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A STUDY ON CHILD CARE SERVICES THROUGH CHILD CARE HOMES IN EAST KHASI HILLS DISTRICT, MEGHALAYA

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ABSTRACT

Child Care Homes (CCHs) provide residential care and support to children who, for different reasons, cannot remain safely within their families. This qualitative study looks at the services available in five registered Child Care Homes in East Khasi Hills District, Meghalaya, the difficulties faced in maintaining those services, and the changes that participants felt were needed. Data were collected through Key Informant Interviews with five persons in charge and three Focus Group Discussions involving 15 staff members (five from each of three Child Care Homes). The material was analysed thematically following Braun and Clarke (2006).

Participants described support in several areas, including routine and emergency health care, nutrition, schooling, counselling, recreation, vocational exposure and children's participation in activities and committees. The homes also relied on hospitals, health facilities, educational institutions, churches, community organisations and other agencies. These services, however, were not free from practical constraints. Financial limitations affected education, health emergencies, infrastructure and activities, while staff shortages, workload, inadequate remuneration and limited role-specific training created additional pressure. Participants were particularly concerned about what happens when young people leave residential care, especially when further education, family reintegration or independent living requires continued support.

The study points to the need for more predictable financial support, stronger staff development, better access to health services and a more organised approach to transition and aftercare. It also highlights the value of working relationships between CCHs, government agencies, families, communities and other service providers. The findings suggest that the quality of care experienced inside a home is closely connected to the support available around it.

KEYWORDS: *Child Care Homes; children in institutional care; child protection; childcare services; aftercare; qualitative research; Meghalaya*

INTRODUCTION

Child Care Homes occupy an important but complex position within the child-protection system. A residential home is expected to do more than provide food and shelter. Children living away from their families may need stable relationships with caregivers, health services, education, emotional support, opportunities for recreation and preparation for adult life. The quality of care therefore depends not only on what happens inside the home but also on how the home connects children with families, schools, health services and the wider community.

The language used to describe children living in residential settings also matters. The term “orphan” is often used in everyday discussion, but not every child living in a Child Care Institution has lost both parents. Children may enter institutional care because of abandonment, family difficulties, neglect, abuse, unsafe circumstances or other situations in which parental care is unavailable or cannot safely be provided. Indian child-protection policy consequently uses the broader framework of children in need of care and protection. The Juvenile Justice (Care and Protection of Children) Act, 2015 places care, protection, development, treatment, rehabilitation and social reintegration at the centre of the statutory system. The Ministry of Women and Child Development similarly describes Mission Vatsalya as a framework for preventive, statutory care and rehabilitation services for children in need of care and protection. (Government of India, 2015; Ministry of Women and Child Development, 2022)

International child-protection literature has also increasingly questioned unnecessary or prolonged institutionalisation. Family and community-based care is generally preferred where it can be provided safely and in the child’s best interests. At the same time, residential care may remain necessary for some children, particularly where family care is temporarily unavailable or unsafe, or where specialised support is required. The relevant question is therefore not simply whether residential care exists, but whether the care provided is safe, child-centred, developmentally appropriate and connected to longer-term rehabilitation and reintegration. (UNICEF India, n.d.; United Nations, 2009)

Research on children living in institutional settings has identified concerns relating to health, emotional wellbeing, social relationships, educational opportunities, safeguarding and transition to adulthood. Systematic evidence has documented risks of violence and abuse in institutional settings, while Indian studies have examined health, hygiene and access to healthcare among children in residential care (Aladegboye & Olowokere, 2024; Mahanta et al., 2022; Moffa et al., 2019; Sherr et al., 2017). Research has also considered recreation and vocational preparation as components of developmental care (Meli, 2015; Taneja et al., 2002). These strands of literature provide a basis for examining both the services offered by CCHs and the conditions under which those services are delivered.

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In India, the legal and policy framework recognises a range of rehabilitation and social-reintegration services, including education, health, nutrition, vocational training, life skills, mental-health interventions, counselling and recreational activities. Mission Vatsalya also places greater emphasis on strengthening the child-protection system and supporting children as they move through different stages of care. (Government of India, 2015; Ministry of Women and Child Development, 2022) UNICEF India has similarly highlighted the importance of preventing unnecessary family separation, strengthening family-based alternative care and improving aftercare for young people leaving care.

