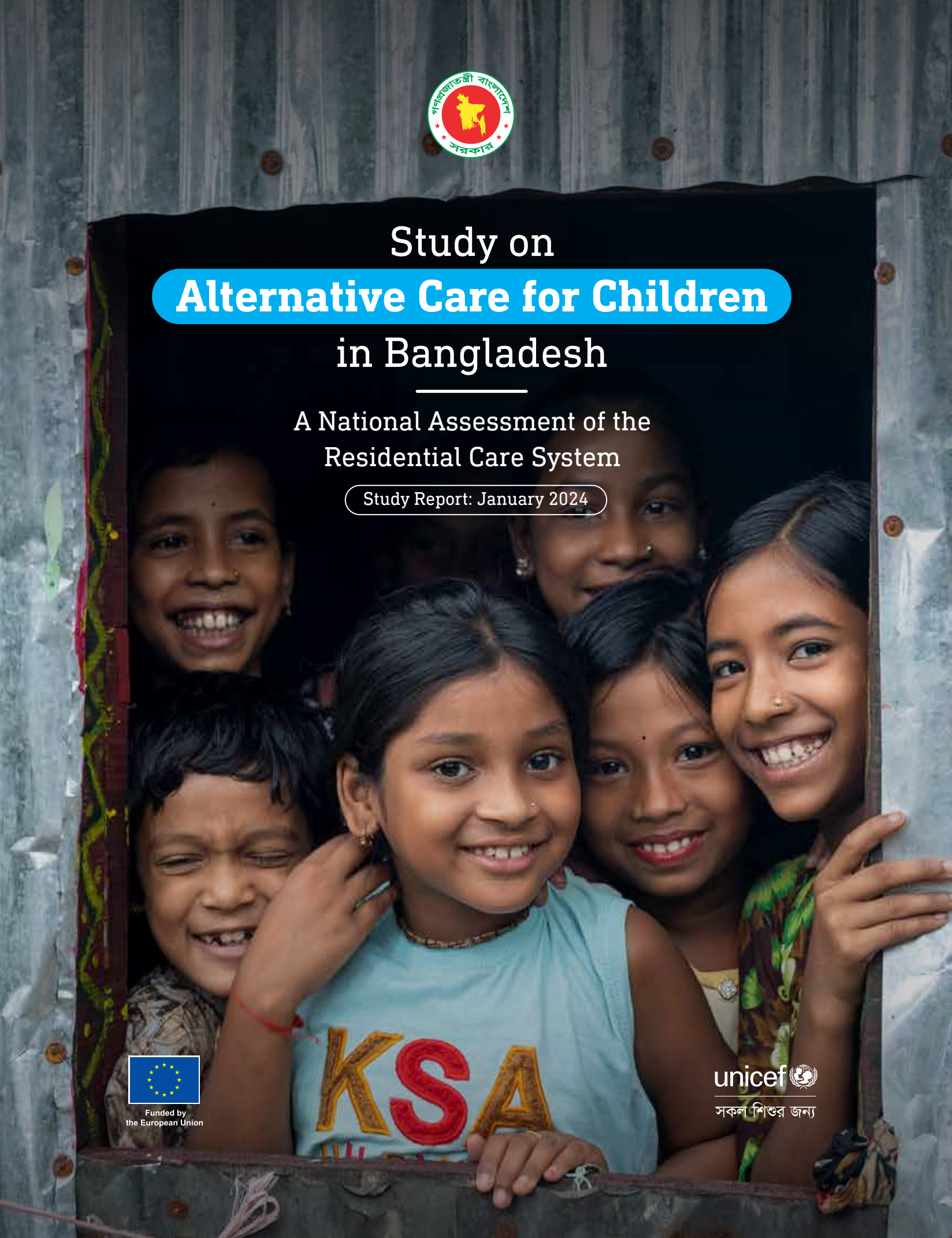

Study on
Alternative Care for Children
in Bangladesh

A National Assessment of the Residential Care System

Study Report: January 2024

Funded by
the European Union

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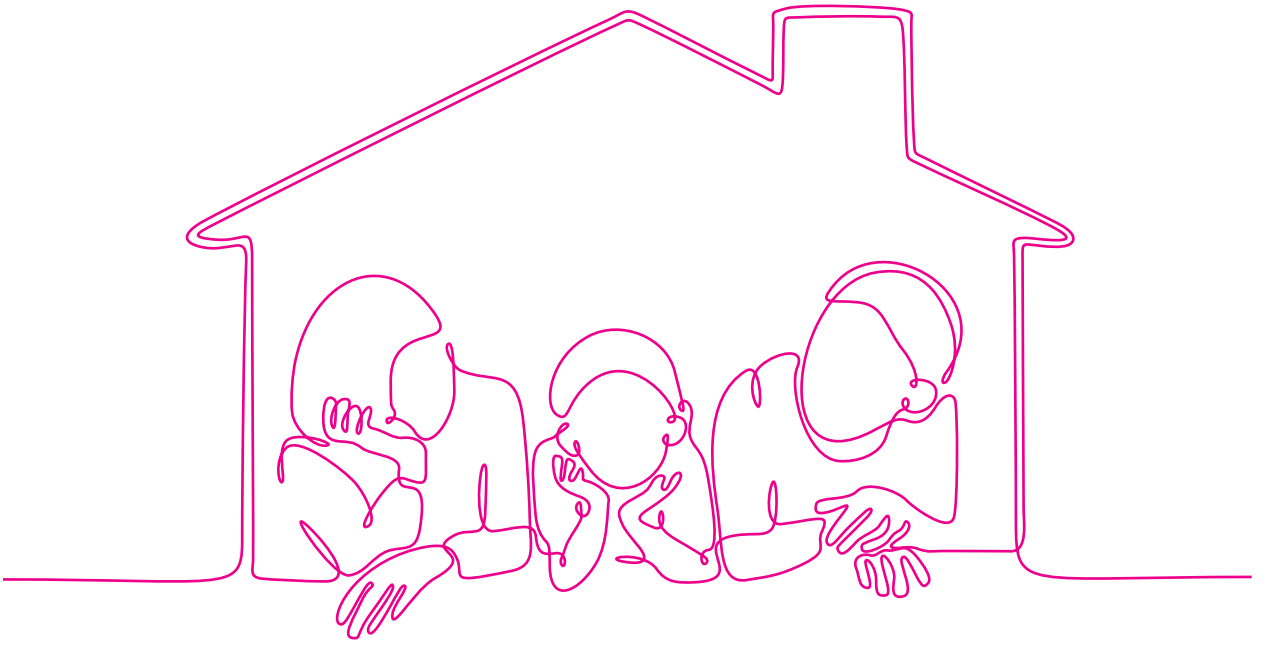

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Study Leadership and Implementation

The study was led by international technical specialist **Lidia Galeano,** in close collaboration with the **Development Research Initiative (DRI),** and conducted under the framework of the **Child Sensitive Social Protection in Bangladesh (CSPB)** Project – Phase II.

Government of Bangladesh

The Ministry of Social Welfare (MoSW) and the Department of Social Services (DSS) provided critical leadership and oversight throughout the study. **Dr. Abu Saleh Mohammad Mostafa Kamal,** Director General, Department of Social Services has shown keen interest in the study, offered valuable suggestions and insights, and extended his all-out support. Their commitment to advancing the national care reform agenda ensured that the study remained grounded in national priorities and aligned with the Government's broader vision to protect the rights and wellbeing of all children.

Child Sensitive Social Protection in Bangladesh (CSPB) Project – Phase II:

The study was conducted under the project of Child Sensitive Social Protection in Bangladesh (CSPB). **Mr. SM Lablur Rahman** (Joint Secretary), National Project Director, **Mr. Md. Amran Khan** (Assistant Director), Assistant Project Director, and the CSPB Project team provided operational support and strategic direction to facilitate the research process. Their ongoing efforts to strengthen child sensitive social protection and promote quality alternative care for children without parental care were pivotal for shaping the scope and relevance of this study.

UNICEF Bangladesh

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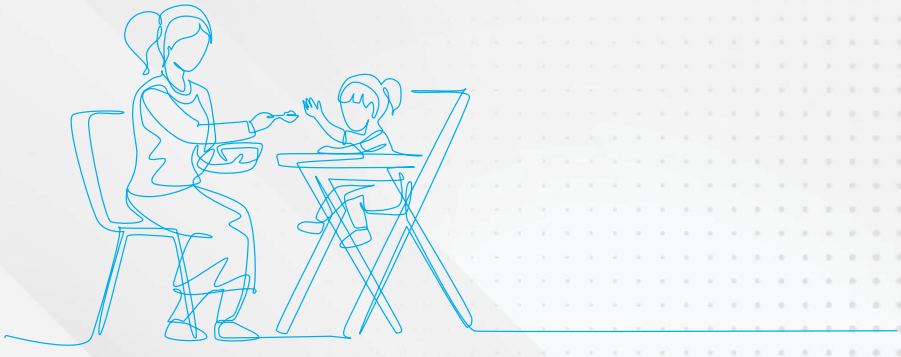
Acronyms

AC	Alternative Care
BBS	Bangladesh Bureau of Statistics
BDT	Bangladeshi Taka
BSA	Bangladesh Shishu Academy
CDC	Child Development Centre
CPIMS+	Child Protection Information Management System Plus
CRPD	Convention on the Rights of Persons with Disabilities
CRC	Convention on the Rights of the Child
CSPB	Child Sensitive Social Protection in Bangladesh
CWBs	Child Welfare Boards
DCA	Department of Children Affairs
DPO	Disabled Persons' Organization
DRI	Development Research Initiative
DSS	Department of Social Services
EU	European Union
FGD	Focus Group Discussion
GoB	Government of Bangladesh
IC	Institutional Care
INGO	International Non-Governmental Organization
MICS	Multiple Indicator Cluster Survey
MoDMR	Ministry of Disaster Management and Relief
MoE	Ministry of Education
MoHFW	Ministry of Health and Family Welfare
MoHA	Ministry of Home Affairs
MoLE	Ministry of Labour and Employment
MoSW	Ministry of Social Welfare
MoWCA	Ministry of Women and Children Affairs

Acronyms

NPA	National Plan of Action
NGO	Non-Governmental Organization
PAR	Participatory Action Research
PHT	Physical Handicapped Training (Center)
RCSDG	Rehabilitation Centres for Socially Disabled Girls
RCCD	Rehabilitation Centre for Children with Disabilities
SDGs	Sustainable Development Goals
SSW	Social Service Workforce
SUK	Shishu Unnayan Kendra
ToR	Terms of Reference
UCD	Urban Community Development
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children's Fund

Executive Summary



Background

In Bangladesh, the majority of children without parental care, or those in need of alternative care arrangements, are placed in institutional settings; often without a comprehensive assessment of their individual needs or consideration of family or community-based alternatives. Although the Children Act 2013 and related policies establish a strong legal framework that prioritizes family preservation by reducing unnecessary separation, supporting family reunification, and promoting community-based care, implementation remains limited. Institutional care is intended to be a measure of last resort; however, in practice, it continues to be the most commonly used option. Weak gatekeeping systems, fragmented regulatory oversight, and the absence of reliable national data have significantly hindered progress of the shift towards a more responsive, rights-based, and child-centered alternative care system.

To address these critical challenges, the Department of Social Services (DSS) under the Ministry of Social Welfare (MoSW), in partnership with UNICEF Bangladesh, commissioned this first-ever national assessment of residential care facilities. The study was conducted under Phase II of the Child Sensitive Social Protection in Bangladesh (CSPB) Project, with generous financial support from the European Union.

Objectives

This large-scale, national assessment aimed to generate a comprehensive understanding of residential childcare institutions in Bangladesh and the situation of children living within them. It further seeks to generate evidence that can inform policy and programming towards a more rights-based, child-centred alternative care system.

Specifically, the study sought to:

- Map and categorize residential childcare institutions nationwide; across different governance and funding models, including public, private, and NGO-managed institutions.
- Profile children residing in institutional care; with a focus on demographics, reasons for placement, and care histories.
- Assess institutional capacity, the quality of care and adherence with national and international standards.
- Examine child protection practices within institutions, including care planning, child participation, safeguarding, and family contact.
- Identify systemic gaps and practices contributing to that contribute to the overuse and normalization of institutional care for children.

Methodology

A mixed-methods approach was used to capture both the scale and depth of residential care in Bangladesh. The quantitative component included a survey of 157 residential care facilities (out of an estimated 4,000 nationwide) and profiling of over 10,600 children. In parallel, qualitative interviews were conducted with institutional staff and administrators to gain deeper insights into care practices, institutional dynamics, and perceptions of child well-being. Facilities were sampled across four typologies: public, private (with and without capitation grants), and NGO-managed institutions.

Data were analyzed using the framework of the UN Guidelines for the Alternative Care of Children and the Convention on the Rights of the Child (CRC) and relevant national child protection and safeguarding legislation and policies.

Key findings

Over-reliance on institutional care

Most institutions cater to long-term, full-time residential care, with **76% housing over 50 children**, contradicting the principle of family-based or small group care

A majority of admissions occur without formal gatekeeping **65% of children are placed based on family application,** not care orders or formal assessments

Socioeconomic hardship, not protection risks, is the main driver of institutionalization. Many children are placed to access food, shelter, education, or clothing—services that should be available within their communities

Private institutions receiving per-child Capitation Grants may be incentivized to increase enrolment, contributing to unnecessary separation of children from families

Diversity and fragmentation of facilities

Residential care is delivered by a wide variety of actors — **public (49%) and private/faith-based (51%),** with minimal oversight of privately run facilities.

5.1% of institutions surveyed were not registered, and significant discrepancies exist between legal mandates and practice

There is no national system of accreditation, licensing, or regular monitoring of private childcare facilities, increasing risks of inconsistent standards and limited accountability

Children's background and profiles

Children in residential care are not necessarily orphans: **only 4% had lost both parents**, while many had families who could potentially care for them with adequate support

Children with disabilities are present in many facilities but **specialized care and rehabilitation services are limited**.

Many children with disabilities are institutionalized due to poverty, social stigma, and lack of accessible services, not because they lack parental care.

Weaknesses in care planning and safeguarding

Less than 30% of children had a documented care plan, and exit planning is rare

Significant gaps in documentation, birth registration, and legal status were observed across institutions

Most institutions lack written safeguarding policies, designated child protection focal points, or routine staff training on abuse prevention

Only a small proportion of facilities reported incidents of child abuse, suggesting possible underreporting due to stigma, fear of reputational damage, or limited understanding of what constitutes as child abuse

Admission practices and institutional incentives

Admission campaigns and public promotions are widespread, especially in private and religious institutions — inadvertently promoting institutionalization

Infrastructure expansion has occurred in nearly 60% of institutions, often to increase intake, without quality safeguards

Key conclusions

The study reveals an urgent need to reorient the alternative care system in Bangladesh toward rights-based, family-first approaches.

Current practices incentivize institutionalization and often fail to meet the best interests of children, particularly those with disabilities or from disadvantaged backgrounds.

Key Recommendations

1. Adopt and Implement the National Plan of Action on Alternative Care (2026–2030) Preventing

Family Separation & Strengthening Family-Based Care that Establishes a clear roadmap for transitioning from institutional to family-based care, grounded in the best interests of the child. The NPA should include a phased deinstitutionalization strategy, promote family and community-based care options, and ensure institutional care is used only as a last resort with time-bound reintegration plans.

2. Strengthen gatekeeping, admission protocols, and funding accountability

Establish and enforce robust gatekeeping mechanisms to regulate the entry of children into formal care. Require that all admissions are based on formal best interests assessments and authorized care orders. Prohibit active recruitment or promotional campaigns by institutions. Reform funding models such as the Capitation Grant to eliminate incentives that drive the unnecessary or prolonged institutionalization.

3. Establish a formal family and community based alternative system

Institutionalize a structured continuum of care options—including kinship care, foster care, and supported independent living for adolescents—within the national alternative care framework. Provide financial, psychosocial, and practical support to families to prevent separation, facilitate safe reintegration, and ensure children grow up in safe and nurturing family environments.

4. Establish and Enforce institutional registration, licensing, and care standards

Ensure that all residential care facilities—government, private, and faith-based—are formally registered, licensed, and routinely monitored under a unified national framework. Enforce minimum standards covering infrastructure, staffing ratios, safeguarding protocols, and child protection procedures, with clear penalties for non-compliance.

5. Provide individualized and specialized care for children in institutions

that every child in residential care receives tailored support through a designated case worker, an individual care plan, and regular case reviews. Ensure access to education, health, MHPSS, and disability-inclusive services. Strengthen Family Tracing and Reunification (FTR) processes as a core part of case management. Promote child participation, safeguarding, and accessible complaint mechanisms to

uphold the best interests and rights of each child.

6. Build a professional, accountable social service workforce

Develop and implement a National Social Work Policy and a Social Service Workforce Strengthening National Plan of Action (NPA) that promotes professionalization, accreditation, registration and strategic deployment. Invest in structured, competency-based technical training, and supervision for all professional, support staff and volunteers to ensure quality, ethical, and child-centered service provision capacity.

7. Reform specialized institutional care models

Redesign Baby Homes to ensure stable caregiver-child attachment and family-like care. Review and reform Safe Homes, Rehabilitation Centres, and Child Development Centres to adopt child-centered, rehabilitative models with defined entry/exit criteria and clear reintegration pathways.

8. Operationalize a centralized alternative care information managment system

Establish a dedicated national database under DSS to register and monitor all residential care institutions—including their compliance with licensing and regulatory standards—as well as all approved foster and kinship carers. Ensure full interoperability with the national child protection information management system to ensure that all children receiving formal alternative care are linked to case management and are receiving ongoing support.

9. Activate and resource Child Welfare Boards and statutory oversight mechanisms

Ensure Child Welfare Boards (CWB) and Probation Officers are fully functional, adequately resourced, and empowered to provide statutory oversight of all alternative care placements. Strengthen their mandate to conduct regular case reviews, ensure adherence to best interest principles, and coordinate multisectoral responses across child protection, justice, education, health, and social welfare systems.

01

Introduction

1.1 Background

All children have the right to grow up in a safe, supportive, and nurturing family environment that enables them to reach their full potential. When parents or primary caregivers are unable to provide adequate care—despite the availability of support services—it is the responsibility of the State to ensure that appropriate alternative care arrangements are provided in accordance with the best interests of the child, as outlined in the **Convention on the Rights of the Child (CRC).**

Globally, an estimated 2.7 million children are living in residential care facilities—though the true number is likely far higher[1]. Recognizing the developmental harm and emotional toll associated with institutionalization, many countries have taken steps to reduce reliance on residential care. These efforts typically focus on preventing unnecessary family separation, and when separation is unavoidable, prioritizing family reunification or placement in family-based care settings such as foster care or kinship care.

In Bangladesh, children under 18 constitute approximately 40% of the population—over 64 million individuals[2]. While several forms of alternative care exist, including institutional and family-based options, there is currently **no comprehensive or reliable national estimate of how many children are living in alternative care arrangements.** Most concerningly, privately-run institutions remain largely unregulated and unrecorded, and data gaps persist even within government-managed care systems.

Moreover, oversight, accountability, and referral mechanisms are weak or fragmented, and family-based care options such as formal foster care, adoption, and supported kinship care remain limited and underutilized. As a result, many children without parental care—particularly those with disabilities or from disadvantaged backgrounds—end up in institutional settings, often without a formal assessment of necessity or suitability.

To address these critical gaps, the **Department of Social Services (DSS)** under the **Ministry of Social Welfare (MoSW),** in partnership with **UNICEF** Bangladesh, conducted this national assessment of residential care facilities. The study was implemented under the **Child Sensitive Social Protection in Bangladesh (CSPB) Project – Phase II,** with generous financial support from the European Union, as part of the broader project "Fostering Rights and Empowerment Among the Most Marginalized Adolescents and Children with Disabilities in Bangladesh.".

