behaviour by '*men*'. Problematically, male harassment was often normalized and accepted by society when girls spoke out.

> I discussed my trouble with the carer here. She told me it was normal, and it had happened to her too. She advised me to ignore it. I went to her again and she ignored me and did not listen to me, because she wanted me to ignore the issue, and I couldn't. (Girl 7-FG3)

Principally, being care experienced presents additional layers of vulnerability and yet, the general narrative was that it was simply being female that resulted in harassment. Dismissive responses from caregivers led to girls feeling '*ignored*' and not listened to. Consequently, the gender divide was emphasized as part of society.

> Boys do what they want. Girls are forced to do things, but boys are not. So, girls should have freedom to do what they want to do as well. Girls are forced to do house chores and are restricted. (Girl 6-FG2)

Gender equality was, therefore, positioned as an aspirational goal in Pakistan, as participants believed that '*girls should have freedom to do what they want to do as well*'. Yet, discrimination was juxtaposed against traditional gender roles of doing '*household chores*' and having their freedom '*restricted*'. The challenge of gender inequality in society was directly anchored to mental health by some.

> Girls get disgraced more quickly and their image gets bad in the society. This ruins our life and how we think. No wonder girls face depression and stress and get scared easily because of all of burden they have to carry. However, with boys their image is not affected at all. (Girl 10–FG1)

Girls are given a lot less importance in comparison to boys. Wherever we go, we face troubles and being unwanted. I sometimes feel I do not do well in school because of all this stress and worry I carry. (Girl 2–FG2)

Participants believed that the impact of gender and care status on mental health was inevitable, due to the 'burden' they must carry. Juxtaposed with '*being unwanted*', they acutely felt societal marginalization, which affected their wellbeing and learning. Indeed, this consideration of the value of education being intrinsically tied to hope for the future was a central theme and is discussed next.

Theme three: Educational opportunity and hope

Although education can provide disadvantaged children with life opportunities, children experiencing disadvantage and adversity tend to face many educational barriers that reflect wider societal inequalities (Rind and Malik, 2024). From the experiential perspective of our participants, it was through educational systems that discrimination against their care status identity was most profound. They thus reported a two-tier system of teaching, whereby children residing in the community were favoured over those who lived in care.

> Girls who come from community are treated better than us. Teachers care for them and their education. We are not special. The classroom environment is discouraging and makes us very unhappy, because we are treated unfairly at the care home and then at the school, too. (Girl 7-FG1)

We are not valued as much as those girls from the community. I don't know the reason, may be the teachers know we do not have parents to ask about our results, they do not care. Girls from community are given more attention and they are encouraged, yet we are not pushed like them. So, if you ask them, the environment of the school is not supporting. Teachers are biased, which makes being at school sad and stressful. (Girl 1-FG3)

The interconnections between education and mental health were made explicit throughout the discussions. Participants attributed their care status identity to not being '*valued*' by teachers, and not

being '*special*' or '*cared*' for. They communicated a negative social comparison with girls in the community in terms of educational focus, values and consequences. They argued that the lack of '*parents to ask*' about progress and attainment, meant that teachers did not feel accountable or pressured to '*care*' about their results or about their future. This meant that teachers did not encourage them to achieve, and this had consequences for both their mental state and educational future. Participants also reported on favouritism by ranking schools in terms of academic results and support systems. They noted that some schools had a foundation upon which children achieved strong educational outcomes and success and others less so. They argued that children who were favoured went to those '*better schools*', while care experienced girls went to schools with a lower resource envelope.

> You will be surprised that favourite girls are sent to better schools with good environment and good support, whilst we are asked to attend schools with limited resources. You can imagine then the environment in such schools. The teachers are not trained enough, the environment is all about grades, with no extra-curricular activities and no attention paid to children. How can we succeed there? (Girl 5–FG3)

We cannot perform well in such schools. When you are not in a supportive environment, you tend to fail and not succeed. I mean, the teachers do not care if we fail, they just care about their favourites. Even if we mention our needs and we tell them we need help, they shrug it off, are we not deserving of fair treatment and attention? They just give orders and demand results. (Girl 9–FG3)

The construction of some schools as '*better*' than others illustrates the perception of girls in residential care that they were being treated differently from those in the community. They argued that schools with higher levels of resources offered a stronger package of education, emotional support and extracurricular activities than the type of schools they found themselves educated through. Specifically, they argued that teachers were partially responsible for contributing to inequalities, which should be addressed by those holding such an important role in society.

> We need teachers and carers who do not discriminate between girls and boys, between all students. Carers and teachers should work on equality amongst the genders. (Girl 6–FG2)

Participants stated that teachers should have a commitment to tackle both gender- and care-related inequalities, jointly with caregivers. Girls thus reported that important adults should take steps to '*work on equality amongst the genders*'. Ultimately, they argued that they wanted a holistic education as foundation for their future wellbeing.