This makes it useful to look more closely at how these expectations are experienced in individual Child Care Homes. Local studies can show how policy is translated into everyday practice, what kinds of external support are actually available and where institutional constraints affect service delivery. The present study focuses on five registered Child Care Homes in East Khasi Hills District, Meghalaya. Rather than treating institutional care as a single service, it examines the range of care provided, the barriers reported by those delivering it and the improvements they consider necessary.

OBJECTIVES OF THE STUDY

The study was guided by three objectives:

1. To examine the childcare services and programmes provided in selected Child Care Homes.
2. To identify the barriers faced by Child Care Homes in providing quality care.
3. To examine suggestions for improving the effectiveness and quality of care.

REVIEW OF LITERATURE AND CONTEXT

Child development is closely connected to stable caregiving relationships. Bowlby's early work on attachment drew attention to the importance of continuity of care and emotional bonds in childhood. Later research has examined the consequences of institutional environments, including the risks associated with inadequate individual attention, unstable caregiving and limited opportunities for normal social development (Bowlby, 1951). The literature does not suggest that every residential setting produces the same outcomes; rather, quality, duration, relationships, stimulation, protection and the circumstances that brought a child into care all matter.

Research from different settings has documented a range of health and developmental concerns among children living in institutional care. Mahanta et al. (2022), for example, examined physical and mental health among children living in orphanages in Assam, while Moffa et al. (2019) reviewed hygiene behaviours and environmental health conditions in institutional settings. Aladegboye and Olowokere (2023) further drew attention to the health service needs of children in orphanages and the practical barriers caregivers may face in responding to those needs. More recent qualitative work in Kerala has also shown that children in residential care may experience emotional, behavioural and social difficulties alongside educational and career concerns, while also developing their own coping strategies (Yohannan & Pa, 2025). Taken together, this literature supports attention to routine health monitoring, nutrition, hygiene, psychosocial support and access to specialised services, while also indicating that children's own experiences should not be reduced to the services adults provide.

Education and skills development are equally important. Residential care can provide children with access to schooling that may otherwise be interrupted, but education also involves tutoring, educational materials, career guidance and pathways beyond secondary school. Vocational education can be particularly relevant for children who need practical pathways towards employment and independent living. Research on vocational skills among children in institutional settings has highlighted the potential role of such programmes in preparing young people for adult life (Meli, 2015). Recent Indian research also suggests that adolescents in institutional care may value existing educational support while identifying gaps in practical preparation for life after care, including life skills, employability and future planning (Mishra & Dutta, 2024).

The transition out of care presents a different set of challenges. A qualitative systematic review by Häggman-Laitila et al. (2018) examined young people leaving foster care and identified difficulties related to education, employment, housing, relationships and independent living. Because that review concerns foster care rather than Indian Child Care Institutions, it is used here only as broader care-leaving evidence. More directly, Indian research on institutional care identifies weaknesses in transition planning, aftercare infrastructure, practical life preparation and employability support (Mishra & Dutta, 2024; Wanglar, 2021). Recent Indian work has also emphasised preparation before leaving care and continuing relational and practical support afterwards (Tyagi & Sawhney, 2026).

The Indian policy context reinforces this continuum. The Juvenile Justice Act, 2015 provides for rehabilitation and social reintegration, while Mission Vatsalya brings together institutional and non-institutional child-protection services. (Government of India, 2015; Ministry of Women and Child Development, 2022) The emphasis on family-based care and prevention of unnecessary institutionalisation does not eliminate the need for residential services; rather, it requires residential homes to function as part of a wider care system that includes family strengthening, restoration, education, health, counselling and aftercare. (Government of India, 2015; Ministry of Women and Child Development, 2022; UNICEF India, n.d.)

Research from institutional and residential care settings also indicates that the quality of care depends on more than the provision of basic necessities. Taneja et al. (2002), for example, demonstrated the developmental value of structured play in an Indian institutional setting. Studies of Indian CCIs have also identified shortages of trained staff, infrastructure constraints, weaknesses in rehabilitation planning and gaps in children's opportunities to express their views (Wanglar, 2021). These findings

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reinforce the importance of examining education, recreation, skills, participation and the wider organisational environment in which residential care is provided.