In addition to producing a baseline assessment, the study developed standard data collection tools that will be used by DSS for **biannual follow-up surveys**. These surveys will measure children's well-being, reasons for placement, and institutional conditions, with the goal of improving monitoring, informing policy reforms, and ultimately ensuring that every child in need of care is raised in a protective, family-like setting.

[1]https://www.unicef.org/protection/children-in-alternative-care

[2]https://www.unicef.org/bangladesh/en/children-bangladesh

1.2 Objectives of the Study

This study aimed to generate a comprehensive understanding of the **situation of children living in institutional care in Bangladesh,** as well as the **capacity and operating conditions** of the facilities that provide such care.

The overarching objective was to assess both the **demographic characteristics of children** in institutional settings—such as age, sex, and disability status—and the **institutional environment,** including staffing, infrastructure, services, funding, governance, licensing, and adherence to care standards and protocols.

Specifically, the study sought to:

- **Assess residential care facilities** registered with child protection authorities, examining the number and characteristics of children in care, staff profiles, physical infrastructure, and available services;
- **Conduct in-depth profiling** of children and institutions across various facility types, including public, private (with or without capitation support), and NGO-run models;
- **Analyze key child protection issues,** including child participation, safeguarding practices, and compliance with national and international standards for alternative care.
- **Identify systemic gaps and institutional practices**—such as inadequate gatekeeping, limited support to families, promotional admissions, and infrastructure-led intake—that contribute to the overuse and normalization of institutional care for children.

1.3 Framework for the Study

This study is grounded in the principles set forth by the **United Nations Guidelines for the Alternative Care of Children (UN Guidelines),** which serve as the primary conceptual and policy framework guiding all phases of the research—from design to analysis and interpretation.

The UN Guidelines were adopted by the United Nations General Assembly in 2009 to reinforce the implementation of the **Convention on the Rights of the Child (CRC)** with regard to children who are without parental care or at risk of losing it. They emerged from concerns raised by the Committee on the Rights of the Child, particularly regarding the widespread institutionalization of children due to poverty and the lack of adequate family support services.

The Guidelines establish two core principles:

- The **necessity principle:** A child should be placed in alternative care only when it is necessary and in their best interest, following a careful assessment of the family situation.
- The **suitability principle:** When alternative care is required, the type and form of care should be appropriate to the child's individual needs and circumstances, with family-based care prioritized over institutional placement.

The UN Guidelines also emphasize that **poverty alone should never justify the separation of a child from their family,** and that **deinstitutionalization strategies should be developed in countries where residential care is prevalent.**

These principles served as the backbone of this study's approach, ensuring that the research remained focused on **children's rights, the promotion of family-based care, and the development of a stronger, rights-respecting alternative care system** in Bangladesh. The aim was not merely to document conditions, but to generate actionable evidence for policymakers and practitioners seeking to improve the care and protection of children without parental care.

Summary of the key provisions – The UN Guidelines on Alternative Care of Children

Alternative care is "a formal or informal arrangement whereby a child is looked after at least overnight outside the parental home, either by decision of a judicial or administrative authority or duly accredited body, or at the initiative of the child, his/her parent(s) or primary caregivers, or spontaneously by a care provider in the absence of parents. This includes informal fostering by family or non-relatives, formal foster care placements, other forms of family-based or family-like care placements, places of safety for emergency childcare, transit centres in emergency situations, other short- and long-term residential care facilities including group homes and supervised independent living arrangements for children".[3]

[3]United Nations General Assembly. (2010). Guidelines for the Alternative Care of Children, A/RES/64/142, para. 29.

The UN Guidelines promote the implementation of the necessity principle and of the suitability principle in the alternative care of children:

- **Necessity:** children must be maintained in or returned to their family or, failing that, the need for alternative care must be carefully assessed.
- **Suitability:** Where alternative care is needed, ensure that the most appropriate forms of alternative care are implemented.[4]

To implement the "necessity principle" countries should have in place policies specifically aiming at **preventing the separation** of children from their family and being placed unnecessarily in alternative care and to ensure that alternative care is only used when necessary, thought rigorous screening and assessment process.

Countries should also have in place **a range of options to enable the suitability principle,** while giving the absolute priority to family-based care. These options are:

Kinship care is the traditional mechanism that is widely practiced informally. It is sometimes referred to as "fostering". Kinship care involves placing the child in the care of a member of the extended family, as culturally understood. As part of protection case management, kinship care can be arranged with the support of the mandated agency or ordered by the authority (formal kinship care). Kinship care is the most adequate solution when the child's parents are facing temporary difficulties, as the children remain in a familiar environment where they enjoy connections with family and culture.

Formal foster care is the placement of children in need of care outside their family of origin in the domestic environment of an existing family with no links to the children's own family ordered by the relevant authority. In a formal foster family, the child enjoys family, where alternative care is needed, and community environment and can establish stable and meaningful relations with foster parents and other family members. Foster families must be identified, assessed, recruited, trained and carefully supported and supervised.

Residential care is care provided in any non-family-based group setting, places for emergency care, transit centers in emergency situations, and all other short and long-term residential care facilities including group homes. According the Guidelines, residential care is a complementary response to family-based options and should be used only for "positive" reasons, when it is assessed that it will be the most appropriate response to the situation and the needs of the child concerned.

Supervised independent living is a type of alternative care that targets young adult between 18 and 21 years of age. It indicates a small group of young adults living together in a subsidized housing accommodation. This type of care is necessary for young adults with very difficult personal situation and is particularly appropriate for those who leave care because they have reached 18 years of age but do not have family ties and for which family reintegration is not an option. They need support to be able to gradually acquire personal autonomy and economic independence.

4

The UN Guidelines promote alternative care of children without parental care where:

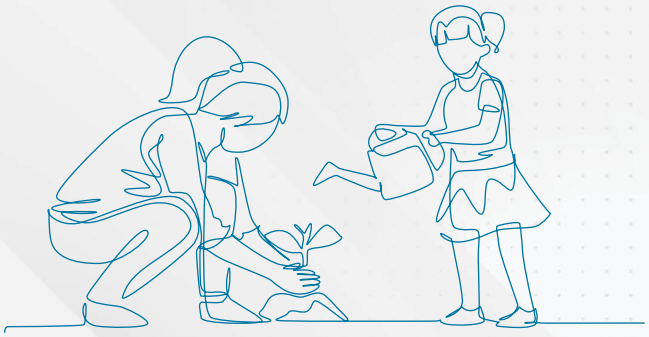
- The priority is given to maintaining the child in the family of origin, if necessary with some form of support.
- A full package of support is available for supporting vulnerable families to enable them to provide adequate care for children.
- Beliefs that lead to the separation of children from parents are challenged while those that keep families together are strengthened.
- The removal of a child from the family is a measure of last resort when inappropriate care or protection concerns put at risk the survival and development of the child. The measure must remain temporary and of the shortest possible duration.
- When the child must be removed, ensure that the child is placed in the most appropriate alternative care option, preferably in a family environment.
- During the alternative care of such child all the efforts must be centred on eliminating the causes that motivated the removal of the child from family care and on the return of the child to his/her family as soon as possible.
- Placement outside the family of origin is regularly reviewed and decisions made accordingly, with a view to promoting the child's return to parental care.
- If family reintegration is impossible, another permanent and family-based solution needs to be found for the child, including through adoption.

Finally, it is worth noting that the UN Guidelines highlight in art.15B that **"Financial and material poverty, or conditions directly and uniquely imputable to such poverty, should never be the only justification for the removal of a child from parental care, for receiving a child into alternative care, or for preventing his/her reintegration, but should be seen as a signal for the need to provide appropriate support to the family."**

The UN Guidelines require that in countries where institutional care is practiced, **"alternatives should be developed in the context of an overall deinstitutionalization strategy, with precise goals and objectives, which will allow for their progressive elimination."** They add that any decisions to establish new institutions should take full account of the deinstitutionalization objective and strategy.

02

Context



2.1 Demographic Context

Child population[5]

Bangladesh has an estimated population of approximately **174 million,** of which children aged 0–17 years make up 36%—highlighting the country's young demographic profile. According to the 2020 **Multidimensional Poverty Index (MPI)** developed by UNICEF, the Bangladesh Bureau of Statistics (BBS), and the General Economics Division (GED), **42.1% of children** are multidimensionally poor, compared to **32.9% of adults.**

Child mortality, malnutrition, child marriage, child labour, and limited access to quality education remain key challenges affecting children's well-being. Despite substantial government efforts and progress in certain areas, systemic inequities and service gaps persist, particularly among vulnerable and marginalized populations.

Children deprived of parental care

The UN Guidelines define children deprived of parental care as "children not living with at least one of their parents." These children often experience emotional distress, social isolation, and developmental delays due to the absence of stable caregiving.

In Bangladesh, accurately estimating the number of children deprived of parental care remains difficult due to:

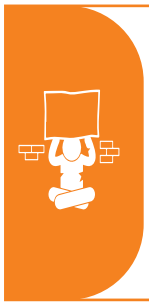
- Incomplete birth registration coverage;
- High levels of internal migration and displacement;
- Limited capacity to monitor street-connected and institutionalized children.

According to the 2019 Multiple Indicator Cluster Survey (MICS),

4% of children aged 0–17 have lost one or both parents, and **4.1%** live with neither biological parent. However, these figures reflect only those living in households and do not capture children residing in institutions, on the streets, or in other informal settings.

[5]Bangladesh Bureau of Statistics and UNICEF - MICS – Multiple Cluster Child Indicators - 2019

StreetConnected Children in Bangladesh: Children living and working on the streets remain among the most visible yet undocumented and underserved groups in Bangladesh. While comprehensive national estimates are limited, recent studies suggest that over



3.4 million children are living in street situations, many without parental care or meaningful family contact[6] [UNICEF Bangladesh. (2024). Children Living in Street Situations in Bangladesh. Retrieved from https://www.unicef.org/bangladesh/en/reports]. A UNICEF-supported study found that more than **70% of street-connected children are unable to read or write, and many lack access to safe shelter, healthcare, or basic protection services**[7] These children are frequently exposed to abuse, exploitation, and harassment in public spaces.

From an alternative care perspective, street-connected children represent a significant group of children effectively separated from their families, often due to poverty, violence, neglect, or the breakdown of social support systems. Many report that their parents have died, abandoned them, or are unable to provide care. Others have fled abusive environments or migrated alone. Despite being outside formal care systems, these children are in urgent need of family tracing, reunification support, or placement in appropriate family-based care. Their situation underscores the critical need for stronger prevention mechanisms, accessible social protection, and community-based alternatives to institutionalisation.

Children in informal care

Informal care refers to caregiving arrangements—typically by relatives, neighbours, or community members—that arise **without legal formalization**, such as court orders or formal guardianship. These arrangements are often prompted by parental death, illness, migration, or economic hardship.

While informal care plays a vital role in supporting vulnerable children, it is **largely unregulated and undocumented, posing challenges for child protection monitoring.** The UN Guidelines recommend that informal care arrangements be **voluntarily registered with child protection** authorities to ensure support and oversight when needed.

In Bangladesh, a significant proportion of children not living with biological parents are cared for by relatives in kinship care. MICS 2019 data shows that

94.4% of children aged 0–14 living without either parent reside with extended family in household settings under informal care arrangements.

[6]UNICEF Bangladesh. (2024). Children Living in Street Situations in Bangladesh. Retrieved from https://www.unicef.org/bangladesh/en/reports
[7]BIGD & RED (2021). *Lives of Street-Connected Children in Bangladesh*. BRAC Institute of Governance and Development. https://bigd.bracu.ac.bd

Children in formal care

Formal care is defined as care arrangements ordered by a competent administrative or judicial authority, or provided in residential environments that meet registration and licensing requirements.

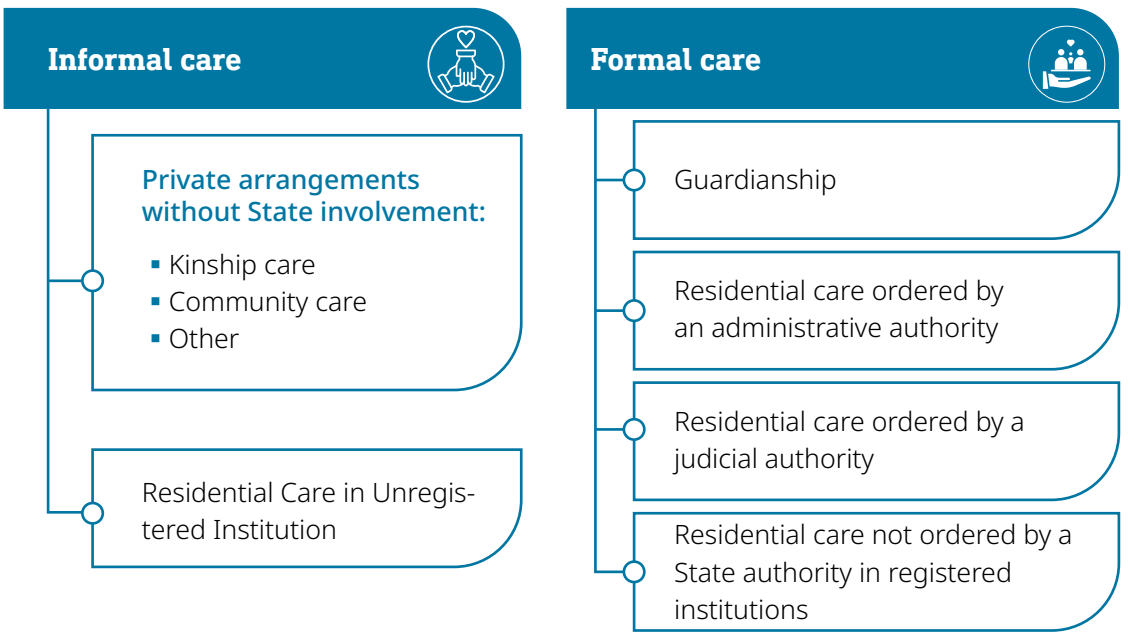
In Bangladesh, the two main forms of formal care are:

1. **Guardianship**
   - Ordered by the Family Court under the Guardians and Wards Act, guardianship enables a designated caregiver to make decisions on behalf of the child regarding health, education, and living arrangements.
   - However, there is no official data on the number of children under guardianship orders.
2. **Residential Care**
   - Residential care includes institutional arrangements for children who are separated from their families. In Bangladesh, this comprises:
     - Public institutions (ordered by administrative or judicial decision);
     - Registered private institutions (admitting children with or without court involvement).

The current system also includes unregistered institutions, which operate without legal authorization. These unlicensed facilities are considered illegal under national law and fall outside any formal monitoring mechanism. The number of children living in such institutions is unknown, raising serious concerns about child safety, rights violations, and regulatory oversight.

The following diagram presents the typology of alternative care arrangements in Bangladesh, highlighting the distinction between formal, informal, and unregistered care.

Figure 1 Alternative care arrangements existing in Bangladesh.



2.2 Regulatory Framework Pertaining to Alternative Care

The legal and policy framework for alternative care in Bangladesh is guided by both international commitments and a national legal architecture. Together, these instruments establish the rights of children to family life, the conditions under which alternative care is appropriate, and the responsibilities of the State and its institutions in safeguarding those rights.

International framework

United Nations Convention on the Rights of the Child (CRC)

The CRC, ratified by Bangladesh in 1990, affirms the child's right to a family environment and the State's obligation to intervene when families are unable to provide adequate care.

Key provisions relevant to alternative care include:

- **Preamble:** Emphasizes that a child should grow up in a family environment, in an atmosphere of happiness, love, and understanding
- **Article 9:** A child should not be separated from parents unless such separation is necessary for their best interests
- **Article 18:** Parents have primary responsibility for upbringing; the State must support them in this role
- **Article 19:** Protection from abuse, neglect, and exploitation
- **Article 20:** Children deprived of family care are entitled to special protection and assistance from the State
- **Article 12:** Children have the right to express their views in matters affecting them
- **Article 23:** Children with disabilities have the right to live in conditions that ensure dignity, promote self-reliance, and facilitate community participation

National legal framework

At the national level the current legal framework on alternative care comprises:

- **Children Act 2013 (amended in 2018)**[8] is the national law regulating child protection and alternative care

[8]The Children Act 2013 entered into force on 21 August 2013 and was amended by the Children (Amendment) Act 2018. The Children Act 2013 (amended in 2018) has overriding effect (per section 3), meaning that if there are any provisions in any other laws in force for the time being which conflict with the Children Act 2013 (amended in 2018), the provisions of the Children Act 2013 (amended in 2018) must prevail.

[9]The Family Courts Ordinance 1985, Section 5(2).

- **Draft Children Rules 2016** (draft Guidelines on the Minimum Standard of Care for Service Providers), a new version was developed in 2020- the rules have not been adopted at time of the assessment.
- **Orphan and Widow Homes Act of 1944** – provides for control and supervision of orphanages, widow's homes and marriage bureau.
- **The Voluntary Organizations (Registration and Control) Ordinance** - regulates and oversees the operations of non-governmental organizations (NGOs) and voluntary organizations within the country.
- **Family Court Ordinance 1985** - Family Courts are competent to hear matters relating to a range of family issues, including guardianship and custody of children[9], according to provisions in the Guardian and Wards Act 1890.
- **Guardian and Wards Act 1890** - provides jurisdiction to the Family Court to appoint a guardian for a child when necessary[10].
- **The Muslim Personal Law (Shariat) Application Act, 1937** - establishes that, for Muslims in Bangladesh, certain matters, including guardianship, must be decided in accordance with Muslim Personal Law (Shariat).[11]
- **Hindu Personal Law** providing for authorized adoption for Hindus.
- **Bangladesh Child Marriage Restraint Act (CMRA), 2017** — Though not directly about alternative care, it's crucial for child protection and preventing family separation due to early marriage.

The Children Act 2013

This Law repealed the 1974 Children Act with the aim of bringing the country in line with provisions of international instruments such as the CRC, as well as decisions of the Bangladesh Supreme Court. The Children Act contains key provisions for children in conflict with the law, provides a system of responses to child victims of violence that integrate the services of health, justice and social protection. The Act designates the Ministry of Social Welfare as the State body with overall responsibility for children's care and protection.

Provisions on Alternative Care in the Children Act : The Children Act contains a full chapter with several provisions regarding alternative care of children with the aim of safeguarding the welfare of children in need of alternative care and ensure that their best interests are upheld throughout the process.

Definition and scope: The Act defines "alternative care" as a measure to ensure the overall welfare and the best interest both of disadvantaged children and children in contact with the law for whom special protection, care and development need to be ensured upon consideration of their familiar social cultural financial ethnical psychological and educational background.

[10]The Guardianship and Wards Act 1890, Article 7(1)(b).

[11]The Muslim Personal Law (Shariat) Application Act, 1937, Section 2.

Target of alternative care: Section 84 recognizes alternative care as one of the measures applicable to "disadvantaged children", namely any child considered in need of special protection, care and development either by the Children's Court or the Child Welfare Board.

Assessment requirement: It indicates that a condition for placing the child in alternative care is that an assessment of the child's circumstances has been conducted. This assessment aims to ensure that the child's specific needs and situation are understood and considered before determining the most suitable form of alternative care for them.

Hierarchy of placement: When a decision on the alternative care must be taken, the priority is given to reintegration with birth parents or one of them, considering the child's opinion. After birth parents, the priority is given to kinship care in the extended family or with a legal guardian. If reintegration within the extended family or placement with a guardian is not feasible, the law allows for the child to be placed in "Institutional care of disadvantaged children".

Institutional care: "Institutional care" is intended in the Law as the alternative care provided by the State/government in any institute under section 85 including:

- Government children's homes *(sharkari shishu paribar)*
- Baby homes *(chotonomi nibash)*
- Training and rehabilitation centers for destitute children.
- Government shelter homes.
- Other institutes to be determined by government.