> I just want to study and receive good education. We are not given this opportunity when we are at home. I want to perform well. I do not care if I become a doctor or an engineer. Other professions are also as valuable. I am just going to focus on my school and become a good human. (Girl 10-FG3)

Despite the multiple layers of vulnerability and disadvantage, notwithstanding the myriad ways in which these participants reported inequality, discrimination and stigma, they continued to hold hope and aspirations for their future. They reported that they wanted to achieve in education and had goals for a career and a profession that is '*valuable*' to society, as they were motivated to '*perform well*' in school.

Discussion

Globally, addressing children's mental health needs is complicated by multiple societal and service challenges (McGorry et al., 2024). The extent of these challenges in Pakistan and other MWC

resource-constrained settings remains not well-understood, because of limited contextual evidence, despite findings that child mental health rates are increasing (Hamdani et al., 2021). Furthermore, our understanding of the mental health of children in residential care homes in is even less-well-researched in MWC. The limited research in this area does show that that these children have multiple adverse experiences which predict high rates of anxiety, depression, post-traumatic stress and behavioural problems, as well as negative social and educational outcomes (Aleem and Naz, 2025; Taelah et al., 2025). Our research offers care-experienced child-led insights that are important in developing recommendations in this area.

While we recognize that our study is somewhat constrained by the children representing only one residential care home in Pakistan, this was nonetheless a large home with 175 residents, and we assert that the voices of these children should be heard. Residential settings vary widely, and their profiles may reflect reasons for admission, quality of care, and staff approaches and training. Participants may have known each other prior to focus group participation and these relationships may have influenced their interactions and responses. It would have been valuable to complement qualitative accounts with quantitative measures of attachment relationships, mental health, social support and academic attainment. Notwithstanding the limitations, the sample size for a small-scale qualitative study was adequate, and the findings are important for later synthesis of knowledge and further replication.

When exploring child mental health in Pakistan from an experiential point of view, it is necessary to be mindful of the complexity of multiple layers of vulnerability. Girls in Pakistan, particularly those in residential care, are living in a society influenced by broader global influence and ideology, as well as by local norms and culture. Global concerns around addressing child poverty are nuanced and specific within any country, and poverty intersects with other risk factors that influence a child's development and longer-term psychosocial outcomes. For example, in Pakistan, a girl living in poverty in a rural setting is likely to only receive an average of 0.75 years of schooling, comparative to a wealthy urban boy who receives an average of 10.76 years of education (UNICEF, 2017). This is despite consensus that education is a strong predictor of wellbeing and employment trajectories.

Intrinsically connected to such inequalities is how childhood and children's rights are conceptualized in Pakistan and other MWC resource-constrained settings (Liebel, 2023). The rights framework in such contexts can in some ways be contradictory, as hierarchical structures can create an imbalance of power (Talha et al., 2024). Talha argued that children are frequently constructed as passive recipients of adult influence, especially in large institutions. In Pakistan, children are faced with increased risk of community violence, physical punishment, child labour, sexual abuse and trafficking, which are particularly pronounced for females in care (UNICEF, 2019). Societal hierarchical structures are pronounced in care settings in ways that limit children's rights such as low educational input, lack of autonomy, limited knowledge regarding their rights, and a dearth of social support (Human Rights Watch, 2018). To advance gender transformative programmes in the community and residential settings, there needs to be greater focus on sexism, misogyny, and patriarchy (Rumble et al., 2024). Rumble et al further argued there needs to be some focus on adultism, recognizing that young girls do have capacity to bring meaningful contributions, and their voices should be heard.

It is the intersecting vulnerabilities of being female during childhood and adolescence and being care-experienced in which our contribution lies; these social positions do not operate in isolation, but combine to create compounded forms of disadvantage (in a culturally-diverse and arguably culturally-rich context). Figure 1 illustrates the compound risks contributing to adverse experiences for care-experienced girls in Pakistan, highlighting the interconnected nature of the challenges across the three themes presented above.