METHODOLOGY

The study covers five registered CCHs in one district, selected on the basis of availability and accessibility. The staff component covered three homes through three FGDs of five participants each. The study does not include direct accounts from children or care leavers and is not statistically representative of CCHs across Meghalaya. It provides a qualitative account of service provision and institutional challenges rather than a formal quality assessment.

Analytical Limitations

The study involved adult participants only and did not require formal ethics committee approval. Participation was voluntary and based on informed consent. Participants were informed about the purpose of the study and consented to take part. Participant identities and identifying information were protected. Because the original research record does not preserve the individual speaker for every quotation, quotations are identified by source type (KII or FGD) rather than invented participant numbers.

Ethical Considerations

The material was analysed thematically following Braun and Clarke (2006). All three researchers participated in coding and interpretation through familiarisation with transcripts, identification and review of recurring patterns, and development of themes in relation to the study objectives. KIIs and FGDs were considered together to identify issues across participant groups and perspectives specific to management or staff. The principal themes were health, nutrition and psychosocial care; education, skills and developmental support; institutional constraints; and transition, reintegration and aftercare. Participants were given access to the findings/material for confirmation. The researchers had no prior personal or professional relationship with the participating CCHs or participants. Reporting was also informed by COREQ (Tong et al., 2007).

Data Analysis

Two qualitative data-collection methods were used. KIIs were conducted with the five persons in charge, covering health care, nutrition, education, psychosocial support, children's participation, vocational preparation, institutional challenges and suggestions. Three FGDs were conducted with staff, with five participants in each group and each group drawn from one participating CCH. Discussions explored day-to-day care, workload, remuneration, training, health monitoring, communication and language-related difficulties, and support during and after institutional care. KIIs and FGDs were audio-recorded with participants' consent and transcribed by the authors.

Data Collection

The study was conducted in East Khasi Hills District, Meghalaya, and covered five registered Child Care Homes. The five homes were selected on the basis of their availability and accessibility to the study team. One person in charge from each selected CCH participated in a Key Informant Interview (KII), giving five key informants. Staff members from three of the five CCHs participated in Focus Group Discussions because these were the homes whose staff consented to participate. Five staff members from each participating CCH took part, giving 15 staff participants across three separate FGDs. Participants were adults involved in the management or day-to-day care of children; children and care leavers were not direct participants.

Study Setting, Sampling and Participants

The study adopted a qualitative approach with a descriptive research design. The design was appropriate because the study sought to understand, through participants' accounts, the services provided by Child Care Homes (CCHs), the difficulties encountered in maintaining quality care, and suggestions for improvement. The study was not intended to produce statistical estimates; instead, it focused on the experiences of adults involved in the management and day-to-day care of the selected homes.

FINDINGS

Health, Nutrition and Psychosocial Care

Access to Routine and Emergency Health Care

Participants described regular health checks as part of the care provided in the homes. Health camps, eye examinations and dental check-ups were reported at intervals ranging from monthly to once every three months, depending on the home and available support. The homes reported working with government health facilities, private hospitals and other health-service providers.

[KII] "Regarding health children are taken to a private hospital in Shillong whenever needed for healthcare services."

The accounts also showed that the homes did not depend entirely on services located inside the institutions. Hospitals and health facilities were used when children required specialised assessment or treatment. One participant described collaboration with the TB Hospital at Mawprem, a tertiary referral hospital and mental-health assessment through a government hospital or a mental-health facility when necessary.

[KII] "Yes, collaborations with hospitals such as a government specialist hospital in Shillong, collaboration with a tertiary referral hospital and we take for mental assessment to a government hospital or a mental-health facility if children are not well."

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Health Education and Psychosocial Support

Health education included hygiene, cleanliness and menstrual hygiene. These activities were reportedly supported by health departments, staff and internship volunteers. Mental and emotional concerns were addressed through counselling and other forms of guidance available within the homes. Participants described cases involving trauma, attachment and behavioural or emotional difficulties as requiring sustained attention rather than one-time intervention.