Support mechanisms: Section 87 outlines essential support mechanisms such as financial aid, counseling for parents or guardians, vocational training for the child, and supervision/monitoring.

Rehabilitation of parents: The Law emphasizes the government's responsibility to rehabilitate parents engaged in "immoral or illegal activities" that might harm the child's well-being, prioritizing the child's reintegration into a safe environment.

Alternative Care decision making authority: The determination of the most suitable type of care for children identified or referred to the police falls under the purview of the **Child Welfare Board (CWB) or the Probation Officer**. These authorities assess the circumstances of the child and make informed decisions regarding the appropriate alternative care needed, ensuring the child's well-being and safety are paramount. (Section 86). In the absence of a Probation Officer, the Children Act 2013 designates the Social Service Officer to assume these responsibilities.

Duration: The duration of alternative care can vary accommodating short term or long-term arrangements based on the child needs' assessment.

Review of placement and periodicity: The Probation officer is responsible for conducting periodic reviews of the adopted alternative care arrangement for ensuring that the objectives of the placement are being pursued and ensuring continued suitability. The Probation Officer must submit an updated assessment to Court on a quarterly basis. This regular reporting ensure that the Court confirms the necessity of the child's placement, remains informed about the child's wellbeing and makes relevant adjustment considering the child's evolving best interest and the family situation.

The placement process: Identification and referral of children in need of alternative care are pivotal aspects outlined in the law. According to these provisions, any individual or organization possessing information about or identifying a 'disadvantaged child' is mandated to report this information to either the police or the Department of Social Services (DSS), or its nearest office. Should the case be reported to the police, the responsibility lies with the police officer to report or refer the child to the Department or its nearest office.

Upon receiving a disadvantaged child, the Department or its offices are entrusted to identify and locate parents, assess the case and take necessary measures, which may include arranging alternative care or institutional care for the child's well-being.

In cases where a social worker assessment deems it in the child's best interest to be removed from their parents, or in the absence of both parents, from the caregiver, supervisory authority, legal guardian, extended family members, or any entrusted person, the matter must be submitted to the District or Upazila Child Welfare Board by the Probation Officer. This Board is responsible for referring the case to the children's court to initiate necessary measures for the child's welfare.

This framework prioritizes the welfare of disadvantaged children by stipulating clear procedures for identification, referral, and appropriate care placement, ensuring their best interests and safety remain paramount throughout the process.

The Orphanages and Widows' Homes Act of 1944

This Act provides "for the better control and supervision of orphanages, widows' homes and marriage bureaux in Bangladesh."

According to the law orphan is "a boy or a girl under eighteen years of age who has lost his or her father or has been abandoned by his or her parents or guardians."

Orphanages are defined as an institution, by whatever name it may be called" where orphans are kept or intended to be kept."

This Act does not apply to childcare institutions created and maintained by the Government and some types of private institutions.

According to this Act, no person can open or operate an orphanage, widows' home, or marriage bureau without a valid license. Those institutions that were functioning when the Act was enacted had six months to obtain the license.

District Magistrates can grant licenses for orphanages, widows' homes, or marriage bureaus based on prescribed conditions. Licenses may be refused unless certain criteria are met, including the formation of a registered charitable society, the respectability of society members, and suitable location and accommodations.

The law stipulates that the District Magistrate is equally responsible for the suspension, or cancellation of licenses for orphanages, as well as conducting regular inspections and random visits to ensure compliance.

The Voluntary Social Welfare Agencies (Registration and Control) Ordinance 1961

This Ordinance regulates and oversees the operations of non-governmental organizations (NGOs) and social welfare voluntary organizations within the country. It mandates that these organizations must register with the NGO Affairs Bureau, which falls under the Office of the Prime Minister in Bangladesh. The registration process involves submitting detailed information about the organization's objectives, activities, funding sources, and governance structure.

Together, these legal instruments provide the framework for regulating the placement, protection, and care of children deprived of parental care. However, the system remains fragmented, with overlapping mandates, enforcement gaps, and limited implementation of oversight mechanisms, especially in relation to privately run and unregistered institutions.

2.3 Policy and Programmatic Frameworks for Alternative Care

The national policy framework on child protection and alternative care in Bangladesh consists of a range of policy and guiding documents that outline the Government's priorities and commitments, and provide direction for strengthening care, protection, and support systems for children without adequate parental care or at risk of separation.

Key National Policies and Guidelines on Child Protection and Alternative Care

- National Social Security Strategy - Drives family support to prevent separation
- National Children Policy 2011 - Drives family support to prevent separation
- The Guidelines for the Management of State Children's Home (Sarkari Shihu Paribar)- December 2022 - Directs institutional care standards
- The Allocation and Distribution Policy for the Capitation Grant in Private Orphanages, introduced in 2015 - Sets oversight for non-state care facilities

Related Child Protection Policies[12]

- National Child Labour Elimination Policy (2010)
- National Action Plan to Prevent Violence Against Women & Children (2013–2025)
- National Plan of Action to Eliminate Child Labour (2021–2025)
- National Action Plan to End Child Marriage (2018–2030)

National Social Security Strategy

The National Social Security Strategy was finalized and adopted in 2015 and outlines the comprehensive policy for responding to socially disadvantaged groups and establish a social security system in the country. The seeks to streamline and strengthen the existing safety net programs and NSSS broadens the scope of Social Security to include employment policies and social insurance. After the implementation of the first Action Plan, Bangladesh has started implementation of the Action Plan Phase-II that covers the period from 2021 to 2026.

Overall, the Plan Phase II aims at Strengthening Child Protection initiatives through:

- Protection and rehabilitation of disadvantaged children through the Sarkari Shishu Paribar, Baby Home and Sheikh Russel Child Training and Rehabilitation Center and through other child related institutions
- Ensuring higher education of children at risks, children with disability through the provision of scholarships and stipends
- Ensuring Life skill education and training for children inmates of all child related Institution
- Construction of 4 transit shelter homes in border areas for trafficked women and children

National Children Policy

The National Children Policy is a broad policy document outlining overarching principles, goals and objectives proving a high-level framework for decision making and guiding actions within the Bangladeshi government. It was developed by the Ministry of Women and Children and endorsed in 2011. The fundamental Principles of the National Children Policy are 1) Ensuring child rights in the light of the constitution of Bangladesh, Child Act and International Charters/ Conventions, 2) Poverty alleviation of the children, 3) Elimination of all forms of child abuse and discrimination, 4) Elimination of all forms of abuse of and discrimination to female child and 5) Participation of the children and accepting their views into consideration in overall protection and, in the best interest of the children. The Policy is silent on the issue of alternative care of children.

[12]Other child protection policy documents include:
- National Child Labour Elimination Policy (2010)
- National Action Plan to Prevent Violence Against Women and Children 2013-2025
- The National Plan of Action on the Elimination of Child Labour (2021–2025)
- National Action Plan to End Child Marriage (2018-2030)

Policy for State Children's Homes

This operational policy applies to residential facilities under the Department of Social Services. The Guidelines for the Management of State Children's Homes were reviewed in 2022. They determine actionable steps, detailing specific procedures, protocols, and Guidelines for implementation of institutional care.

Child Sensitive Social Protection in Bangladesh (CSPB) Project

The **Child-Sensitive Social Protection (CSPB) Project**[13] is a joint initiative of the Department of Social Services (DSS) and UNICEF. Currently in its second phase (2017–2024), the project aims to strengthen the national child protection system to effectively prevent and respond to violence, abuse, exploitation, and neglect of children.

The CSPB project operates at both national and subnational levels across Bangladesh, prioritizing the provision of quality preventative and responsive child protection services for children and their families at risk of harm or in need in care and protection, with a particular focus on strengthening the alternative care system through two key strategies:

- Improving the quality of institutional care as a measure of last resort for children placed in DSS-run institutions or private facilities receiving DSS grants
- Piloting and promoting family-based and community-based alternative care models, including formal kindship care arrangements and community foster care, for children without parental care

To enhance community-level protection, **Community-Based Child Protection Committees (CBCPCs)** are established at the ward level. Supported by DSS through social workers, these committees include key community stakeholders—such as children, teachers, NGO workers, community members, and local leaders—and serve as a bridge between Upazila Child Welfare Boards and communities. Their core functions include:

- Raising awareness of child protection issues
- Promoting child participation and safe recreational activities
- Identifying and referring children in need of care and protection to social workers and relevant atthorites
- Facilitating community access to essential social services

CBCPCs meet every three months to coordinate and monitor their efforts.

Complementing the CBCPCs, **Village and Ward Social Service Volunteers** are engaged as part of the community protection mechanism. These trained volunteers play a critical frontline role in monitoring vulnerable households, identifying children at risk, and supporting timely referrals to social workers and available services. Their presence strengthens local surveillance and response capacity, ensuring protection concerns are addressed closer to the source.

[13]DSS CSPB project, DSS website: http://www.dss.gov.bd/site/page/62d8a66e-2334-4bed-ac95-01036a0d2c35/CSPB-Project

Together, the CBCPCs and volunteers play a crucial role in identifying kinship and safe community-based care options, supporting the Family Tracing and Reunification (FTR) process, and providing essential on-the-ground assistance to social workers, probation officers, and social service officials in carrying out their responsibilities—through regular follow-up and monitoring support.

In addition to these community mechanisms, the project also supports:

- **Social service workforce strengthening** to enhance the planning, delivery, and supervision of child protection services at national, subnational, and community levels.
- **Child Helpline 1098**, a 24/7 national helpline operated by DSS, including on weekends and public holidays. The helpline provides immediate support and referrals to relevant services, including temporary shelter where necessary.

Capitation grant program

The Capitation Grant Program is a long-standing initiative within Bangladesh's national social security system, designed to support private orphanages that care for children without parental care, particularly those from socioeconomically disadvantaged backgrounds. Initially introduced in the early 1960s to support religious leaders operating orphanages, the program has since evolved into a formalized mechanism for financing child care in private institutions.[14]

The **Allocation and Distribution Policy for the Capitation Grant in Private Orphanages**, introduced in 2015, outlines eligibility criteria, application procedures, and implementation guidelines. To participate, institutions must be registered under the **Voluntary Organizations (Registration and Control) Ordinance of 1961** and comply with the standards detailed in the capitation grant manual. All children must be enrolled in formal or religious education and be between the ages of 6 and 18.

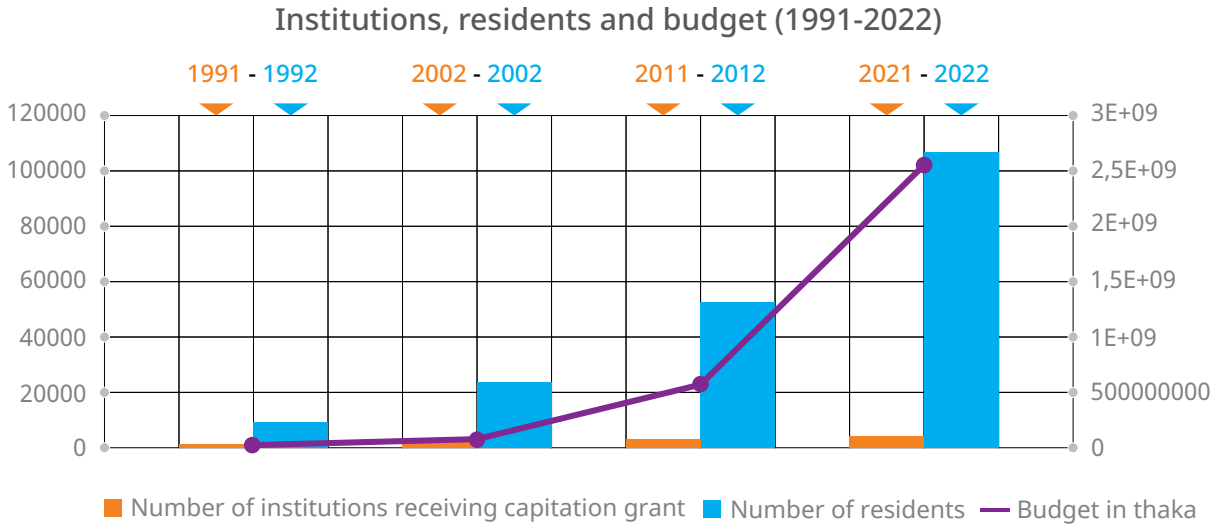
Capitation grants are currently disbursed to institutions providing care for both biological and socially orphaned children. Approximately **50% of children in eligible orphanages receive support through this program.** Institutions must accommodate **a minimum of 10 children,** and the **current per-child monthly allocation is BDT 2,000**.

At the local level, application and selection processes involve scrutiny of admission forms and approval by the Upazila Women Vice Chairman. Oversight and monitoring responsibilities rest with the **Deputy Director, Assistant Director, Registration Officer, and Upazila** and **UCD Social Services Officers**.

As shown in **Figure 2,** the program has significantly expanded over the last three decades, both in terms of budget and number of residents. Between 1991 and 2022, the number of residents and overall financial investment has grown markedly (data provided by DSS, November 2023).

[14]According to Article 2A (3) of the Orphanage and Widows' House Act of 1944, the word 'orphan' refers to any child under the age of 18 whose father is dead and has been abandoned by his parents or legal guardian.

Figure 2 Institutions receiving capitation grant, residents and budget 1991-2022.



The average number of children per institution has increased from 11.3 in 1991–1992 to 28.3 in 2023–2024 (see Table 1).

Table 1 Average number of children with capitation grant per fiscal year.

Fiscal year	1991-1992	2001-2002	2011-2012	2021-2022	2023-2024
Average # of children per institution	11,3	15,3	15,5	26, 4	28,3

The amount of the monthly allocation per capita is 2000 thaka.

As of the 2023–2024 fiscal year, the capitation grant is being provided to approximately 116,666 children across 4,118 private orphanages.[15]

2.4 Institutional Architecture for Child Protection and Alternative Care

The child protection and alternative care system in Bangladesh is supported by a range of government institutions, statutory bodies, and civil society actors working in coordination to uphold children's rights and well-being.

The Ministry of Social Welfare

The **Ministry of Social Welfare (MoSW)** plays a central role in promoting the welfare of marginalized and disadvantaged populations, including vulnerable children. Under MoSW, the **Department of Social Services (DSS)** is responsible for implementing national social protection and child welfare programs, including oversight of the **Children Act 2013.**

[15]DSS site updated 19 January 2023

At the national level, DSS is organized into key functional units:

- **Administration and Finance:** Manages grants and financial oversight for institutions, including orphanages.
- **Institutional Services:** Oversees the regulation, management, and monitoring of residential care facilities.
- **Community-Based and Youth Services:** Responsible for registration and control of community initiatives.
- **Social Safety Net Programmes:** Implements and manages safety net schemes targeting vulnerable populations.
- **Child Protection (CP) Unit:** A newly established unit responsible for overseeing child protection services across Bangladesh and coordinating CP-related projects and programs supported by development partners. The CSPB project plays a central role in supporting the development and operationalization of this unit, strengthening its capacity to lead national child protection interventions, including case management, prevention of family separation, and community-based mechanisms such as CBCPCs.

Under Institutional Services, residential care facilities are organized under the following categories:

- **Child Protection 1**
  - Government orphanages (Shishu Paribar)
  - Baby Homes (Chotomoni Nibash)
  - Training and rehabilitation centres for destitute children
- **Child Protection 2**
  - Capitation grant-supported institutions
  - Sheikh Russel Children's Homes
- **Disability Services**
  - Schools for visually impaired children
  - Centres for children with hearing or speech impairments
  - Institutions for children with intellectual disabilities
- **Prevention of Social Degradation (Adolescent Development & Probation)**
  - Training and rehabilitation centres for socially disadvantaged women
  - Safe Homes
  - Vagrant Homes

DSS maintains a network of offices at the **division, district, and upazila levels. District-level DSS offices** are primarily responsible for managing and monitoring residential childcare institutions.

Child Welfare Boards

Established under the Children Act 2013, Child Welfare Boards (CWBs) are multi-sectoral statutory bodies mandated to safeguard the rights and welfare of children in need of care and protection.

- **The National Child Welfare Board, chaired by the Minister of Social Welfare, includes high-level representatives from:**
    - Parliament (including two female MPs)
    - Police, Ministry of Home Affairs, Ministry of Women and Children Affairs
    - Ministries of Education, Labour and Employment, Local Government, Information, and Justice
    - Legislative and Parliamentary Affairs Division
    - The Supreme Court Bar Association
    - One non-governmental representative

Key responsibilities include:

- Developing and monitoring child protection policies and guidelines
- Overseeing and inspecting residential childcare facilities and child development centres
- Placing children in alternative care and acting as guardian where no parent is available
- Coordinating national and local implementation of child protection programmes

District and Upazila Child Welfare Boards mirror the structure and functions of the national board and serve as the frontline decision-making bodies for children in contact with the law or those referred for protection. Their specific responsibilities include:

- Deciding the most suitable type of alternative care
- Reviewing children's care and protection plans
- Supervising child development centres and certified institutions

Meeting Frequency:

- National Board: Every 6 months
- District Boards: Every 4 months
- Upazila Boards: Every 3 months

Ministry of Women and Children Affairs (MoWCA)

The **Ministry of Women and Children Affairs (MoWCA)** plays a policy leadership role in promoting the rights and protection of children. It oversees:

- **Bangladesh Shishu Academy,** which promotes children's cultural development and child rights awareness
- **Several residential institutions** that provide shelter and protection to vulnerable children, particularly those in need of emergency or temporary care

MoWCA works closely with other ministries and development partners to implement national child protection strategies and child-focused services.

Non-governmental organizations

Numerous NGOs in Bangladesh play an active role in delivering child protection services. These include:

- Operating shelters and care centres for children at risk
- Providing non-formal education, psychosocial support, and reintegration services
- Advocating for policy reform and promoting children's rights

A limited number of NGOs operate **residential care facilities** in alignment with government priorities, often in partnership with DSS or MoWCA. However, many NGO-run services are focused on **community-based prevention**, family strengthening, and early intervention efforts.

03

Methodology

This study employed a **mixed-methods approach**, combining both **quantitative and qualitative research techniques** to provide a comprehensive understanding of the institutional residential care landscape in Bangladesh. The methodology was designed to assess both the **profile of children in care**—including age, sex, and disability status—and the **capacity, characteristics, and practices** of the institutions providing care.

Custom research tools were developed to capture:

- Demographic data on children in care;
- Infrastructure, staffing, and services within facilities;
- Budget and funding sources;
- Governance, licensing, and accreditation status;
- Adherence to protocols, care standards, and operating procedures.

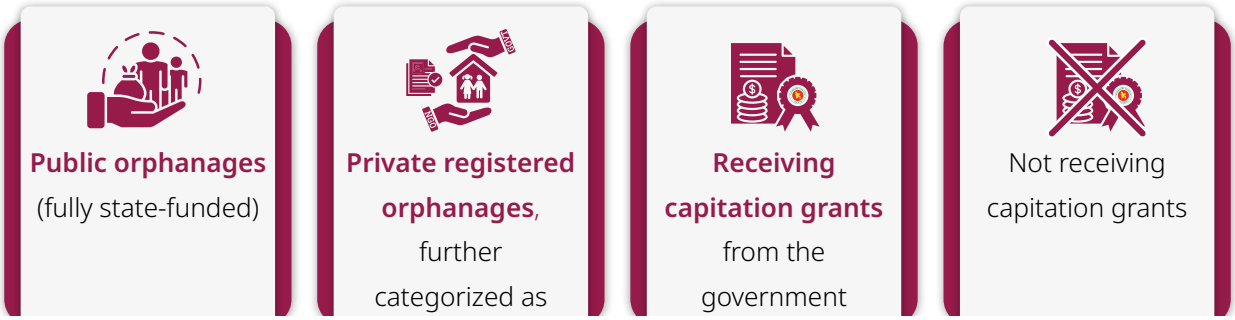
At the outset, the **Development Research Initiative (dRi)** conducted a **rigorous desk review** and collaborated with technical experts from **UNICEF and the Department of Social Services (DSS)** to finalize a typology of residential care facilities. Following the development and validation of the study tools, dRi trained field enumerators and mobilized them for nationwide data collection.
The data collection process was followed by **systematic analysis**, with initial findings presented to UNICEF for feedback. The final report incorporates inputs from UNICEF technical teams, DSS counterparts, and the **international consultant** supporting the study, ensuring that the results are both methodologically sound and aligned with programmatic priorities.