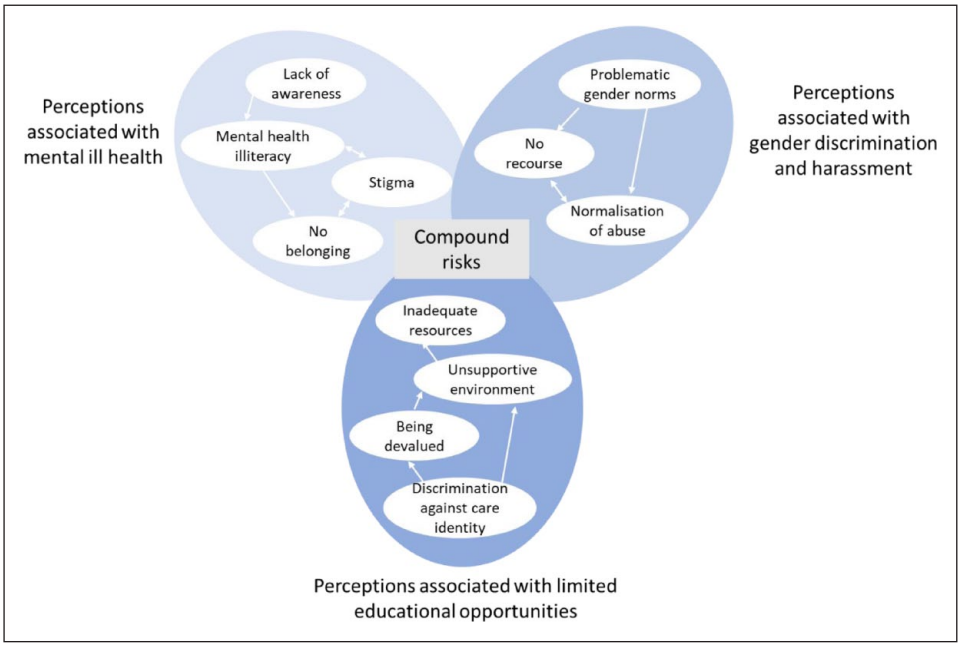

Figure 1. The compound nature of the perceived risks shared by participants.

The first theme (mental health), is shaped not only by a lack of awareness, stigma, unbelonging, but how these are compounded in an intersectional sense through the interaction of gender and care-related marginalization. The second theme addresses gender discrimination and harassment, which perpetuate the normalization of abuse and leave individuals with no recourse to address their experiences of violence or inequity. In effect leaving these young people doubly silenced. The third theme, structural and environmental factors, examines how inadequate resources, unsupportive environments and devaluation of individuals are compounded by discrimination that is *both* gendered *and* care identity-specific. At the intersection of these three themes lies the zone of *compounded risks and multiple marginalizations*. This is where the overlapping challenges mutually reinforce one another, intensifying vulnerability and limiting pathways to better-than-expected outcomes.

When these findings are contrasted with the international residential care literature, which is largely based on evidence from the Global Minority, there are similarities in pre-care traumatic experiences, which are accentuated by care-related vulnerabilities and impact of mental health (Butterworth et al., 2017). However, females in residential care settings in Pakistan are further disadvantaged by some cultural gender norms and expectations, and by the absence of structural supports, especially in safeguarding and mental health. Compared to girls living in stable family environments, care-experienced girls face layered exclusions: greater ostracization, restricted educational and social opportunities, and harsher caregiving practices (Ali et al., 2020).

This holistic view underscores the importance of addressing systemic, cultural and interpersonal factors simultaneously to mitigate these risks pre-, during and post-care. For example, solely focusing on increasing resources will not address inequitable educational opportunity if girls are stigmatized or experience discrimination against their care identity. Similarly, intervening for abuse without simultaneously addressing stigma will not lead to sustained recovery. For this

reason, it is important that policy, welfare and health services, and interventions are informed by multi-modal strategies, which also tap into informal support systems such as communities and religion (Kohrt et al., 2018). What our participants have taught us, therefore, is that to address these interconnected risks meaningfully, organizations and stakeholders/rightsholders must implement targeted, context-specific interventions informed by local realities. We make five suggestions here.

First, integrate residential settings with community-led programs that engage religious, educational and cultural leaders to challenge harmful norms such as stigmatization of mental health and normalization of gender-based violence. These leaders often hold significant sway in shaping beliefs and behaviours and can act as allies in driving change (Howard et al., 2023). Second, establish peer-led mental health initiatives within care-dominant communities, where young females – such as care leavers or girls living in the community or attending the same school – are trained as peer educators, mentors or support workers, who hold unique lived experience, to engage, support and advocate for other vulnerable young females (Ajayi et al., 2023). Third, integrate vocational training programmes with trauma-informed care that explicitly consider the unique barriers faced by care-experienced women such as caregiving responsibilities or discrimination (Dutta, 2017). Fourth, adopt cross-sector partnerships to design intersectional policies for all residential care settings that embed safeguarding, gender equity, mental health access and anti-violence strategies into existing education, health and employment systems (Ministry of Planning, Development and Special Initiatives, 2022). For example, local schools or community centres could serve as hubs for simultaneous skills training, psychological counselling, and awareness campaigns, and these should be accessible to girls in care. Finally, support all initiatives with interprofessional training such as for residential caregivers and other professionals or community volunteers supporting children in residential care on enhancing their nurturing and mental health skills (Chaudhry, 2015).

In conclusion, our research findings and recommendations show that child mental health need is a growing challenge for Pakistan, and that vulnerable and disadvantaged groups like those in care require more tailored and specific attention. Given the gender dynamics that operate, focusing on girls is especially important. Our work has shown that research in this area and hearing the voices of girls in care is critical for the improvement of interventions, services and care facilities and that researchers must engage and involve care-experienced children to better understand the issues at stake. Any developed interventions should be multi-modal and intersectoral and underpinned by robust evaluation frameworks that monitor long-term outcomes and identify replicable strategies for scale-up, fostering sustainable change in deeply entrenched systems of inequality.

Author note

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