The findings also indicate that some homes use spiritual practices, prayer and motivational guidance as part of everyday support. These practices should be understood as part of the local care environment reported by participants rather than treated as substitutes for professional mental-health services. When staff considered a case difficult to manage within the home, referral to the Child Welfare Committee or other services was reported.

Children's Participation

An important feature reported by participants was children's involvement in committees and meetings within the homes. These committees provide opportunities for children to raise concerns, contribute suggestions and participate in planning activities. One participant explained that children use home-management meetings to express their views and make suggestions.

[KII] "Yes, in home management they have different committee, and they have meetings so in those meetings they give suggestions and their point of views."

This practice is relevant to child-centred care because participation allows children to have a voice in matters affecting their daily lives. However, the present study captures the existence of these mechanisms through staff accounts and does not independently assess how much influence children have over decisions.

Nutrition and Dietary Management

Participants reported that children generally receive four meals a day: breakfast, lunch, evening tea or snacks and dinner. The foods described included cereals, vegetables, seasonal fruits, milk, eggs, fish and meat. Some homes also reported using produce from kitchen gardens. Diet planning involved the in-charge, nursing staff, food committees and, where available, dietetic advice.

[KII] "Proteins, cereals, carbohydrates, vegetables grown by ourselves, seasonal fruits and milk."

Dietary needs could become more complicated when children were ill or required a modified diet. One example concerned children receiving treatment for tuberculosis, where staff described the need to arrange additional or different food while also managing comparisons between children receiving different diets. Participants also reported that some newly admitted children arrived in poor nutritional condition and received medical assessment and dietary support after admission.

[KII] "Yes, at first new children are malnourished but after taken to doctor and doctor's guidelines they provide food and medicine and hence children get better."

External support also contributed to food provision. Participants referred to support through ICDS services on some days and assistance from organisations and churches. These linkages appear to supplement, rather than replace, the food systems maintained by the homes.

Education, Skills and Development

School Education and Academic Support

Education was identified as a central component of care. The homes reported enrolling children in schools, including nearby and private schools. Academic progress was followed through report cards, examination results, attendance and tuition. Staff also described providing additional study support when children experienced difficulty with particular subjects.

[KII] "Performance report card at the end of the result also monitor through attendance."

Participants also described efforts to encourage higher education for children who wished to continue studying. Examples included children preparing for university entrance and receiving career guidance. One home described supporting a young person studying in Allahabad and another preparing for CUET.

Educational Funding Constraints

Although education was prioritised, the cost of schooling was repeatedly identified as a constraint. Participants referred to school fees, tutoring and the need for additional academic support in subjects such as mathematics and science, particularly at Classes 10 and 12. Some homes reported raising funds or seeking concessions when institutional resources were insufficient.

[KII] "Funding for providing education because the regular tutor look up to for the small kids and we need funding like for tutors for class 10 & 12 for maths and science."

The problem was therefore not simply school enrolment. The wider educational package—tuition, fees, materials and preparation for higher education—required resources that participants felt were not consistently available.

Career Counselling and Vocational Training

Career preparation included counselling, short courses and vocational training. Participants described identifying children's interests and abilities and then connecting them with opportunities such as bakery, beauty care, sewing, tailoring and music. In some cases, homes searched for sponsorship or external networks to support children in areas that matched their interests.

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[KII] "Identify children before where they are good at and not good in studies. So they have vocational training on skills like bakery, beautician, sewing, tailoring music, once a week they have classes for those interested."

The findings suggest that vocational education was not viewed only as an alternative to academic education. It was also used to broaden children's options and develop practical skills that could be useful later in life.

Recreation, Skills and Confidence

Recreation formed another part of the daily environment. Participants mentioned football, basketball, indoor games, television, picnics, drawing, quizzes, fancy dress, gardening, arts and crafts, music and cultural programmes. Vocational and creative activities included tailoring, embroidery, crocheting, cooking, gardening, carpentry and computer lessons.

Participants linked these activities with confidence, leadership and social development. They described children organising programmes and taking responsibility for activities. Such observations are consistent with the wider literature that treats recreation, participation and structured activities as relevant dimensions of child development rather than as optional extras.

[KII] "Build confidence, they organize program by themselves, build leadership and organizing skills."