3.1 Sampling and Data Collection Method for Quantitative Study

Sampling Method

There are an estimated **4,000 residential childcare institutions** operating across Bangladesh. Given the scale and diversity of these facilities, it was not feasible to conduct a full census. Instead, the research team employed a **stratified purposive sampling strategy,** using the official list of registered facilities provided by the **Department of Social Services (DSS).**

The sampling strategy aimed to ensure geographic representation and typological diversity across both public and private residential care facilities. The primary facility types included in the sampling frame were:



For categories with **fewer than eight registered facilities,** the study included all available institutions. For categories with **more than eight facilities,** the team selected **two facilities per division** (one urban and one rural where possible), ensuring **representation from all eight administrative divisions** of Bangladesh. This yielded an intended sample size of **168 institutions, with 16 facilities per typology.**

Due to field-level challenges and institutional access constraints, the final sample included **157 alternative care institutions**—a slight deviation from the original design. These 157 facilities were subsequently organized and analyzed according to their **typology, governance, and funding source,** providing a comprehensive and representative overview of the national residential care landscape.

In the table below, given the high number of childcare facilities, the sample has been organized per categories, namely:

Table 2 Sample Distribution.

Type of institution	Total Number	Sampling criteria	Proposed Sample size from each category	Conducted Tool 1 (Facility assessment)	Conducted Tool 2 (Children's profile)
Type I. PUBLIC, FULLY GOVERNMENT FUNDED					
Public Orphanage	85	2/division (1 rural,1 urban)	16	17	16
Safe Home	6	All	6	6	5
Baby Home	6	All	6	5	5
Rehabilitation Centre for Socially Disabled Girls	6	All	6	4	4
Vagrant Homes	5	All	5	0	0
Sheikh Russel Children Training and Rehabilitation Centre	13	1/division	7	8	8
MOWCA Centres/ Shelter homes	6	All	6	5	5
Residential integrated centres for children with disabilities (visually impaired)	66	2/division (1 rural,1 urban)	16	16	15

Type of institution	Total Number	Sampling criteria	Proposed Sample size from each category	Conducted Tool 1 (Facility assessment)	Conducted Tool 2 (Children's profile)
PHT centres	12	1/division	6	6	6
Dumb and deaf school	4	All	4	4	4
Mental disabled children institute	1	All	1	1	0
National special education centre	1	All	1	1	1
SUK/Child Development Center	3	All	3	3	1
TOTAL	**211**		**83**	**76**	**70**
Type II. PRIVATE REGISTERED					
STATE SUPPORTED Orphanages (Capitation grant)[16]					
1-20 children	2151	2/division (1 rural,1 urban)	16	16	16
20-50 children	1542	2/division (1 rural,1 urban)	16	15	15
50- 100 children	320	2/division (1 rural,1 urban)	16	16	16
Over 100 children	49	2/division (1 rural,1 urban)	16	15	15
TOTAL	**4062**		**64**	**62**	**62**
Type III. PRIVATE REGISTERED (No Capitation Grant)					
Orphanages		2/division (1 rural,1 urban)	**16**	**15**	**15**
Type IV. RESIDENTIAL ALTERNATIVE CARE FACILITIES RUN BY INTERNATIONAL NGOS					
Dhaka Ahsania Mission		Yes	1	1	0
LEEDO		Yes	1	1	1
Association for Community Development		Yes	1	1	1
BERDO		Yes	1	1	1
TOTAL			**5**	**4**	**3**
GRAND TOTAL			**168**	**157**	**150**

[16]These facilities are very homogeneous in origin, operation and structure, hence instead of proportionate sampling, only geographic dispersion is considered here.

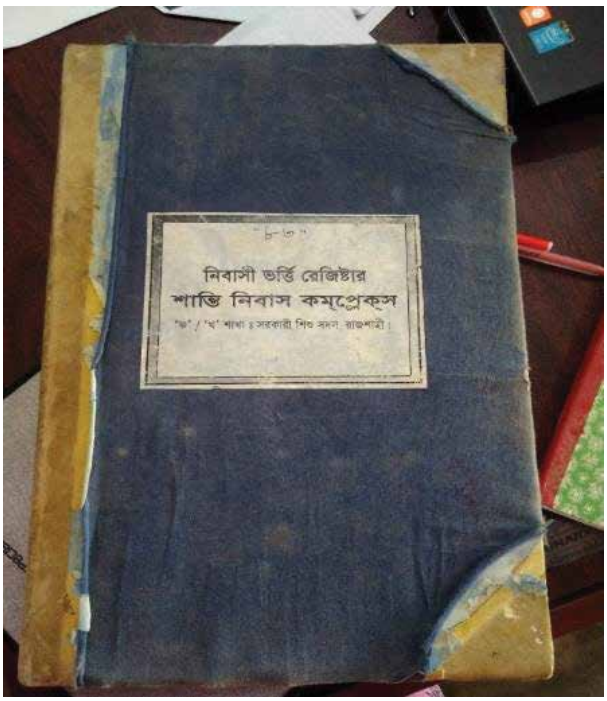
Data collection method

Data collection method for Facility Assessment

For the **Facility Assessment (Tool 1),** structured interviews were conducted with institutional authorities—typically the **managers, superintendents, or directors** of residential care facilities. These interviews took place on-site, generally within the office of the facility head.(sample provided in Figure 3).

In addition to oral responses, enumerators **reviewed institutional records and documentation** to validate and cross-check reported data. This included reviewing **registers, staff rosters, admission records, and infrastructure-related documents**, where available. Where discrepancies or missing information were encountered, field teams noted the limitations and triangulated data where possible.

Figure 3: Picture of a register that was reviewed during data collection



Facility assessments were completed in **all 157 institutions** included in the final sample. Each interview took approximately **two hours,** depending on the availability of documents and the complexity of the institution's structure and services.

The combination of structured interviews and document review provided a comprehensive understanding of each facility's operations, registration status, staffing, infrastructure, services, and compliance with care standards.

Data collection method for Children's Profile

For the **Children's Profile Assessment (Tool 2),** data were collected in **150 out of the 157 sampled institutions,** reflecting a slight deviation from the original plan. The reasons for this deviation—including access limitations and documentation gaps—are detailed in **Section 3.1.3** of this report.

Tool 2 focused on collecting **individual-level information** on children residing in institutional care, including data on age, sex, disability status, health, education, admission modality, care plans, and family background. Information was obtained through **structured interviews** with facility staff—such as dormitory supervisors or child welfare officers—and by **reviewing children's files and admission registers,** where available.

Due to these constraints, the **total number of profiled children** was lower than the total number of children residing in the institutions. Despite this limitation, the data collected offers a rich and representative overview of the demographic and care-related characteristics of children in residential care across the sampled facilities.

Summary figures on the total number of residents, children, and profiled cases are presented in **Table 3.**

Table 3 Total number of residents, children, and profiled residents.

Total residents[17]			Total children[18]			Profiled children (tool 2)[19]	
13,838			**13,081**			**10,678**	
157 institutions			**157 institutions**			**150 institutions**	
Male	**Female**	**No response**	**Male**	**Female**	**No response**	**Male**	**Female**
10,204	3,443	191	9,901	2,989	191	7,443	3,235

For **Tool 2**, data collection was conducted through **interviews with facility authorities and dormitory supervisors,** complemented by a **review of resident files and documentation**. Information was cross-verified using available records such as admission forms, birth certificates, health cards, and education documents.

The **time required to complete profiling per child** varied depending on the availability and organization of records. Where documentation was complete, it took approximately **3–5 minutes per child** to review files and enter the data.

Across the **150 institutions where Tool 2 was applied**, the total number of residents was **12,546.** Although the intention was to profile every child, the field team was only able to complete **10,678 profiles**, leaving **1,868 children unprofiled**. The discrepancy was due to a combination of practical and administrative challenges.

In **public institutions**, where Tool 2 was conducted in **70 facilities**, specific barriers included:

- **High resident volume:** In two large institutions (with 336 and 176 residents, respectively), it was not feasible to complete full profiling within the time available. The team gathered partial data from these centres.
- **Incomplete documentation:** In 13 institutions, critical documents such as **birth certificates or care plans** were missing or incomplete, limiting verification.

[17]"Residents" refer to all residents irrespective of age range, i.e., including children between 0-18 years, youth between 18-21 years, adult above 21 years, and elderly. Residents are referred accordingly throughout the report.

[18]"Children" refers to only the residents between 0-18 years of age. Children are referred accordingly throughout the report.

[19]"Profiled residents" refer children between 0-18 years, youth between 18-21 years who have been profiled using Tool 2. Tool 2 was conducted in 150 institutions of the sample. Profiled children are referred accordingly throughout the report.

Additional field challenges included:

- **Fragmented custody of records:** (a) In some institutions, children's files were held by multiple dormitory supervisors ("Khalas"), and only one was present during the visit. The absence of the others meant several records could not be accessed.
- **Non-disclosure of staff children's data and age-related exclusions:** (b) In one facility, 14 children were identified as offspring of staff members and the institution declined to provide their data. Additionally, 11 residents were reportedly over the age of 21, and the management could not validate their age through documentation.
- **Relocation in progress:** (c) One facility was in the process of relocating, and could not provide access to resident files during the field visit, despite the presence of UNICEF field staff.

Despite these limitations, the breadth and depth of data collected offer a **robust and representative** overview of children residing in institutional care and provide valuable insights into operational bottlenecks, documentation practices, and institutional capacities.

Respondents

Respondents engaged in the data collection process represented a **diverse range of staff categories** across the sampled institutions. In most cases, the individual responding to the interview was the most **knowledgeable staff member available at the time of the visit**, though not always the designated head of the facility.

The **largest share of responses (40%)** came from individuals in **managerial positions**, including directors, coordinators, managers, and deputy managers.

Professional staff—primarily **teachers**, but also including a limited number of **social workers**—comprised **approximately 37%** of respondents.

Administrative personnel (e.g., clerical or finance staff) accounted for **19%** of respondents.

A small proportion **(3%)** of interviews were conducted with **non-professional staff**, such as support or auxiliary personnel.

This distribution reflects a contextual reality where, in the absence of the facility manager or head, field teams interviewed the best-informed available staff member. While this approach ensured continuity

in data collection, it may have introduced some variability in the depth and specificity of responses, particularly in relation to institutional protocols or case management practices.

The respondent categories are detailed in **Annex 3: Staff Categories**. The study's findings were derived from interviews with 63 residential care managers, 64 practitioners[20] and 30 admins.

Table 4 Category of facility staff who were interviewed.

Category of Institution	Category of staff interviewed			
	Manager n(%)	Admin n(%)	Practitioners n(%)	Total (N)
Total (n %)	**63 40.13%**	**30 19.11%**	**64 40.76%**	**157**
Baby Home	2 40%	2 40%	1 20%	5
Madrassa/religious education school	39 59.09%	8 12.12%	19 28.78%	66
MOWCA Centre	0	1 20%	4 80%	5
NGO (national and international)	3 75%	1 25%	0	4
PHT Centres	1 16.67%	1 16.67%	4 66.67%	6
Private orphanage	6 54.55%	2 18.18%	3 27.27%	11
Public orphanage	2 11.76%	9 52.95%	6 35.29%	17
Residential Centre for Children with Disabilities	4 18.18%	0	18 81.81%	22
Rehabilitation Centre for Socially Disabled Girls	1 25%	2 50%	1 25%	4
Safe Home	2 33.33%	2 33.33%	2 33.33%	6
Sheikh Russel Home	3 37.50%	1 12.50%	4 50%	8
SUK/CDC	0	1 33.33%	2 66.67%	3

Qualitative data collection

To complement the quantitative analysis, the study employed **qualitative methods** aimed at exploring - **child participation, - child safeguarding,** and - **perceptions of service quality** within residential childcare institutions.

Field teams used **open-ended questions** during interviews to capture detailed insights from respondents. These responses were **transcribed verbatim** and analyzed using a **content analysis**

[20]Practitioners included childcare staff, education staff, healthcare staff, social workers, and therapists & counsellors

framework, allowing the research team to identify **recurring themes, patterns, and institutional narratives** across facility types.

The qualitative data enriched the study by offering a **deeper, context-sensitive understanding** of institutional practices, staff perceptions, and lived experiences—elements often not captured through structured tools alone. This approach helped illuminate both systemic strengths and critical gaps in care provision, safeguarding protocols, and accountability mechanisms.

By integrating these findings with the quantitative data, the study presents a **more holistic view** of the child protection and residential care landscape in Bangladesh.

Type I: Public, fully state-funded facilities

- **Public Orphanage**

  One facility, Sarkari Shishu Paribar (Mirpur-10, Dhaka), did not allow implementation of Tool 2 (Children's Profile). The superintendent stated that, upon consultation with DSS, they were instructed not to provide resident information.

- **Safe Home**

  In Women and Children Juvenile Safe Home, Sylhet, Tool 2 could not be implemented. While general facility information was shared, the superintendent declined to provide resident data without a court order, citing confidentiality requirements for juvenile cases.

- **Baby Home**

  At Chotomoni Nibash, Azimpur (Dhaka), the facility in-charge declined participation altogether, resulting in the exclusion of both Tool 1 and Tool 2.

- **Rehabilitation Centres for Socially Disabled Girls**

  Two institutions (Bagura and Brahmanbaria) were found to be closed at the time of the visit, preventing interviews or data collection.

- **Vagrant Homes**

  None of the vagrant homes listed by DSS were operational at the time of fieldwork, resulting in complete exclusion of this category.

- **MOWCA Centers/Shelter Homes**

  Chittagong Shishu Bikash Kendra, listed under MOWCA, was found to be permanently closed upon arrival.

- **Institute for Children with Intellectual Disabilities:**

  The only such facility in Chittagong declined to participate in Tool 2, citing the absence of a facility-specific authorization letter and confidentiality policies.

- **Shishu Unnayan Kendras (SUK/CDC)**
  Two facilities—one for boys in Tongi, Gazipur, and one for girls in Konabari, Gazipur—refused to share resident-level information despite being shown the official authorization letter, again citing confidentiality restrictions.

Type II: Private registered, state-supported orphanages

- **No deviations** were encountered. All targeted facilities under this category participated fully in the data collection process.

Type III: Private registered (no capitation grant)

- DSS was unable to provide a definitive list of privately registered institutions that do not receive capitation grants. As a result, the field team used a **snowball sampling approach** to identify these facilities.
- In one instance, a facility in **Mymensingh Division** was found to be non-operational, as it no longer had resident children, resulting in a slight shortfall in the intended sample size.

These deviations, while modest in scope, reflect real-world challenges in conducting large-scale research in a diverse and fragmented institutional landscape. The adjustments were made while maintaining the **integrity, representativeness, and regional balance** of the study.

3.2 Challenges During Data Collection

Throughout the implementation of the study, the research team encountered a range of operational and administrative challenges that impacted the data collection process across all facility types. These challenges, while not unexpected given the diversity of institutions and regulatory environments, led to delays, deviations from the original sampling plan, and in some cases, partial or missing data.

Type I: Public, fully state-funded facilities

Bureaucratic and access barriers

A key challenge faced during data collection in public institutions was the limited recognition of the official authorization letter issued by UNICEF. Several facility heads refused to cooperate based solely on the letter, citing concerns over:

- Confidentiality
- Overlapping commitments (e.g., Eid holidays)
- Uncertainty about the legitimacy of the data collection

To overcome these barriers, field researchers were often required to:

- Seek **additional permissions** from Divisional **Directors and Deputy Directors** of the CSPB Project;
- Obtain **written validation** at the **district and upazila levels;**
- Leverage **local relationships** and dRi's institutional network to build trust with facility staff.

In some divisions, such as **Rangpur**, supplementary authorization letters were issued by division-level directors, explicitly naming each district to facilitate smoother access.

Despite these efforts, **delays were significant**, and in several cases, **data could not be collected at all**, as reflected in the final sample distribution.

Type II: Private registered facilities (state-supported orphanages)

Influence of ownership and perceived risks

Many of these institutions are registered under the names of **influential individuals**—including political, religious, or community leaders. This status occasionally created resistance to full disclosure due to fears that the findings could:

- Jeopardize their capitation grant eligibility; or.
- Lead to increased scrutiny from government regulators.

Even after being assured of confidentiality, **some respondents withheld critical financial or child-level data.**

Lack of documentation for informal donations

Many state-supported private facilities receive **additional community-based donations** (e.g., from local leaders, mosque committees), which are:

- Poorly documented or not recorded in official budgets;
- Used for facility operations and children's welfare, but without formal tracking.

This lack of transparency limited the study's ability to provide a **complete picture of financial flows** and institutional sustainability.

Type III: Private registered facilities (non-capitation grant)

Absence of a centralized registry

The **DSS was unable to provide a comprehensive list** of privately registered facilities not receiving capitation support. As a result, the field team adopted a **snowball sampling strategy**, identifying eligible facilities through informal networks and referrals during field visits.

This approach presented several logistical challenges:

- Researchers had to **travel across multiple districts** to locate eligible and operational institutions;
- Many facilities were **non-functional**, had **no residents**, or refused participation;
- The process significantly **extended the data collection timeline** and contributed to the **slight deviation** in the final sample size.

These challenges reflect broader systemic issues in **governance, registration, and oversight** of residential care institutions in Bangladesh. They underscore the **urgent need for a unified, regularly updated database of all facilities**, enhanced transparency in institutional operations, and stronger inter-agency coordination to facilitate future research and monitoring efforts.

3.3 Dataset Limitations

While the study employed rigorous data collection and verification protocols, several limitations were encountered that impacted the completeness and consistency of the dataset. These limitations stemmed largely from systemic weaknesses in institutional documentation, access, and transparency.

- **Missing Information Due to Poor Documentation and Verification Gaps** – Tool 2 required sensitive, child-specific data to be verified through official documentation (e.g., birth certificates, admission forms, health records). However, many institutions—particularly public facilities—lacked adequate record-keeping systems. As a result:
    - Some child profiles remained incomplete or unverified;
    - Data inconsistencies arose where documents were missing or contradictory;
    - Institutional practices varied widely in how resident information was recorded and stored.
- **Transparency and Disclosure Barriers:** Despite receiving the necessary authorizations, several public institutions declined to share key data, particularly related to:
    - **Facility budgets** and expenditures, often citing confidentiality;
    - **Child-level documentation,** such as care plans or birth certificates, which were either missing, disorganized, or inaccessible.

  This lack of transparency hindered the ability of the research team to validate institutional practices and fully assess compliance with care standards.
- **Incomplete Budget Data in Non-Capitation Facilities:** Private registered facilities that do not receive government capitation support typically rely on **informal funding streams**, including:
    - Local donations,.
    - Religious and community contributions,.
    - Personal networks of facility founders or managers.
- While these institutions often maintain financial records for auditing purposes, many lacked **consolidated or itemized budgets** that could be reviewed or shared. This made it difficult for researchers to obtain a complete picture of:
    - Funding adequacy;
    - Expenditure on child welfare;
    - Financial sustainability of operations.

04

Findings:
Institutional Landscape and Systemic Practices

This section presents a system-level overview of the residential care landscape in Bangladesh. Drawing on data from 157 institutions, it outlines the types and geographic distribution of facilities, registration and licensing status, admission pathways, physical infrastructure, and population size. It further explores systemic practices such as promotional admissions, infrastructure expansion, and cohabitation patterns that contribute to the normalization and overuse of institutional care. These findings provide critical context for understanding the operational environment in which children are placed and the extent to which residential care is being used in line with national policy and international norms.

4.1 Overview of Residential Care

Geographic distribution of sampled facilities

This study assessed 157 residential childcare facilities across Bangladesh, representing a diverse range of public and private institutions. Table 5 presents the division-wise distribution of sampled facilities. The highest concentration was found in Dhaka Division (16.6%), followed by Chittagong and Khulna (15.3% each). Other notable shares include Rajshahi (12.7%), Sylhet and Barisal (around 11%), Rangpur (10.2%), and Mymensingh (7.6%).

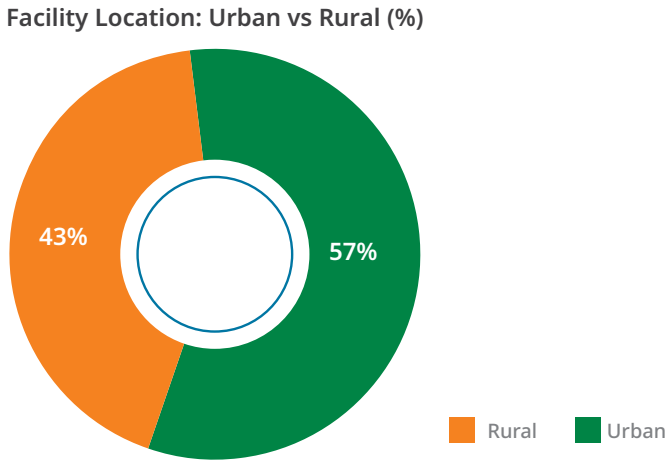
Table 5 Division-wise distribution of sampled facilities: n (%)

Division	Frequency (n)	Percentage (%)
Barisal	17	10.8
Chittagong	24	15.3
Dhaka	26	16.6
Khulna	24	15.3
Mymensingh	12	7.6
Rajshahi	20	12.7
Rangpur	16	10.2
Sylhet	18	11.5
Total	**157**	**100%**

Urban-rural distribution

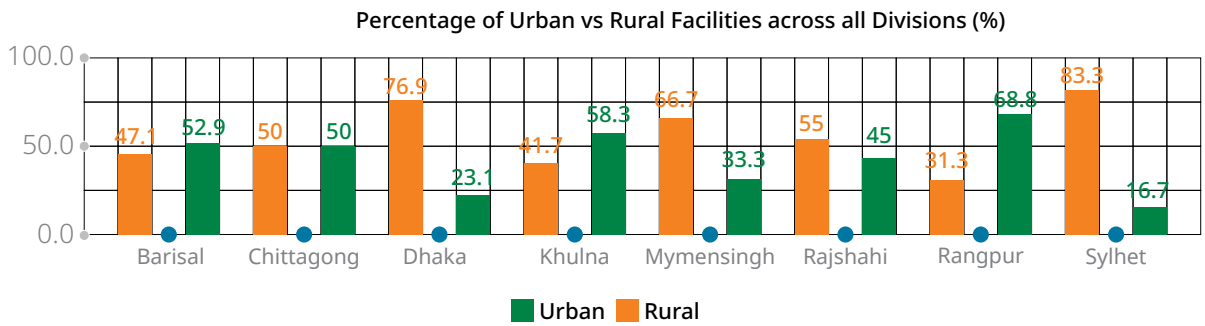
As shown in Figure 1, 56.7% of the surveyed facilities (n=89) were located in urban areas, while 43.3% (n=68) were situated in rural regions. "Rural" was defined as areas outside city corporations and municipalities.

Figure 4: Facility Location: Urban vs Rural (%)



A regional breakdown shows notable rural facility concentrations in **Rangpur (68.8%), Khulna (58.3%), and Barisal (52.9%).** In contrast**, Sylhet (83.3%), Dhaka (76.9%), Mymensingh (66.7%),** and **Rajshahi (55%)** had higher urban facility representation. Chittagong exhibited an even distribution across both areas (50% urban and 50% rural). See Figure 3.

Figure 5 : Percentage of urban vs rural facilities across all divisions



Distribution by facility type and division

Table 3 details the spread of different types of institutions across divisions. The assessment included:

- **Public, fully government-funded institutions,** such as orphanages, baby homes, and special education centers;
- **State-supported private orphanages** receiving **capitation grants**, categorized by size (1–20, 20–50, 50–100, over 100 children);
- **Private registered institutions** not receiving state funding; and.
- **Residential alternative care facilities run by international NGOs.**

This stratification allows for comparison of infrastructure, funding sources, and care models across administrative regions.

Table 6 Type of Institution Sampled by Division.

			Divisions							
Type of institution	**Total #**	**Sample size**	**Barisal**	**Chittagong**	**Dhaka**	**Khulna**	**Mymensingh**	**Rajshahi**	**Rangpur**	**Sylhet**
Type I. PUBLIC, FULLY GOVERNMENT FUNDED										
Public Orphanage	85	17	2	3	2	2	2	2	2	2
Safe Home	6	6	1	1	1	1	0	1	0	1
Baby Home	6	5	1	1	0	1	0	1	0	1
Rehabilitation Centre for Socially Disabled Girls	6	4	1	0	1	1	0	0	0	1
Vagrant Homes	5	0	0	0	0	0	0	0	0	0
Sheikh Russel Children Training and Rehabilitation Centre	13	8	1	2	1	1	0	1	1	1
MOWCA Centres/ Shelter homes	6	5	0	0	3	1	0	1	0	0
Residential integrated centres for children with disabilities (visually impaired)	66	16	2	2	2	2	2	2	2	2
PHT centres	12	6	1	1	1	1	0	1	0	1
Dumb and deaf school	4	4	0	1	1	1	0	0	0	1
Mental disabled children institute	1	1	0	1	0	0	0	0	0	0
National special education centre	1	1	0	0	1	0	0	0	0	0
SUK/CDC	3	3	0	0	2	1	0	0	0	0
Sub-total	**211**	**76**	**9**	**12**	**15**	**12**	**4**	**9**	**5**	**10**
Type II. PRIVATE REGISTERED, STATE SUPPORTED Orphanages (Capitation Grant)[21]										
1-20 children	2151	16	2	2	2	2	2	2	2	2
20-50 children	1542	15	2	2	1	2	2	2	2	2
50- 100 children	320	16	2	2	2	2	2	2	2	2
Over 100 children	49	15	2	2	2	2	1	2	2	2
Sub-total	**4062**	**62**	**8**	**8**	**7**	**8**	**7**	**8**	**8**	**8**
Type III. PRIVATE REGISTERED (No Capitation Grant)										
Orphanages	-	**15**	**0**	**4**	**2**	**4**	**1**	**2**	**2**	**0**

[21]These facilities are very homogeneous in origin, operation and structure, hence instead of proportionate sampling, only geographic dispersion is considered here.

			Divisions							
Type of institution	**Total #**	**Sample size**	**Barisal**	**Chittagong**	**Dhaka**	**Khulna**	**Mymensingh**	**Rajshahi**	**Rangpur**	**Sylhet**
Type IV. RESIDENTIAL ALTERNATIVE CARE FACILITIES RUN BY INTERNATIONAL NGOS										
Dhaka Ahsania Mission	1	1	0	0	0	0	0	0	1	0
LEEDO	1	1	0	0	1	0	0	0	0	0
Association for Community Development	1	1	0	0	0	0	0	1	0	0
BERDO	1	1	0	0	1	0	0	0	0	0
Sub-total	**4**	**4**	**0**	**0**	**2**	**0**	**0**	**1**	**1**	**0**
TOTAL		**157**	**17**	**24**	**26**	**24**	**12**	**20**	**16**	**18**

Private facility breakdown

A closer look at private institutions (Table 7) shows that 82.5% of them were affiliated with **madrassas or religious education schools**, while **12.5%** were classified as private orphanages and 5% were NGO-operated. Private facilities were most concentrated in **Chittagong (15%), Khulna (15%), and Dhaka (13.75%).**

Table 7 Division-wise distribution of sampled private facilities.

Private funding Institution	**Barisal**	**Chittagong**	**Dhaka**	**Khulna**	**Mymensingh**	**Rajshahi**	**Rangpur**	**Sylhet**	**Total (N)**
Total (n %)	**8 (10%)**	**12 (15%)**	**11 (13.75%)**	**12 (15%)**	**8 (10%)**	**10 (12.5%)**	**11 (13.75%)**	**8 (10%)**	**80 100%**
Madrassa/ religious education school	7 (10.61%)	7 (10.61%)	8 (12.12%)	12 (18.18%)	8 (12.12%)	8 (12.12%)	10 (15.15%)	6 (9.09%)	66 82.5%
NGO (national and international)	0	0	2 (50.00%)	0	0	1 (25.00%)	1 (25.00%)	0	4 5%
Private orphanage	1 (10%)	5 (50%)	1 (10%)	0	0	1 (10%)	0	2 (20%)	10 12.5%

4.2 Facilities' Categorization

To enable a comprehensive analysis, the 157 sampled public and private institutions were grouped into 12 categories, based on their administrative status and the specific populations they serve. This classification supports clearer interpretation of data and key trends.

Public residential childcare institutions

- **Baby Homes:** These facilities cater to abandoned or endangered children aged 0–7 years. The Director General of DSS serves as the statutory guardian. The number of Baby Homes has increased from three in 2008 (serving 225 infants) to six today, with a total capacity of 550 children[22]. Uponturning 7, children are either reunited with family or transferred to another facility.
- **MOWCA Centres:** Operated by Bangladesh Shishu Academy under the Ministry of Women and Children Affairs, these residential centres provide care and protection to vulnerable children.
- **PHT Centres:** These three facilities (two for boys, one for girls) serve destitute children with disabilities, typically admitted between 8–9 years of age. Services include accommodation, education, vocational training, and employment support until age 18.
- **Public Orphanages (Shishu Paribar):** A total of 85 government-run orphanages currently host around 10,300 children aged 6–18 years and beyond[23] . Entry is based on an application reviewed by a committee, with advertisements issued when vacancies arise. The DSS Institutional Services Branch manages these facilities.
- **Rehabilitation Centres for Socially Disabled Girls (RCSDGs):** Six centres were established between 2002–2003 to support girls formerly involved in sex work. Services include protection, education, vocational training, psychological support, and reintegration assistance.
- **Residential Centres for Children with Disabilities (RCCDs):** These include Residential Integrated Centres for Visually Impaired Children, Dumb and Deaf Schools, the Institute for Mentally Disabled Children, and the National Special Education Centre.
- **Safe Homes:** Located in six divisions (seven centres in total), Safe Homes provide interim shelter and services (education, healthcare, legal aid, and vocational training) for women, children, and adolescents awaiting legal proceedings under the Children Act 1974, the Prevention of Violence Against Women and Children Act 2000, or related laws. The court determines the length of stay.
- **Sheikh Russel Children Training and Rehabilitation Centres:** Launched in 2012, these centres provide care and training for children in need of protection. Each is designed for 100 boys or 100 girls (in separate centres), with a maximum stay of two years (extendable by one year). According to DSS data, the number of residents has decreased from 2,402 (2015–16) to 710 (2022–23), while reunification rates have increased.
- **SUK/Child Development Centres (CDC):** Managed by DSS, these include one centre in Tongi (est. 1978) for 200 boys, one in Konabari (2003) for 150 girls, and one in Jessore (1995) for 150 boys. They serve children deemed "uncontrollable" by parents or referred by courts under suspicion, accusation, or conviction[24] .

[22]UNICEF, Situation assessment and analysis of children and women in Bangladesh, 2009

[23]DSS – NSSS presentation, without date

[24]According to the Guidelines, residential facilities hosting children in conflict with the law should not be considered as "alternative care facilities". However, we decided to include the SUK/CDC in our study as they also host children in need of care and protection, which aligns with the criteria for "alternative care arrangements".

Private residential childcare institutions

- **Madrassas:** These are residential institutions that provide care and support for orphaned or abandoned children within an Islamic educational setting. They aim to meet the children's basic needs while also imparting religious education and values. Madrassas are primarily funded through community donations, individual contributions, and support from religious or philanthropic organizations. Some madrassas receive Capitation Grants.
- **Private orphanages:** A private orphanage is an institution "aiming to nurture and develop the orphaned children of poor families in the country" who are orphaned or without parental care. These facilities may be supported by private donors, charitable foundations, or community-based fundraising efforts. Recipients of Capitation Grant, if registered and approved under the 2015 Allocation and Distribution Policy.
- **NGO-run residential care facilities:** These are institutions run by national or international NGOs providing care, protection, and shelter to children in vulnerable circumstances. Funding for these facilities typically comes from international donors, aid agencies, and development partners, often aligned with specific donor set child protection mandates.

Note: Some categories were fully captured in the sample, such as Baby Homes, RCSDGs, and Safe Homes. Others were sampled proportionally. This is outlined in Table 8 below:

Table 8 Institution Type and Sample Size Distribution.

Institution Type	Number of facilities in sample	Percentage of the sample	Percentage of total registered facilities
Baby Home	5	3.18%	100%
Madrassa/religious education school	66	42.04%	N/A[25]
MOWCA Centre	5	3.18%	83%
NGO (national and international)	4	2.55%	N/A
PHT Centers	6	3.82%	50%
Private orphanage	11	7.01%	N/A
Public orphanage	17	10.83%	20%
Residential Center for Children with Disabilities[26]	22	14.01%	30.56%
Rehabilitation Centre for Socially Disabled Girls	4	2.55%	66.67%
Safe Home	6	3.82%	100%
Sheikh Russel Home	8	5.10%	61.54%
SUK/CDC	3	1.91%	100%
Total / Average	**157**	**100%**	**68%**

[25]The cells presenting "N/A" indicate that no data could be found for total number of registered facilities currently operating in Bangladesh.

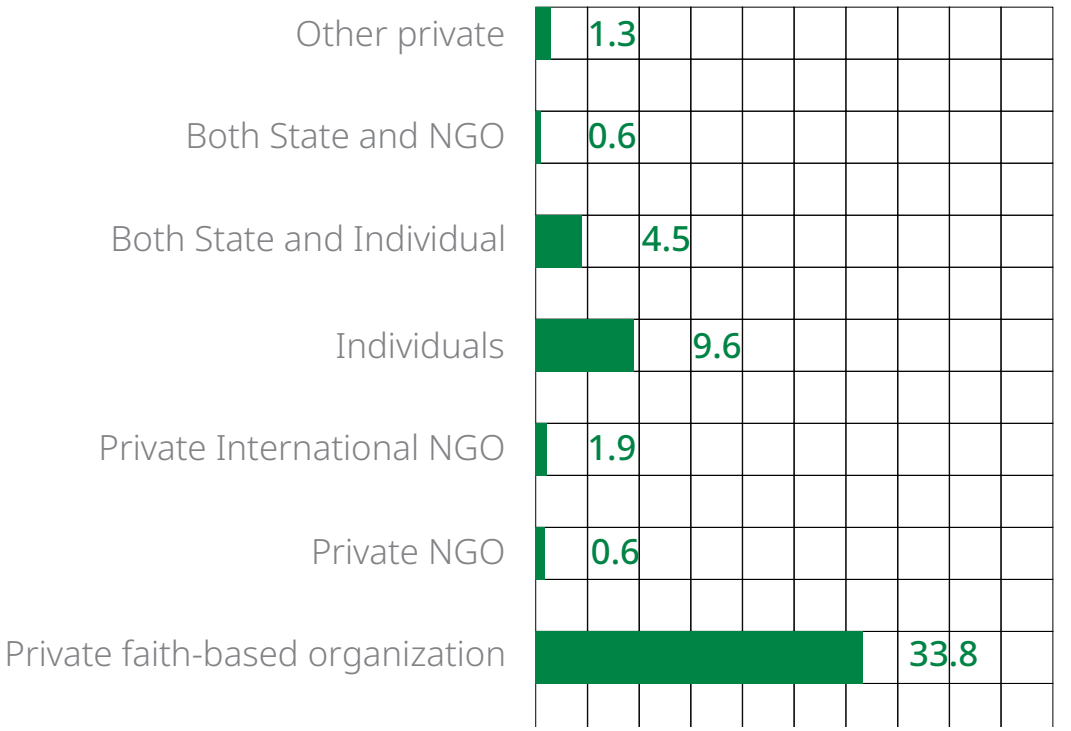
[26]Residential Center for Children with Disabilities compiles the following institutions: i) 16 (sixteen) Residential integrated centers for children with disabilities (visually impaired), ii) 04 (four) Dumb and deaf school, iii) 01 (one) Mental disabled children institute, and iv) 01 (one) National special education center

Categorization of facilities by operating authority and financial source

To gain a comprehensive understanding of facility types, this study categorized residential childcare institutions by their operating entity and funding source. As illustrated in **Figure 3,** nearly half of the facilities (47.8%) are exclusively operated by the State. An additional 4.5% are jointly managed by the State and individuals, and 0.6% are run in collaboration with both the State and NGOs.

Among private entities, faith-based organizations constitute the largest share, operating 33.8% of facilities. Individuals run 9.6%, followed by international NGOs (1.9%), other private entities (1.3%), and national NGOs (0.6%).

Figure 6 : Segmentation of Institutions by Operating Entity



Meanwhile, funding sources (see Table 6) reveal that **49.04%** of institutions are **fully State-funded**, which includes both those **operated directly by the government** and **private institutions receiving Capitation Grants**. The remaining **50.96%** are privately funded, either through individual donors, faith-based groups, or NGOs.

Table 9 Funding source of facilities across different categories.

Category	Public (Fully State funded)		Private		Total (N)
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	
Total	**77**	**49.04**	**80**	**50.96**	**157**
Baby Home	5	100	0	0	5
Madrassa/religious education school	0	0.00	66	100	66
MoWCA Centre	5	100	0	0	5
NGO (national and international)	0	0.00	4	100	4
PHT Centers	6	100	0	0	6
Private orphanage	1	9.09	10	90.91	11
Public orphanage	17	100	0	0	17
Residential Centre for Children with Disabilities	22	100	0	0	22
Rehabilitation Centre for Socially Disabled Girls	4	100	0	0	4
Safe Home	6	100	0	0	6
Sheikh Russel Home	8	100	0	0	8
SUK/CDC	3	100	0	0	3

4.3 Residential Facilities Assessment: Facility Profile

This section presents essential characteristics of the surveyed residential facilities, including registration status, communication activities, size, age, stated purpose, admission criteria, occupancy rates, and trends in child admissions and exits.

Registration

Registration with the government is the minimum legal requirement for a childcare institution to operate in Bangladesh. It involves meeting basic operational standards and submitting required documentation such as the institution's name, location, and governing details.

When asked about their registration status, **94.9%** of respondents **confirmed their facility was registered with the government,** while **5.1% reported being non-registered**. All private and NGO-run facilities reported being registered. However, **10.5% of respondents from government-funded facilities indicated their institutions were not registered, as shown in Table 10**

Table 10 Registration Status of facilities.

Category of the institution	Registered		Non-registered		Total (N)
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	
Total	**149**	**94.9**	**8**	**5.1**	**157**
Baby Home	5	100	0	0.00	5

Category of the institution	Registered		Non-registered		Total (N)
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	
Madrassa/religious education school	65	98.48	1	1.52	66
MOWCA Centre	5	100	0	0.00	5
NGO (national and international)	4	100	0	0.00	4
PHT Centers	6	100	0	0.00	6
Private orphanage	11	100	0	0.00	11
Public orphanage	17	100	0	0.00	17
Residential Centre for Children with Disabilities	17	77.27	5	22.73	22
Rehabilitation Centre for Socially Disabled Girls	4	100	0	0.00	4
Safe Home	6	100	0	0.00	6
Sheikh Russel Home	6	75.00	2	25.00	8
SUK/CDC	3	100	0	0.00	3

Note: Despite expectations, some state-funded institutions (such as Residential Centres for Children with Disabilities and Sheikh Russel Homes) were marked as non-registered by their respondents. This discrepancy persisted even after multiple rounds of clarification, which may reflect administrative or reporting gaps rather than actual legal status.