Challenges Affecting Quality of Care

Financial Constraints

Financial limitations emerged as the most consistently reported challenge. Participants referred to school fees, medical emergencies, hospitalisation, infrastructure maintenance, educational materials and staff salaries. Homes reported that available support was insufficient to cover all of these needs consistently.

[KII] "Funding is one of them and cannot plan for any major activity or renovation, no support for education there is no consistent flow of fund so has to mobilize from private institution that provide skill education or like ask concessions from school."

Financial insecurity also affected planning. When funds were uncertain, larger activities or repairs were difficult to undertake, and homes had to approach private institutions, donors or other organisations. This indicates that the quality of residential care is partly dependent on the ability of institutions to mobilise resources beyond routine government support.

Staffing and Workload

Staff shortage was identified by two Child Care Homes as a direct challenge. Participants also described situations in which staff had to undertake several responsibilities at the same time. The FGD indicated that workload could exceed what participants considered reasonable in relation to their remuneration.

[FGD] "Overload of work but the salary does not match."

Staffing is important in residential care because children require continuous supervision and individual attention. When staffing levels are low, the capacity to respond to health needs, provide activities, maintain records and establish individual relationships can be affected. The present study does not quantify staffing ratios, so it cannot determine the extent of the staffing gap against a formal standard.

Health Emergencies and Complex Needs

Participants reported that chronic illness and health emergencies could place considerable pressure on staff and available resources. Such situations required additional attention from caregivers and nurses and could generate unexpected expenses. The findings point to the need for reliable referral pathways and financial arrangements for specialised health care.

Training and Capacity Gaps

The FGD highlighted a lack of regular training for some staff, including house mothers and other caregivers. Participants wanted training to be linked to designation and responsibility rather than delivered as a generic programme. They also requested updates on child-protection laws, policies and amendments, including POCSO and related guidance.

[FGD] "Specific training for the home staff according to their designation."

Participants also noted that training programmes can be difficult to understand when language becomes a barrier. They suggested simpler explanations and locally accessible modes of communication. This is a practical issue for capacity building because knowledge of a law or guideline is only useful when staff can understand and apply it in their work.

Transition, Reintegration and Aftercare

Transition out of residential care emerged as a significant concern. Participants described attempts to assess whether children could return to relatives or families after reaching adulthood. In some cases, homes maintained educational support when family reintegration was not feasible. One participant described periodic visits to relatives as a way of maintaining family relationships.

[KII] "Yes, after 18, we see if we can transfer or not through home visit etc. We restore again to those families if they are ready to accept. But in some cases if they don't accept they go for further education."

The accounts suggest that family relationships and aftercare cannot be treated as separate from the period of residential care. Maintaining safe relationships, assessing family circumstances and preparing children for education or employment all have implications for what happens after exit. Participants nevertheless identified the lack of consistent post-exit support as a major gap.

[KII] "If Government can still do follow up."

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Staff suggested scholarships, skills training, employment-related support and continued follow-up for young people leaving care. These concerns are consistent with the broader Indian policy emphasis on rehabilitation and social reintegration and with international research on the difficulties faced by care leavers. (Government of India, 2015; UNICEF India, n.d.; Häggman-Laitila et al., 2018)

Suggestions for Improvement

The suggestions offered by participants were closely connected to the problems described above. The first priority was stronger and more predictable financial support. Participants linked funding with education, health emergencies, staffing, training, infrastructure and aftercare.

[KII] "Educational aid or scholarship for the education of children and financial aid in times of emergency, such as illness and hospitalization."

A second priority was regular, role-specific capacity building. Participants wanted separate training for different categories of staff and periodic orientation whenever laws, policies or procedures changed. They identified child-protection legislation, POCSO, child rights and practical childcare as areas requiring continuing learning.

[KII] "Training for housefathers and staff separately according to their roles and responsibilities. Trainings regarding acts, guidelines to be well equipped with new amendments."

A third priority was health staffing. The FGD suggested residential arrangements for a paramedical nurse where feasible so that health and hygiene could be monitored more consistently and medication schedules could be followed safely.

[FGD] "According to my personal experience in the home I feel that residential for nurses should be given because we need continuous follow up."

A fourth priority was aftercare. Participants recommended educational scholarships, vocational training, employment-related support and follow-up after children leave the home. They also emphasised community participation, volunteering, awareness on child rights and constructive support from stakeholders.

Taken together, these suggestions point to a continuum of support rather than a single institutional intervention: resources for care inside the home, preparation for adulthood and continued assistance after exit.

DISCUSSION

Across the five homes, participants described a fairly broad range of services. Their role extends beyond accommodation to health care, nutrition, schooling, counselling, recreation, vocational preparation and opportunities for participation. This multidimensional pattern is consistent with the statutory framework for rehabilitation and social reintegration under the Juvenile Justice system, which identifies education, health, nutrition, vocational training, life skills, mental-health interventions, counselling and recreation among the services relevant to children in institutional care. (Government of India, 2015; Ministry of Women and Child Development, 2022)

At the same time, having several services in place does not mean that every need can be met without difficulty. Financial constraints cut across several domains. Education is available, but fees and additional tutoring create pressure. Health services are available through external facilities, but chronic illness and emergencies generate costs and require staff time. Recreational and vocational programmes exist, but their continuation depends partly on external support and institutional resources. Staff are committed to care, yet shortages and inadequate remuneration affect the conditions under which they work.

This is important because the quality of care depends not only on the commitment of individual caregivers but also on the conditions in which they work. A home may have motivated staff and a strong routine, but sustained quality requires predictable financing, adequate staffing, access to specialised services, safe infrastructure and continuing professional development. The present study therefore supports a systems perspective: improvements cannot depend only on individual caregivers or the goodwill of donors.

The accounts about children's participation also deserve attention. Participants reported children's committees and meetings in which children can raise concerns and make suggestions. This indicates an effort to create participatory spaces within residential settings. However, participation should not be understood simply as the presence of a committee. Meaningful participation requires that children's views are listened to, taken seriously and reflected in decisions where appropriate. Recent qualitative research in Kerala, based directly on interviews with children living in residential care, illustrates why children's own accounts are important for understanding emotional wellbeing, social relationships, behaviour, education and aspirations (Yohannan & Pa, 2025). Because children were not directly interviewed in the present study, the extent to which the reported participation mechanisms influence decisions remains an area for future research.

The education findings point to a distinction that is easy to overlook. School enrolment is an essential starting point, but educational support extends beyond attendance. Children may need tutoring, subject-specific assistance, educational materials, career counselling and financial support for higher education. The accounts from the homes suggest that the transition from school to higher education or employment is one of the points at which institutional resources become particularly stretched. This is consistent with Indian research on institutional care, which identifies gaps in practical preparation, employability and future planning (Meli, 2015; Mishra & Dutta, 2024; Wanglar, 2021).

Aftercare emerged as one of the more pressing issues in the accounts. The Indian child-protection framework places rehabilitation and social reintegration within the statutory responsibilities of the child-protection system (Government of India,

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2015; Ministry of Women and Child Development, 2022). Indian research on institutional care has similarly identified weaknesses in transition planning, practical preparation and aftercare infrastructure (Mishra & Dutta, 2024; Wanglar, 2021). A recent practitioner inquiry involving care-experienced young people across five Indian states further emphasises preparation before leaving care, mentoring and continuing support during transition (Tyagi & Sawhney, 2026). The accounts in this study therefore add a local provider perspective to an issue already identified in Indian literature: the challenge is not simply recognising aftercare in policy, but making transition support consistent and sustained in practice.

The concern about staff training also has significance when considered alongside Indian CCI research. Wanglar (2021) identified shortages of professional and trained staff as one of the challenges affecting rehabilitation and social integration, while Wanglar (2022) reported caregivers' calls for trained and professional personnel and stronger institutional arrangements. In the present study, participants did not ask only for more training; they described a need for training matched to staff responsibilities and for clearer communication of changes in child-protection law and practice. This supports a differentiated approach to staff development rather than treating all CCH personnel as having identical training needs.

The Meghalaya setting adds an important local dimension. The study shows how CCHs rely on networks of hospitals, educational institutions, churches, community groups and other organisations to supplement their internal resources. These relationships can be valuable, but reliance on informal or external support can also create uncertainty if services or donations are not predictable. Strengthening formal referral and support networks could therefore reduce the burden on individual homes while maintaining the community relationships that already contribute to care.