Registration by year of establishment

Data on the **year of registration** indicates that only **13 institutions** existed prior to Bangladesh's independence in 1971. Among these, four were public orphanages. Registrations increased significantly from 1991 onwards, peaking between **1991–2010**. Although the trend slightly declined post-2010, registration remained relatively high until 2020. Table 8 provides the breakdown by institution type and period of registration.

Table 8 highlights:

- Majority of Madrassas (28.8%) and Public Orphanages (41.2%) were registered between 1981–2000.
- Most Baby Homes and Sheikh Russel Homes were registered after 2001.
- NGO-run institutions and Safe Homes mostly registered between 1991–2020.
- A small portion (5.7%) remain unregistered or unverified.

Table 11 Year of Registration.

Category of Institution	1940-1950 n(%)	1950-1960 n(%)	1961-1970 n(%)	1971-1980 n(%)	1981-1990 n(%)	1991-2000 n(%)	2001-2010 n(%)	2011-2020 n(%)	2021-2023 n(%)	Unknown/ Not registered n(%)	Total (N)
Total (n %)	2 1.27%	2 1.27%	9 5.73%	16 10.19%	21 13.38%	33 21.02%	34 21.66%	24 15.29%	7 4.46%	9 5.73%	157
Baby Home	0	0	0	0	2 40%	0	3 60%	0	0	0	5
Madrassa/ religious education school	0	0	2 3.03%	4 6.06%	12 18.18%	19 28.79%	13 19.70%	9 13.64%	6 9.09%	1 1.52%	66
MoWCA Centre	0	0	0	0	0	0	3 60%	2 40%	0	0	5
NGO national and international)	0	0	1 25%	0	1 25%	2 50%	0	0	0	0	4
PHT Centres	0	0	3 50%	1 16.67%	0	0	0	2 33.33%	0	0	6
Private orphanage	0	0	1 9.09%	1 9.09%	2 18.18%	3 27.27%	0	3 27.27%	1 9.09%	0	11
Public orphanage	2 11.76%	2 11.76%	1 5.88%	7 41.18%	1 5.88%	1 5.88%	2 11.76%	0	0	1 5.88%	17
Residential Centre for Children with Disabilities	0	0	1 4.55%	2 9.09%	3 13.64%	6 27.27%	2 9.09%	3 13.64%	0	5 22.73%	22
Rehabilitation Centre for Socially Disabled Girls	0	0	0	0	0	1 25%	3 75%	0	0	0	4
Safe Home	0	0	0	0	0	0	6 100%	0	0	0	6
Sheikh Russel Home	0	0	0	0	0	0	1 12.50%	5 62.50%	0	2 25%	8
SUK/CDC	0	0	0	1 33.33%	0	1 33.33%	1 33.33%	0	0	0	3

Year of operation vs. registration gaps

The study also examined whether institutions began operations prior to obtaining registration, as per legal requirements, and whether any gaps existed between the start of operations and formal registration.

Year of Starting Operation: Analysis of institutional start years **(Table 9)** reveals that while a few facilities were established before 1971, most began operating in the 1991–2020 period. The highest proportion of facilities (22.3%) started between 2011–2020, followed by 2001–2010 (19.1%) and 1991–2000 (14.0%). Only 2 facilities (1.3%) reported beginning operations after 2020.

- Safe Homes, Sheikh Russel Homes, and Rehabilitation Centres for Socially Disabled Girls all began operation post-2000.
- Madrassas showed the broadest distribution, with several facilities beginning prior to 1971 and continuing up to 2020.
- Public orphanages and residential centres for children with disabilities had long-standing operations, many dating to the 1970s and 1980s.

Table 12 Year of starting operation

Category of Institution	Year of Starting Operation											
	Before 1900 n(%)	1900-1950 n(%)	1951-1960 n(%)	1961-1970 n(%)	1971-1980 n(%)	1981-1990 n(%)	1991-2000 n(%)	2001-2010 n(%)	2011-2020 n(%)	After 2020 n(%)	Unknown n(%)	Total (N)
Total (n %)	**2 1.27%**	**5 3.18%**	**4 2.55%**	**10 6.37%**	**21 13.38%**	**22 14.01%**	**30 19.11%**	**35 22.29%**	**25 15.92%**	**2 1.27%**	**1 0.64%**	**157**
Baby Home	0	0	0	0	0	2 40%	0	3 60%	0	0	0	5
Madrassa/ religious education school	2 3.03%	3 4.55%	1 1.52%	2 3.03%	9 13.64%	13 19.70%	19 28.79%)	11 16.67%	4 6.06%	1 1.52%	1 1.52%	66
MoWCA Centre	0	0	0	0	0	0	0	2 40%	2 40%	1 20%	0	5
NGO (national and international)	0	0	0	0	0	0	1 25%	1 25%	2 50%	0	0	4
PHT Centres	0	0	0	4 66.67%	0	0	0	0	2 33.33%	0	0	6
Private orphanage	0	0	1 9.09%	1 9.09%	1 9.09%	3 27.27%	1 9.09%	2 18.18%	2 18.18%	0	0	11
Public orphanage	0	2 11.76%	2 11.76%	1 5.88%	7 41.18%	2 11.76%	1 5.88%	2 11.76%	0	0	0	17
Residential Centre for Children with Disabilities	0	0	0	2 9.09%	3 13.64%	2 9.09%	8 36.36%	2 9.09%	5 22.73%	0	0	22
Rehabilitation Centre for Socially Disabled Girls	0	0	0	0	0	0	0	4 100%	0	0	0	4

Category of Institution	Year of Starting Operation											
	Before 1900 n(%)	1900-1950 n(%)	1951-1960 n(%)	1961-1970 n(%)	1971-1980 n(%)	1981-1990 n(%)	1991-2000 n(%)	2001-2010 n(%)	2011-2020 n(%)	After 2020 n(%)	Unknown n(%)	Total (N)
Safe Home	0	0	0	0	0	0	0	6 100%	0	0	0	6
Sheikh Russel Home	0	0	0	0	0	0	0	0	8 100%	0	0	8
SUK/CDC	0	0	0	0	1 33.33%	0	0	2 66.67%	0	0	0	3

Gaps Between Start of Operation and Registration: The study further analyzed the gap between the year of starting operation and the year of registration **(Table 10)**. Findings highlight that **numerous private**

institutions—particularly Madrassas (40.9%) and private orphanages (36.4%)—**commenced operations more than five years before acquiring registration.**

In contrast, all four NGO-run institutions reported securing registration before initiating services. Public institutions generally had shorter or no gaps, with 88.2% of public orphanages registered within five years of starting..

These results underscore persistent challenges in regulatory compliance and reinforce the need for stronger oversight, especially among private faith-based and individual-run institutions.

Table 13 Gap in year between starting operation and attaining registration.

Category of institution	Year Gap								
	0-5 n (%)	6-10 n (%)	11-15 n(%)	16-20 n(%)	21-50 n(%)	51-100 n(%)	More Than 100 n(%)	No information n(%)	Total (N)
Total (n %)	**107 68.15%**	**11 7.01%**	**12 7.64%**	**2 1.27%**	**13 8.28%**	**2 1.27%**	**1 0.64%**	**9 5.73%**	**157**
Baby Home	5 100%	0	0	0	0	0	0	0	5
Madrassa/religious education school	38 57.58%	7 10.61%	6 9.09%	2 3.03%	9 13.64%	2 3.03%	1 1.52%	1 1.52%	66
MOWCA Centre	4 80%	0	1 20%	0	0	0	0	0	5
NGO (national and international)	0	1 25%	2 50%	0	1 25%	0	0	0	4
PHT Centres	5 83.33%	0	1 16.67%	0	0	0	0	0	6

Category of institution	Year Gap								
	0-5 n (%)	6-10 n (%)	11-15 n(%)	16-20 n(%)	21-50 n(%)	51-100 n(%)	More Than 100 n(%)	No information n(%)	Total (N)
Private orphanage	7 63.64%	1 9.09%	1 9.09%	0	2 18.18%	0	0	0	11
Public orphanage	15 88.24%	0	1 5.88%	0	0	0	0	1 5.88%	17
Residential Centre for Children with Disabilities	16 72.73%	0	0	0	1 4.55%	0	0	5 22.73%	22
Rehabilitation Centre for Socially Disabled Girls	3 75%	1 25%	0	0	0	0	0	0	4
Safe Home	6 100%	0	0	0	0	0	0	0	6
Sheikh Russel Home	6 75%	0	0	0	0	0	0	2 25%	8
SUK/CDC	2 66.67%	1 33.33%	0	0	0	0	0	0	3

4.4 Communication Practices that Reinforce Institutionalisation

Promotion and advertising of institutional care

To assess how residential childcare institutions connect with the public and potential users, the study examined whether sampled facilities engage in communication, advertising, or outreach activities.

A significant majority of facilities (81.53%) reported engaging in communication or marketing efforts to inform the community about their services, enrolment processes, and admission criteria.

This included all MoWCA Centres, NGOs, private orphanages, and Sheikh Russel Homes. On the other hand, 18.47% of facilities reported no such activities.

Facilities that did not report any communication activities included all Safe Homes and SUK/CDC centres. Baby Homes and Rehabilitation Centres for Socially Disabled Girls also had a relatively low level of engagement in communication efforts.

Institutions that conduct outreach often employ a range of communication channels, such as:

- Microphone or loudspeaker announcements.

- Distribution of flyers or leaflets.
- Community engagement at religious gatherings (e.g. waz mahfil)
- Announcements in mosques and other public spaces.
- Door-to-door campaigns.

Table 11 highlights:

- **100% of MoWCA Centres, NGOs, private orphanages, and Sheikh Russel Homes** conducted communication activities.
- **96.96% of madrassas** engaged in marketing activities.
- **Safe Homes and SUK/CDC** reported no communication efforts at all.
- Only **20% of Baby Homes and 25% of Rehabilitation Centres for Socially Disabled Girls** reported any community outreach.
- **Residential Centres for Children with Disabilities** showed mixed engagement, with 72.7% participating.

Table 14 Childcare institutions engaging in communication activities.

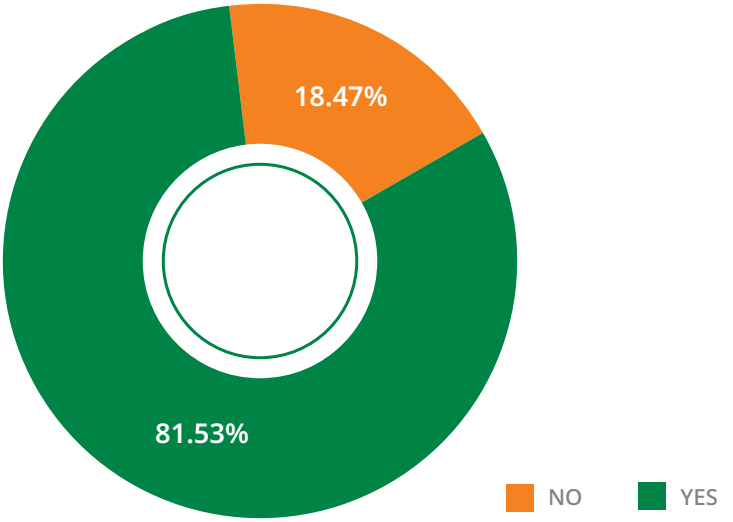
Institution Category	Yes n(%)	No n(%)
Baby Home	1 20%	4 80%
Madrassa/religious ed	64 96.96%	2 3.04%
MoWCA Centre	5 100%	0
NGO (national and international)	4 100%	0
PHT Centres	4 66.66%	2 33.34%
Private orphanage	11 100%	0
Public orphanage	14 82.35%	3 17.65%
Residential Center for Children with Disabilities	16 72.72%	6 92.28
Rehabilitation Center for Socially Disabled Girls	1 25%	3 75%
Safe Home	0	6 100%
Sheikh Russel Home	8 100%	0
SUK/CDC	0	3 100%
N (%)	**128 81.53%**	**29 18.47%**

Figure 4: The pie chart visually presents this distribution, showing that:

- **81.53%** of all institutions engage in communication activities ("Yes").

- **18.47%** do not participate in such outreach ("No").

Figure 7: Residential Care Facilities Engaging in Promotion and Marketing Activities.



Type of communication activities and potential risks of promoting institutionalisation.

The study further explored the types of communication activities conducted by residential childcare institutions to engage with the public. The most commonly reported method was media advertisement, cited by 44.59% of respondents. This was particularly prevalent among madrassas, private orphanages, and public orphanages, where institutions reported using radio, television, posters, and flyers to attract children and funding. The second most common approach was community outreach through religious and cultural events as well as community meetings and councils, which formed the basis for public engagement in many facilities.

Other forms of outreach included community engagement programs (5.1%), field-level engagement (3.82%), collaborations with government and social services (4.46%), and use of institutional calendars or websites (0.64%). Institutions such as Sheikh Russel Homes and Residential Centres for Children with Disabilities reported varied approaches, while Safe Homes, SUK/CDC, and Rehabilitation Centres for Socially Disabled Girls reported no active outreach campaigns.

Table 12 highlights the diversity in outreach methods used across facility types. Media advertisements were most prevalent (44.59%), followed by religious/cultural events (10.19%) and community meetings (8.28%). Facilities like Safe Homes and SUK/CDC reported no communication activity, raising concerns about transparency and integration into referral networks. The data underscore the need for national guidance to standardize institutional outreach in alignment with deinstitutionalisation goals and the promotion of family- and community-based alternatives.

Table 15 Type of communication activities.

	Community Engagement Programs n(%)	Community Meetings and Councils n(%)	Educational Programs n(%)	Field-Level Engagement n(%)	Government and Social Service Collaboration n(%)	Institutional Calendar and Website n(%)	Media Advertisements n(%)	Religious and Cultural Events n(%)	Specialized Outreach n(%)	Special Campaigns n(%)	No Activity n(%)	Number of institutions & percentage of sample
Baby Home	1 12.5%	0	0	0	0	0	0	0	0	0	4 13.79%	5 3.18%
Madrassa	3 37.5%	7 53.85%	0	0	0	1 100%	39 55.71%	12 75%	2 40%	0	2 6.9%	66 42.04%
MoWCA Centre	0	1 7.69%	0	0	1 14.29%	0	1 1.43%	0	2 40%	0	0	5 3.18%
NGO	0	0	0	1 16.67%	0	0	3 4.29%	0	0	0	0	4 2.55%
PHT Centre	0	0	0	0	0	0	3 4.29%	1 6.25%	0	0	2 6.9%	6 3.82%
Private orphanage	0	1 7.69%	0	0	0	0	9 12.86%	1 6.25%	0	0	0	11 7.01%
Public orphanage	0	2 15.38%	0	0	2 28.57%	0	9 12.86%	1 6.25%	0	0	3 10.34%	17 10.83%
Residential Center Children with Disabilities	2 25%	2 15.38%	1 100%	1 16.67%	3 42.86%	0	5 7.14%	1 6.25%	2 20%	0	6 20.69%	22 14.01%
Rehabilitation Center for Socially Disabled Girls	0	0	0	0	0	0	0	0	0	1 100%	3 10.34%	4 2.55%
Safe Home	0	0	0	0	0	0	0	0	0	0	6 20.69%	6 3.82%
Sheikh Russel Home	2 25%	0	0	4 66.67%	1 14.29%	0	1 1.43%	0	0	0	0	8 5.1%
SUK/CDC	0	0	0	0	0	0	0	0	0	0	3 10.34%	3 1.91%
N (%)	**8** **5.10%**	**13** **8.28%**	**1** **0.64%**	**6** **3.82%**	**7** **4.46%**	**1** **0.64%**	**70** **44.59%**	**16** **10.19%**	**5** **3.18%**	**1** **0.64%**	**29** **18.47%**	**157** **100%**

Unintended Impacts of Communication on Institutionalisation: There is a critical dimension to the communication activities carried out by institutions offering services to children, particularly in the context of child institutionalisation. These campaigns reflect a proactive effort by institutions to reach out to potential beneficiaries in need of support and to engage with the wider community. Importantly, when institutions have internal policies and funding models that are directly linked to the number of children they accommodate, such campaigns can unintentionally create incentives for institutionalisation. **By promoting their services to the public, institutions may encourage families to place their children in care—even when family-based alternatives might exist and be more suitable.**

In this way, communication activities can shape positive public perceptions of institutional care, reinforcing it as a favourable or default option. These perceptions can have long-term implications by undermining efforts to promote family-based care and to support children within their families or communities—environments that are generally more nurturing and developmentally appropriate.

At the same time, there remains a need for childcare institutions to be visible and well-connected with relevant government departments, social services, NGOs, and community-based organisations. Effective communication and collaboration at the local level are essential to ensure coordination and mutual understanding. Clear stakeholder awareness of each institution's purpose, target age groups, and admission criteria is crucial for establishing a functioning referral system—one that connects children and families in need to the most appropriate support services.

In summary, **communication campaigns by childcare institutions should be implemented with care.** It is essential to **strike a balance between informing the public and ensuring accessibility of services, while not unintentionally encouraging child institutionalisation.** A well-designed communication approach should reinforce the primacy of family-based care wherever possible and ensure that institutional outreach does not act as a driver of unnecessary separation from families.

4.5 Size and Declared Housing Capacity of Residential Childcare Institutions

Understanding the size of residential childcare institutions is crucial for assessing the living conditions and quality of care provided to children. Respondents were asked to indicate the number of children their facility was designed to accommodate—referred to here as the declared capacity or size. This helps determine whether the scale of care is conducive to child wellbeing.

The table 13 outlines the declared capacities—that is, the intended number of children that facilities are designed to accommodate—across various types of residential childcare institutions.

- **76.43%** of childcare institutions have a declared capacity above 50 children, and **36.31%** have a capacity exceeding 100 children.
- **23.57%** of institutions report a capacity between 101 and 200 children.

- **12.74%** have a capacity of over 200 children, including those with capacities from 201 up to more than 500.
- **Madrassas are the most common among high-capacity institutions,** with a wide range—from fewer than 50 to over 500 children. 40.91% of madrassas have a declared capacity above 100 children (28.79% in the 101–200 range and 12.12% above 200).
- The smallest institutions are **Residential Centres for Children with Disabilities (RCCD),** where **72.73%** (16 of 22) report a capacity of 1–20 children.

Breakdown by institutional category:

- **Baby Homes, Safe Homes, and Rehabilitation Centres for Socially Disabled Girls (RCSDG)** each have standardized capacities of 100, 50, and 100 children respectively.
- **Public orphanages** report varied capacities ranging from 20 to 200, with the majority (64.71%) declaring a capacity of 51–100.
- **Sheikh Russel Homes** vary between 75, 100, and 200 children. Based on the data: 6 homes have a capacity of 51–100; 2 have a capacity of 101–200.
- **PHT Centres** span 21 to 200 in declared capacity, with half having 101–200.
- **RCCD facilities** are small-scale: most (16 of 22) serve 1–20 children.
- **SUK/CDC facilities** are medium-to-large, with two having capacities of 150 and one with 300.
- **MOWCA Centres** fall in the 51–300 range, with most (3 of 5) in the 101–200 bracket.
- **NGOs** include a mix—declared capacities are 25, 70, and 500 children.
- **Private orphanages** span a range of 70–160 children, mostly in the 51–150 range.

Table 16 Declared capacity of the facilities.