Taken together, the findings suggest that residential care cannot be considered in isolation from the wider child-protection system. The objective should not be to expand institutionalisation. Rather, where residential care is necessary, it should be safe, child-centred and connected to family strengthening, restoration where appropriate, education, health, skills development and planned aftercare. This position is consistent with the current policy direction towards preventing unnecessary family separation while improving the quality of care for children who require protection outside their families. (Government of India, 2015; Ministry of Women and Child Development, 2022; UNICEF India, n.d.)

Implications for Social Work Practice and Policy

The findings suggest several practice implications for social work, considered alongside the child-protection literature and the limits of this study. Social workers working with CCHs can approach care through case management rather than viewing accommodation as the main intervention. Individual planning can link health, education, psychosocial wellbeing, family relationships, skills and transition preparation. Social workers can also strengthen coordination among CCHs, Child Welfare Committees, District Child Protection Units, schools, hospitals and community organisations. Staff development can be continuous and differentiated by role, while aftercare can be planned before a child leaves the home and matched to the young person's circumstances and the applicable programme framework. These are practice implications drawn from the study findings and relevant literature, rather than direct evaluations of social-work programmes.

RECOMMENDATIONS

1. Strengthen predictable government and institutional funding for education, health emergencies, infrastructure, staff development and developmental activities.
2. Develop education-support mechanisms for children in institutional care, including assistance with school fees, tutoring, learning materials, higher education and vocational pathways where eligible.
3. Introduce regular, role-specific capacity-building programmes for CCH staff covering child protection law, POCSO, child rights, safeguarding, psychosocial support, health and hygiene, documentation and updated government guidelines.
4. Improve access to health services through formal referral linkages with hospitals and health facilities and, where feasible and justified, appropriate residential or on-call arrangements for nursing support.
5. Strengthen children's participation mechanisms so that children can safely express concerns and contribute to decisions affecting their daily lives.
6. Develop individual transition plans for children approaching the end of residential care, covering education, skills, family relationships, accommodation, employment and other relevant needs.
7. Strengthen aftercare and follow-up in line with the applicable child-protection framework, with attention to education, skills, employment, psychosocial support and safe reintegration.

LIMITATIONS OF THE STUDY

The study has several limitations. First, it covers five Child Care Homes in one district and therefore cannot be treated as statistically representative of all CCHs in Meghalaya. Second, the evidence comes primarily from persons in charge and staff; children and young people who have left care were not directly interviewed. Third, the study is descriptive and does not independently audit the homes against a formal quality-of-care standard. Fourth, the available manuscript does not provide sufficient information to establish a detailed sampling frame or to quantify the size of individual staffing, funding or child populations in the participating homes. These limitations should be considered when interpreting the findings.

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CONCLUSION

The five Child Care Homes examined in this study provide a range of services covering health, nutrition, education, psychosocial support, recreation and skills development. The accounts of persons in charge and staff show that these services are supported by networks of hospitals, schools, community organisations, churches and other agencies. Children's participation in committees and activities also indicates an effort to involve them in aspects of everyday life within the homes.

At the same time, the study identifies a clear set of constraints. Financial insecurity affects education, health emergencies, infrastructure and activities. Staffing shortages and workload place pressure on caregivers, while limited role-specific training can restrict the capacity of staff to respond to changing child-protection requirements. The transition from residential care to adulthood is another significant concern, particularly where family reintegration is not possible or where young people wish to continue their education or develop vocational skills.

The central point from the study is that quality residential care cannot be separated from the wider child-protection system. Homes require stable resources and skilled staff, but children also require continuity between residential care, family relationships, education, health services and aftercare. Strengthening these connections would allow Child Care Homes to function not simply as places of residence, but as part of a broader process of protection, development, rehabilitation and transition to independent adult life.

Future research should place children's own voices more centrally and follow young people after leaving care. Such research would help determine whether the services described by caregivers translate into sustained educational, employment, psychosocial and social outcomes. It would also provide a stronger basis for developing child-centred aftercare systems in Meghalaya.

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