Declared capacity	1-20 n(%)	21-50 n(%)	51-100 n(%)	101-200 n(%)	201-300 n(%)	301-400 n(%)	401-500 n(%)	Over 500 n(%)	Total (N)
Total (n %)	17 10.83%	20 12.74%	63 40.13%	37 23.57%	10 6.37%	6 3.82%	3 1.91%	1 0.64%	157
Baby Home	0	0	5 100%	0	0	0	0	0	**5**
Madrassa/religious education school	0	9 13.64%	23 34.85%	19 28.79%	8 12.12%	4 6.06%	2 3.03%	1 1.52%	**66**
M□WCA Centre	0	0	1 20.00%	3 60.00%	1 20.00%	0	0	0	**5**
NGO (national and international)	0	1 25.00%	2 50.00%	0	0	0	1 25.00%	0	**4**
PHT Centres	0	1 16.67%	2 33.33%	3 50.00%	0	0	0	0	**6**

Declared capacity	1-20 n(%)	21-50 n(%)	51-100 n(%)	101-200 n(%)	201-300 n(%)	301-400 n(%)	401-500 n(%)	Over 500 n(%)	Total (N)
Private orphanage	0	1 9.09%	5 45.45%	3 27.27%	0	2 18.18%	0	0	**11**
Public orphanage	1 5.88%	0	11 64.71%	5 29.41%	0	0	0	0	**17**
Residential Centre for Children with Disabilities	16 72.73%	2 9.09%	4 18.18%	0	0	0	0	0	**22**
Rehabilitation Centre for Socially Disabled Girls	0	0	4 100%	0	0	0	0	0	**4**
Safe Home	0	6 100%	0	0	0	0	0	0	**6**
Sheikh Russel Home	0	0	6 75.00%	2 25.00%	0	0	0	0	**8**
SUK/CDC	0	0	0	2 66.67%	1 33.33%	0	0	0	**3**

Note: Table 16 confirms that the majority of institutions do not reflect a 'small, home-like setting' as encouraged by the UN Guidelines for the Alternative Care of Children. Instead, the system is dominated by medium to large institutions.

Implications of Institutional Size on Quality of Care: The size and capacity of residential institutions for children are of great importance. Large institutions often face significant challenges in delivering personalized care due to the sheer number of children they are designed to accommodate. High child-to-caregiver ratios can place considerable strain on available resources, limit the amount of individualized attention provided, and hinder the development of meaningful personal bonds between children and caregivers. This can negatively affect a child's emotional well-being and sense of security, making the environment feel impersonal and institutional rather than nurturing and supportive.

In contrast, smaller institutions tend to be better equipped to provide individualized, higher-quality, child-centered care. These settings are more likely to replicate a home-like environment, where staff can respond more effectively to each child's needs and foster stronger emotional connections.

Need for De-Institutionalization: Given the predominance of large-scale childcare institutions in Bangladesh—especially madrassas and state-run homes—there is an urgent need to re-evaluate current care models. The data underscores the importance of advancing a de-institutionalization strategy, which involves a **gradual transition from large, overcrowded facilities to smaller, more personalized residential care options.** This process must go hand-in-hand with the development and scaling-up of family-based alternatives, such as kinship care, foster care, and supported reunification programs.

This shift is crucial to align the national care system with international standards and principles, as outlined in the UN Guidelines for the Alternative Care of Children, which emphasize **that institutional care should be used only as a last resort and that every child has the right to grow up in a family-like environment that supports their holistic development.**

4.6 Changes in Infrastructure Capacity Over Time

To understand trends in child institutionalization, the study explored whether the infrastructure capacity of institutions has remained constant or increased over the years.

Overall Findings: 60% of surveyed institutions reported no change in their capacity since establishment. This includes all Baby Homes, MoWCA Centres, and SUK/CDC facilities, which have maintained the same size over time.

Institutions Reporting Growth: The remaining 40% of institutions indicated an increase in capacity. Of these, nearly three-quarters are madrassas, making them the group with the most significant expansion trend. Other institutions that reported growth include several private and public orphanages, three rehabilitation centres for children, two Safe Homes, two Sheikh Russel Children Homes (SRCH), and one Rehabilitation Centre for Socially Disabled Girls (RCSDG). The second highest rate of capacity growth was found among private orphanages.

Capacity Increased Over the Years by Category, as illustrated in Table 17:

- All Baby Homes, MoWCA Centres, and SUK/CDC facilities reported no increase in capacity.
- Madrassas showed the highest rate of increase, with 67% expanding their capacity.
- Private orphanages and NGOs also showed significant growth (55% and 50%, respectively).
- Minimal expansion was observed in PHT Centres, Public orphanages, Rehabilitation centres, and Sheikh Russel Homes.
- The Residential Centres for Children with Disabilities (RCCD) largely remained static, with only 9% reporting capacity increases.

Table 17 Infrastructures' Capacity Increased Over the Years.

Category of institutions	Whether infrastructure's capacity for children has increased over the years?		
	Yes (%)	No (%)	Total (N)
Total (n %)	64 40.76%	93 59.24%	157
Baby Home	0	5 100%	**5**

Category of institutions	Whether infrastructure's capacity for children has increased over the years?		
	Yes (%)	No (%)	Total (N)
Madrassa/religious education school	44 66.67%	22 33.33%	**66**
MoWCA Centre	0	5 100%	**5**
NGO (national and international)	2 50.00%	2 50.00%	**4**
PHT Centres	1 16.67%	5 83.33%	**6**
Private orphanage	6 54.55%	5 45.45%	**11**
Public orphanage	4 23.53%	13 76.47%	**17**
Residential Centre for Children with Disabilities	2 9.09%	20 90.91%	**22**
Rehabilitation Centre for Socially Disabled Girls	1 25.00%	3 75.00%	**4**
Safe Home	2 33.33%	4 66.67%	**6**
Sheikh Russel Home	2 25.00%	6 75.00%	**8**
SUK/CDC	0	3 100%	**3**

Implications of Expansion on Child Institutionalization: An expansion in capacity may indicate a response to a growing demand for accommodating more children in need of care or the availability of additional resources to upsize the institution. However, this trend prompts a critical reflection: On one side, there is a necessity for standardized sizes for these establishments, aligning with the fundamental principle of avoiding sizes that could lead to depersonalization and poor quality of care. On the other side, there is a risk that an increased availability of resources motivates the increase in capacity and in consequence, the recruitment of children who could stay with their families.

4.7 Age of Infrastructure

The study examined the age of childcare facility infrastructures, recognizing that this factor may significantly influence the living environment and quality of care provided to resident children. Except for 1.27% of facilities that could not provide this information, all others were able to report the age of their buildings.

As shown in **Table 18,** the majority of childcare institutions (63%) are between 10 to 50 years old:

- **23.57%** of facilities are less than 10 years old, representing more modern construction
- **33.76%** fall in the 10–25 years age bracket
- **29.30%** are between 25–50 years old
- **12.10%** of facilities are over 50 years old, including seven madrassas, six public orphanages, three PHT centers, and one MOWCA center

Modern infrastructure (under 10 years) was found mainly in madrassas, Residential Centres for Children with Disabilities (RCCD), and one Sheikh Russel Home. In contrast, older buildings were more frequently found among public institutions, raising concerns regarding outdated facilities and their ability to meet current safety, hygiene, and accessibility standards.

Table 18 Age of infrastructure.

Category of facility	Age of infrastructure					
	0-10 Years (%)	10-25 Years (%)	25-50 Years (%)	Over 50 Years (%)	Unknown (%)	Total
Total (n %)	37 23.57%	53 33.76%	46 29.30%	19 12.10%	2 1.27%	157
Baby Home	0	4 80.00%	1 20.00%	0	0	**5**
Madrassa/religious education school	20 30.30%	20 30.30%	19 28.79%	7 10.61%	0	**66**
MOWCA Centre	0	2 40.00%	1 20.00%	2 40.00%	0	**5**
NGO (national and international)	2 50.00%	1 25.00%	1 25.00%	0	0	**4**
PHT Centres	2 33.33%	0	1 16.67%	3 50.00%	0	**6**
Private orphanage	1 9.09%	6 54.55%	4 36.36%	0	0	**11**
Public orphanage	1 5.88%	5 29.41%	4 23.53%	6 35.29%	1 5.88%	**17**
Residential Centre for Children with Disabilities	8 36.36%	3 13.64%	10 45.45%	1 4.55%	0	**22**
Rehabilitation Centre for Socially Disabled Girls	0	4 100%	0	0	0	**4**
Safe Home	0	5 83.33%	1 16.67%	0	0	**6**
Sheikh Russel Home	3 37.50%	2 25.00%	2 25.00%	0	1 12.50%	**8**

Category of facility	Age of infrastructure					
	0-10 Years (%)	10-25 Years (%)	25-50 Years (%)	Over 50 Years (%)	Unknown (%)	Total
SUK/CDC	0	1 33.33%	2 66.67%	0	0	**3**

Implications of Infrastructure Age on Child Well-being and Care Standards: Older infrastructure may pose challenges related to safety, hygiene, accessibility, and child-friendly design. These buildings often require significant upgrades to align with contemporary care standards. By contrast, newer facilities tend to offer improved conditions that support a healthier, more nurturing environment for children. Evaluating infrastructure age is thus essential when planning system improvements, ensuring all children reside in environments that support their development and well-being.

4.8 Purpose of Infrastructure

The study explored whether the physical infrastructure of each facility was originally constructed for the purpose of residential care, or whether it had been adapted from another use. This distinction is critical, as facilities not designed specifically for child care may face challenges related to safety, accessibility, and the overall suitability of the living environment for children.

According to responses, 80.25% of institutions were built specifically to provide residential care for children. The remaining 19.11% were adapted from other purposes, and 0.64% of respondents were unaware of the original purpose of the infrastructure.

Table 16 highlights the distribution of purpose-built versus adapted infrastructure across institutional types:

- All **Residential Centres for Children with Disabilities** and **Rehabilitation Centres for Socially Disabled Girls** reported purpose-built infrastructure.
- **Madrassas** showed the highest rate of purpose-built infrastructure among large categories, with 93.94%.
- In contrast, only **20% of MOWCA Centres** and **16.67% of Safe Homes** were originally designed for residential care purposes.
- **All eight Sheikh Russel Homes** were adapted from structures previously used for other purposes.
- NGOs and private orphanages showed mixed results, with 50–82% having purpose-built infrastructure.
- **SUK/CDC** facilities also reflected partial adaptation, with only two out of three purpose-built.

Additional insights were gathered on prior uses of the adapted infrastructure:

- **Six out of eight Sheikh Russel Homes** were converted from other uses
- **Four MOWCA Centres** were repurposed residential or multipurpose buildings
- **Four Safe Homes** previously served as residential facilities for the elderly
- **Eight madrassas** operated in buildings initially constructed for different uses

Table 19 Purpose of infrastructure.

Category of institutions	Whether infrastructure was built for the purpose?			
	Yes (%)	No (%)	Unknown (%)	Total
Total (n %)	**126 80.25%**	**30 19.11%**	**1 0.64%**	**157**
Baby Home	4 80.00%	0	1 20.00%	**5**
Madrassa/religious education school	62 93.94%	4 6.06%	0	**66**
MOWCA Centre	1 20.00%	4 80.00%	0	**5**
NGO (national and international)	2 50.00%	2 50.00%	0	**4**
PHT Centres	6 100%	0	0	**6**
Private orphanage	9 81.82%	2 18.18%	0	**11**
Public orphanage	13 76.47%	4 23.53%	0	**17**
Residential Centre for Children with Disabilities	22 100%	0	0	**22**
Rehabilitation Centre for Socially Disabled Girls	4 100%	0	0	**4**
Safe Home	1 16.67%	5 83.33%	0	**6**
Sheikh Russel Home	0	8 100%	0	**8**
SUK/CDC	2 66.67%	1 33.33%	0	**3**

Previous use of adapted infrastructure

In addition to determining whether facilities were originally constructed for residential care, the study also examined what the previous use of adapted infrastructure had been. Among the 19.75% of facilities that were not purpose-built, the majority had been converted from **social and welfare institutions (7.01%), educational facilities (3.82%),** or **government/public service buildings (3.82%).** A small proportion (1.27%) had unclear or unknown prior functions.

Breakdown of Adapted Infrastructure by Type of Institution shown in Table 20:

- All **Baby Homes, RCCDs, RCSDGs, and PHT Centres** were purpose-built and had not been adapted from other uses
- Among **Sheikh Russel Homes,** 75% had been repurposed from other functions, most commonly from government buildings or public services
- Safe Homes showed the highest share of adaptation from **social and welfare institutions** (66.67%)
- **NGOs and MoWCA Centres** were also among those most likely to operate from repurposed infrastructure

Table 20 Original purpose of adapted infrastructures.

Category of institution	Not adapted from another destination or use (n %)	Original Purpose of adapted infrastructures					
		Educational Institutions (n %)	Government and Public Service (n %)	Miscellaneous and Unknown (n %)	Residential Buildings (n %)	Social and Welfare Institutions (n %)	Total (N)
Total (n %)	**129 82.17%**	**6 3.82%**	**6 3.82%**	**2 1.27%**	**3 1.91%**	**11 7.01%**	**157**
Baby Home	5 100%	0	0	0	0	0	**5**
Madrassa/religious education school	61 92.42%	3 4.55%	0	1 1.52%	0	1 1.52%	**66**
MoWCA Centre	1 20.00%	1 20.00%	1 20.00%	0	2 40.00%	0	**5**
NGO (national and international)	2 50.00%	1 25.00%	0	0	0	1 25.00%	**4**
PHT Centres	6 100%	0	0	0	0	0	**6**
Private orphanage	9 81.82%	1 9.09%	1 9.09%	0	0	0	**11**
Public orphanage	13 76.47%	0	0	0	0	4 23.53%	**17**
Residential Centre for Children with Disabilities	22 100%	0	0	0	0	0	**22**

Category of institution	Not adapted from another destination or use (n %)	Original Purpose of adapted infrastructures					
		Educational Institutions (n %)	Government and Public Service (n %)	Miscellaneous and Unknown (n %)	Residential Buildings (n %)	Social and Welfare Institutions (n %)	Total (N)
Rehabilitation Centre for Socially Disabled Girls	4 100%	0	0	0	0	0	**4**
Safe Home	2 33.33%	0	0	0	0	4 66.67%	**6**
Sheikh Russel Home	2 25.00%	0	3 37.50%	1 12.50%	1 12.50%	1 12.50%	**8**
SUK/CDC	2 66.67%	0	1 33.33%	0	0	0	**3**

Risks and Limitations of Adapted Infrastructure: While repurposing existing structures can be cost-effective, it raises important questions about whether such facilities meet the required standards for children's safety, accessibility, and developmental needs. Adapted infrastructure may lack proximity to essential services or adequate environmental conditions conducive to children's well-being.

This concern is particularly relevant for children with disabilities, who require accessible infrastructure tailored to their mobility, communication, and support needs. Facilities not originally built for residential childcare may lack essential inclusive design features, such as ramps, accessible toilets, or appropriate living spaces—potentially excluding children with disabilities from equitable care.

These findings underscore the importance of assessing and, where necessary, upgrading non-purpose-built facilities to meet child protection, disability inclusion, and quality care standards.

4.9 Categories of Children Targeted for Admission

The study explored both **the target groups** and **admission criteria** across different types of residential care institutions. Target groups refer to the categories of children the facility is designed to serve, while admission criteria typically outline eligibility based on **age, gender,** or **legal status** (e.g., referral or court order).

Patterns in admission mandates across facility types

Facilities were able to select multiple child categories.

Patterns in how institutions define their mandates: These findings are summarized in **Table 21 below.**

- **Orphans** are given the highest priority for admission across **MoWCA Centers, madrassas, public and private orphanages,** and **Baby Homes**

- **Disadvantaged children referred by authorities** are the primary group for **MoWCA Centers, Sheikh Russel Homes,** and **Safe Homes**
- **Abandoned or lost children,** including foundlings, are prioritised by **Sheikh Russel Homes, MoWCA Centers,** and **Baby Homes**
- **Street children** are the primary target for **Sheikh Russel Homes, MoWCA Centers,** and **RCSDGs,** with the latter exclusively reporting this group as their core target
- **Children with disabilities** are primarily admitted into **dedicated facilities** such as **Residential Centres for Children with Disabilities (RCCD)** and **PHT Centres,** but also appear as a target group for **Baby Homes,** which is an unexpected finding
- **Private and public orphanages** also admit a mix of vulnerable children, including those described as **"helpless and poor"** or **rescued**

.Table 21 Child categories for admission into different institutions.

Category of Institutions (Could select more than one choice)	Child categories for admission										Total (N)
	Orphan n(%)	Disadvantaged child, according to children's act with referral from authority n(%)	Abandoned or lost child, child found in the street with no parent or guardian n(%)	Street child n(%)	Vagrants n(%)	Child with disability n(%)	By court order n(%)	Helpless and Poor n(%)	Rescued n(%)	Visually Challenged/ blind n(%)	
Baby Home	4 80.00%	3 60.00%	4 80.00%	3 60.00%	2 40.00%	3 60.00%	2 40.00%	0.00	0.00	0.00	**5**
Madrassa/ religious education school	65 98.48%	20 30.30%	19 28.79%	15 22.73%	2 3.03%	14 21.21%	0.00	15 22.73%	0.00	0.00	**66**
MOWCA Centre	5 100.00%	5 100.00%	4 80.00%	4 80.00%	1 20.00%	2 40.00%	0.00	1 20.00%	0.00	0.00	**5**
NGO (national and international)	2 50.00%	3 75.00%	3 75.00%	2 50.00%	1 25.00%	2 50.00%	0.00	1 25.00%	0.00	0.00	**4**
PHT Centres	2 33.33%	2 33.33%	1 16.67%	1 16.67%	0.00	6 100.00%	0.00	1 16.67%	0.00	0.00	**6**
Private orphanage	10 90.91%	2 18.18%	3 27.27%	0.00	0.00	3 27.27%	0.00	5 45.45%	1 9.09%	0.00	**11**
Public orphanage	16 94.12%	10 58.82%	8 47.06%	4 23.53%	0.00	1 5.88%	0.00	0.00	0.00	0.00	**17**
Residential Centre for Children with Disabilities	0.00	3 13.64%	0.00	0.00	0.00	17 77.27%	1 4.55%	0.00	0.00	3 13.64%	**22**

Category of Institutions (Could select more than one choice)	Child categories for admission										Total (N)
	Orphan n(%)	Disadvantaged child, according to children's act with referral from authority n(%)	Abandoned or lost child, child found in the street with no parent or guardian n(%)	Street child n(%)	Vagrants n(%)	Child with disability n(%)	By court order n(%)	Helpless and Poor n(%)	Rescued n(%)	Visually Challenged/ blind n(%)	
Rehabilitation Centre for Socially Disabled Girls	1 25.00%	2 50.00%	2 50.00%	4 100.00%	2 50.00%	2 50.00%	0.00	0.00	1 25.00%	0.00	**4**
Safe Home	0.00	5 83.33%	1 16.67%	1 16.67%	1 16.67%	1 16.67%	1 16.67%	0.00	1 16.67%	0.00	**6**
Sheikh Russel Home	5 62.50%	8 100.00%	8 100.00%	7 87.50%	3 37.50%	3 37.50%	1 12.50%	0.00	1 12.50%	0.00	**8**
SUK/CDC	0.00	3 100.00%	0.00	0.00	0.00	1 33.33%	1 33.33%	0.00	0.00	0.00	**3**

Variability within institution categories

A notable insight is the **lack of consistency within institutional categories**. For example, RCSDGs—all part of the same institutional type—highlight divergent target groups across different locations. This trend suggests an **absence of standardized guidance or application of admission criteria, leaving interpretation to individual administrators.**

This lack of uniformity raises important questions regarding policy clarity, admission equity, and how the mandate of child care institutions is operationalized on the ground. Further sections will explore how this inconsistency extends to other areas such as referral mechanisms and service delivery.

4.10 Gender criteria for admission and Co-Education Practices in Residential Childcare Institutions

This section explores the gender-based admission criteria used by residential institutions, aiming to assess the extent to which co-education—where boys and girls are accommodated together—is practiced versus gender segregation.

Extent of Gender Segregation: The findings reveal that the majority of institutions (64.97%) exclusively admit boys, while 18.47% admit only girls. Only a small proportion (16.56%) accommodate both genders within the same facility. Certain types of institutions, such as MOWCA Centers, public orphanages, RCSDG (Rehabilitation Centres for Socially Disabled Girls), and SUK/CDC, strictly follow a gender-segregated model by admitting children of only one gender.

Institutions Practicing Co-Education: In contrast, institutions that admit both girls and boys include Baby Homes, Sheikh Russel Homes, and PHT Centers. Additionally, two Safe Homes admit children of both genders, though boys are only accepted if they are under the age of seven. A limited number of RCCDs (18.18%), private orphanages (18.18%), and four madrassas (6.06%) also accommodate both genders. The co-educational nature of Baby Homes may be linked to the young age of the children, where gender differences are generally less emphasized. In such cases, a more inclusive approach may be considered appropriate.

Table 22 Gender criteria for admission

Category of institution	Gender Criteria for Admission			
	Only girls n(%)	Only boys n(%)	Girls and boys n(%)	Total (N)
Total (n %)	**29 18.47%**	**102 64.97%**	**26 16.56%**	**157 100%**
Baby Home	0	0	5 100.00%	**5**
Madrassa/religious education school	3 4.55%	59 89.39%	4 6.06%	**66**
MoWCA Centre	1 20.00%	4 80.00%	0	**5**
NGO (national and international)	1 25%	2 50%	1 25%	**4**
PHT Centres	2 33.33%	0	4 66.67%	**6**
Private orphanage	1 9.09%	8 72.73%	2 18.18%	**11**
Public orphanage	8 47.06%	9 52.94%	0	**17**
Residential Centre for Children with Disabilities	0	18 81.82%	4 18.18%	**22**
Rehabilitation Centre for Socially Disabled Girls	4 100%	0	0	**4**
Safe Home	4 66.67%	0	2 33.33%	**6**
Sheikh Russel Home	4 50%	0	4 50%	**8**
SUK/CDC	1 33.33%	2 66.67%	0	**3**

Benefits and Safeguards of Co-Educational Settings: **While only 16.56% of institutions currently host children of both sexes**, this practice holds significant value. Co-education supports gender equality

by fostering environments where boys and girls can learn, grow, and socialize together. It promotes equal access to resources and helps challenge traditional gender stereotypes. Additionally, it better prepares children for life in a diverse society by enabling them to develop mutual understanding, cooperation skills, and respect across genders.study delved deeper into admission criteria based on gender, aiming to assess the extent of implementing co-education – indicating a system where female and male children live together - versus gender segregation in childcare facilities.

However, while co-educational arrangements can support positive social development, it is essential that **appropriate safeguarding protocols, adequate oversight, and gender-sensitive staffing are in place to ensure the safety and protection of all children of all genders in such settings.**

4.11 Age Criteria for Admission

The study examined the age criteria used by residential care institutions when admitting children, as this is an essential determinant of service scope, developmental appropriateness, and transition planning.

Among **Public Institutions, the age brackets are largely standardized and are as follows:**

- **Baby Homes** admit children aged **0–7 years**
- **Sheikh Russel Homes** admit children aged **6–18 years**
- **SUK/CDC** centers serve children aged **9–18 years**
- **Safe Homes** vary in their criteria, commonly serving children aged 6–9 up to 18 years
- MOWCA centers typically admit children between **6–16 years**
- **PHT centers** report a broad age range, **from 6–7 years to 21 years and above**
- **Public orphanages** define two distinct age bands: **6–18 years and 10–18 years**

In **Private Institutions, age criteria are more varied:**

- **Madrassas** may enroll children from a very young age, but the majority report **6–18 years** as the primary range
- **Private orphanages** often start admitting children **below age 7** and typically continue care up to **18 years**
- **NGOs** indicate diverse age admission brackets within the **6–18-year** spectrum

These age ranges are summarized in **Table 23,** showing institution-wise variations and overlaps.

Such diversity in age eligibility reflects the **varying mandates** and **specialized roles** of the institutions. While many follow child development stages aligned with formal education systems, others cater to children with longer or more flexible support needs (e.g. RCCD and PHT centers extending beyond 18 years). This also underscores the importance of **transition planning** for children nearing adulthood, particularly in institutions admitting children over 18.

Table 23 presents the number and percentage of facilities with their stated age of admission.

Table 23 Age criteria for admitting children

Category of admission	Age criteria for admission																											Total (N)
	No limit	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	
Baby Home		5 100%	5 100%	5 100%	5 100%	5 100%	5 100%	5 100%	5 100%																			5
Madrassa/ religious education school		2 3.03%	2 3.03%	3 4.55%	5 7.58%	9 14%	19 29%	46 70%	57 85%	65 98%	66 100%	66 100%	62 94%	60 91%	53 80%	53 80%	52 79%	44 67%	40 61%	38 58%	4 6%	3 4.55%	1 1.52%	1 1.52%				66
MoWCA Centre						2 40%	2 40%	5 100%	5 100%	5 100%	5 100%	5 100%	5 100%	5 100%	5 100%	5 100%	5 100%	5 100%	2 40%	2 40%								5
NGO								3 75%	3 75%	4 100%	4 100%	4 100%	3 75%	3 75%	3 75%	3 75%	2 50%	2 50%	2 50%	2 50%								4
PHT Centres								2 33%	4 67%	4 67%	4 67%	4 67%	2 33%	2 33%	2 33%	2 33%	4 67%	4 67%	4 67%	4 67%	2 33%	2 33%	2 33%	2 33%	2 33%	2 33%	2 33%	6
Private orphanage					1 6%	2 12%	4 24%	8 47%	11 65%	11 65%	11 65%	10 59%	10 59%	10 59%	10 59%	9 53%	9 53%	7 41%	6 35%	6 35%								11
Public orphanage								17 100%	17 100%	17 100%	17 100%	6 35%	6 35%	6 35%	6 35%	6 35%	6 35%	6 35%	6 35%	6 35%								17
RCCD								19 86%	21 95%	22 100%	22 100%	17 77%	17 77%	15 68%	14 64%	13 59%	13 59%	13 59%	7 32%	6 27%								22
RCSDG	1 25%	1 25%	1 25%	1 25%	1 25%	1 25%	1 25%	2 50%	2 50%	2 50%	2 50%	2 50%	2 50%	3 75%	3 75%	3 75%	3 75%	3 75%	3 75%	3 75%								4
Safe Home	4 67%							1 13%	1 13%	1 13%	2 33%	2 33%	2 33%	2 33%	2 33%	2 33%	2 33%	2 33%	2 33%	2 33%								6
Sheikh Russel Home								8 100%	8 100%	8 100%	8 100%	8 100%	8 100%	8 100%	8 100%	8 100%	8 100%	8 100%	8 100%	7 87.5%								8
SUK/CDC											3 100%	3 100%	3 100%	3 100%	3 100%	3 100%	3 100%	3 100%	3 100%	2 67%								3

4.12 Admission and Inclusion of Children with Disabilities in Residential Care Institutions

This section explores whether residential care institutions in Bangladesh demonstrate inclusivity in admitting children with disabilities and whether they are equipped to meet the needs of these children. The analysis also provides insights into the types of disabilities present among the resident population and the capacity of institutions dedicated specifically to children with disabilities.

Prevalence and types of disability

The findings show that children with various forms of disabilities are present in many types of institutions:

- **Sensorial disabilities** (blindness, deafness, or speech impairments) are the most commonly reported (39% of institutions)
- **Mental disabilities** were reported in 24% of institutions
- **Motor disabilities** were present in 20%
- **Multiple disabilities** were reported in 15%

The distribution by institution type reveals the following trends:

- **All Baby Homes** host children with sensor and multiple disabilities, and most also admit those with motor and mental disabilities
- **All Safe Homes** accommodate children with sensorial and mental disabilities; 67% also have children with motor disabilities and 83% with multiple disabilities
- **All RCSDGs** admit girls with sensorial disabilities, and 75% have girls with mental disabilities
- **Residential Centres for Children with Disabilities (RCCD)** and **PHT centres** unsurprisingly report high numbers of children with sensor disabilities. Three PHT centres also report children with mental disabilities
- **Madrassas, public orphanages, and private orphanages** have the lowest rates of admission for children with disabilities, suggesting limited inclusivity in these settings

Detailed data are provided in Table 24:

Table 24 Admission of children with disabilities

Category of Institution	Admission of children with disability											
	Whether there were children with sensor disability (blind, deaf, dumb)?			Whether there were children with motor disability?			Whether there were children with mental disability?			Whether there were children with multiple disability?		
	Yes n(%)	No n(%)	Total (N)	Yes n(%)	No n(%)	Total (N)	Yes n(%)	No n(%)	Total (N)	Yes n(%)	No n(%)	Total (N)
Total (n %)	**61 38.85%**	**96 61.15%**	**157**	**31 19.75%**	**126 80.25%**	**157**	**38 24.20%**	**119 75.80%**	**157**	**24 15.29%**	**133 84.71%**	**157**
Baby Home	5 100%	0	5	4 80.00%	1 20.00%	5	3 60.00%	2 40.00%	5	5 100%	0	5
Madrassa/ religious education school	7 10.61%	59 89.39%	66	12 18.00%	54 82.00%	66	8 12.12%	58 87.88%	66	2 3.03%	64 96.97%	66
MoWCA Centre	2 40.00%	3 60.00%	5	0	5 100%	5	1 20.00%	4 80.00%	5	0	5 100%	5
NGO (national and international)	2 50.00%	2 50.00%	4	1 25.00%	3 75.00%	4	2 50.00%	2 50.00%	4	2 50.00%	2 50.00%	4
PHT Centres	5 83.33%	1 16.67%	6	0	6 100%	6	3 50.00%	3 50.00%	6	2 33.33%	4 66.67%	6
Private orphanage	2 18.18%	9 81.82%	11	1 9.00%	10 91.00%	11	1 9.09%	10 90.91%	11	0	11 100%	11
Public orphanage	1 5.88%	16 94.12%	17	2 12.00%	15 88.00%	17	3 17.65%	14 82.35%	17	1 5.88%	16 94.12%	17
Residential Centre for Children with Disabilities	20 90.91%	2 9.09%	22	4 18.00%	18 82.00%	22	3 13.64%	19 86.36%	22	4 18.18%	18 81.82%	22
Rehabilitation Centre for Socially Disabled Girls	4 100%	0	4	0	4 100%	4	3 75.00%	1 25.00%	4	1 25.00%	3 75.00%	4
Safe Home	6 100%	0	6	4 67.00%	2 33.00%	6	6 100%	0	6	5 83.33%	1 16.67%	6
Sheikh Russel Home	6 75.00%	2 25.00%	8	3 38.00%	5 63.00%	8	5 13.16%	3 37.5%	8	2 25.00%	6 75.00%	8
SUK/CDC	1 33.33%	2 66.67%	3	0	3 100%	3	0	3 100%	3	0	3 100%	3

Considerations for rights and resource adequacy

The presence of children with disabilities in general institutions may reflect a move toward inclusion. However, it raises two key concerns:

Drivers of Institutionalization: There is a need to investigate whether the disability itself led to the child's admission. The **institutionalization of children due to their disability or their parent's**

disability contradicts the principles of Article 23(4) of the Convention on the Rights of Persons with Disabilities (CRPD), which states:

"Children with disabilities shall have equal rights with respect to family life. [...] In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents. "

Capacity to Respond to Special Needs: While some institutions admit children with disabilities, **many lack the specialized services**—including rehabilitation, accessible infrastructure, and trained staff—necessary to support their development. This gap suggests that admission may **be tokenistic or based on necessity rather than readiness,** potentially resulting in **unmet needs and limited opportunities** for children to reach their full potential.

4.13 Admission Procedure: by which Children are Screened and Admitted into Institutions

In addition to understanding admission criteria, the study explored the procedures by which children are screened and admitted into residential childcare institutions. These procedures reflect the decision-making processes that determine whether a child's placement in residential care is necessary. From a child protection standpoint—where residential care should be a last resort—the admission process serves as a gatekeeping mechanism to ensure children are placed in such settings only when absolutely necessary.

Types of admission procedures

The study identified **four primary types of admission procedures used across childcare facilities:**

- **Simple enrolment with no conditions:** Children are admitted without any formal eligibility checks or documentation.
- **Application and screening:** An application must be submitted, typically to a selection committee, and eligibility is verified. This may include documentation such as a death certificate or an assessment of the caregiver's socio-economic condition.
- **Referral by relevant authority:** A child is admitted upon the request of an administrative authority (e. g. Department of Social Services, Probation Officer, Police).
- **Court-issued care order:** Admission is based on a formal care order issued by a Child Court Judge.

Prevalence of procedures across institutions

Table 25 presents the distribution of institutions using each type of procedure. Key findings include:

- **Screening-based application procedures** are the most widely used, followed by **referrals by relevant authorities**. The majority of admissions in MOWCA Centres, madrassas, orphanages, and rehabilitation centers are subject to committee screening.

- **Referral by administrative authorities** (not the court) is the second most common route. This is particularly prevalent in Baby Homes, Safe Homes, and RCSDGs, where admissions are often made urgently and later validated by Child Welfare Boards.
- A **minority of institutions** admit children via **self-referral with no screening**—mostly NGOs, private orphanages, madrassas, MOWCA centres, and some Sheikh Russel Homes.
- **Court-ordered placements** are rare, reported in only one Baby Home, one Safe Home, one Sheikh Russel Home, and one RCCD.

Table 25 Admission procedure

Category of institution	Admission procedure				Total (N)
	Simple enrolment with no conditions n(%)	Application to be admitted subject to screening/acceptance by selection committee n(%)	Referral/request by relevant authority (Probation Officer, DSS, police station or a social worker) n(%)	Care order n(%)	
Total (n %)	**20 12.74%**	**102 64.97%**	**31 19.75%**	**4 2.55%**	**157 100%**
Baby Home	0	0	4 80.00%	1 20.00%	**5**
Madrassa/religious education school	15 22.73%	50 75.76%	1 1.52%	0	**66**
MoWCA Centre	1 20.00%	4 80.00%	0	0	**5**
NGO (national and international)	1 25%	1 25%	2 50%	0	**4**
PHT Centres	1 16.67%	4 66.67%	1 16.67%	0	**6**
Private orphanage	0	10 90.91%	1 9.09%	0	**11**
Public orphanage	0	13 76.47%	4 23.53%	0	**17**
Residential Centre for Children with Disabilities	1 4.55%	18 81.82%	2 9.09%	1 4.55%	**22**
Rehabilitation Centre for Socially Disabled Girls	0	0	4 100%	0	**4**
Safe Home	0	0	5 83.33%	1 16.67%	**6**
Sheikh Russel Home	1 12.5%	2 25%	4 50%	1 12.5%	**8**
SUK/CDC	0	0	3 100%	0	**3**

Categorization of Institutions by gatekeeping structure

Based on the nature of their admission processes, institutions may be grouped into two broad categories:

Institutions with Voluntary, Family-Initiated Admission

(Referred to as Child Social Protection Institutions)

These institutions admit children based on applications submitted by parents, guardians, or the children themselves. Admission decisions are not regulated by administrative or judicial child protection authorities. Children are often admitted due to socio-economic hardship, with orphanhood being the primary characteristic for eligibility. **The absence of a formal gatekeeping mechanism implies that admission is voluntary and family-driven, reflecting a social support function rather than a protective mandate.**

Institutions with Mandated, Authority-Regulated Admission

(Referred to as Child Protection Institutions)

These institutions serve children who are **referred by administrative bodies or placed under court orders.** Their admission process is regulated, requiring approval from child protection authorities. This group primarily caters to children who are victims of abuse, neglect, or abandonment, and who require protection from further harm. They follow a structured and regulated admission system, ensuring that placement decisions are informed by professional assessments.

4.14 Type of Accommodation Provided by Residential Institutions

This dominance of long-term, full-time accommodation

This section examines the nature of accommodation provided in residential childcare institutions, distinguishing between short-**term shelter-based care** and **long-term full-time housing**. Of the 157 institutions surveyed, **99. 36% reported offering long-term, full-time accommodation,** while **only one Safe Home (0. 64%)** indicated that it provides **short-term shelter services** (less than 3 months), consistent with its formal mandate.

Table 26 Institutions providing accommodation

Category of institution	Shelter (short time, less than 3 months)	Long term accommodation & Full-time accommodation	Total (N)
Total (n %)	1 0.64%	156 99.36%	157
Baby Home	0	5 100%	**5**

Category of institution	Shelter (short time, less than 3 months)	Long term accommodation & Full-time accommodation	Total (N)
Madrassa/religious education school	0	66 100%	**66**
MoWCA Centre	0	5 100%	**5**
NGO (national and international)	0	4 100%	**4**
PHT Centres	0	6 100%	**6**
Private orphanage	0	11 100%	**11**
Public orphanage	0	17 100%	**17**
Residential Centre for Children with Disabilities	0	22 100%	**22**
Rehabilitation Centre for Socially Disabled Girls	0	4 100%	**4**
Safe Home	1 16.67%	5 83.33%	**6**
Sheikh Russel Home	0	8 100%	**8**
SUK/CDC	0	3 100%	**3**

Implications for Care Models and Policy Alignment: The overwhelming focus on **long-term placements** reflects the dominant model of residential care in Bangladesh, where institutions often serve as extended living arrangements for children. Most children remain in care for prolonged durations, sometimes until they reach adulthood. This approach, however, stands in contrast to **international guidelines,** which emphasize that residential care should be used **only as a temporary, last-resort option** and for the **shortest possible duration.**

According to the **UN Guidelines for the Alternative Care of Children,** paragraphs 14 and 21:

"Children should be admitted to alternative care only when necessary, and when it is in their best interests, with preference always given to family-based care. ". "Residential care should be used only when necessary and should be limited to cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests. "

Furthermore, **Bangladesh's National Strategy for Child Protection (2015–2020)** reiterates the need for strengthening **family- and community-based alternatives** and **gradually reducing reliance on institutional care**. It highlights that institutional care, where unavoidable, must be temporary and supported by care plans that promote reintegration with families or transition to family-based alternatives.

This overreliance on long-term institutional accommodation—particularly where no individual reintegration planning or care planning is in place—may indicate a lack of effective gatekeeping systems, insufficient family-based options, and underutilization of temporary emergency shelter models designed for immediate protection responses.

4.15 Cohabitation Patterns

This section explores the living arrangements of children in residential care facilities in Bangladesh. It examines key indicators including the number of resident children per institution, gender composition, presence of sibling groups, and co-residency with non-staff adults.

Distribution by institutional size

The study found that a significant proportion of children live in large-scale institutions:

- **29. 29%** of children reside in facilities with over 100 children
- **29. 30%** in institutions housing 51–100 children
- **24. 20%** in institutions with 21–50 children, and
- **17. 20%** in smaller facilities with 20 or fewer children

These findings suggest that most children are in large-scale settings that align with the definition of "institutional care, " which tends to offer less individualized attention and care. In contrast, only a minority live in smaller, more family-like residential arrangements, which are generally considered a more appropriate form of care. (See **Table 27: Total Number of Residents by Institution Type**)

Table 27 Total number of residents

Category of institutions	Total number of residents in the institutions								Total N(%)
	No Residence	1-20 n(%)	21-50 n(%)	51-100 n(%)	101-150 n(%)	151-200 n(%)	251-300 n(%)	Over 300 n(%)	
Total (n %)	**1 0.64%**	**26 16.56%**	**38 24.20%**	**46 29.30%**	**25 15.92%**	**15 9.55%**	**3 1.91%**	**3 1.91%**	**157 100%**
Baby Home	0	3 60.00%	2 40.00%	0	0	0	0	0	**5**
Madrassa/religious education school	0	1 1.52%	23 34.85%	17 25.76%	16 24.24%	6 9.09%	2 3.03%	1 1.52%	**66**
MoWCA Centre	0	0	0	2 40.00%	2 40.00%	1 20.00%	0	0	**5**
NGO (national and international)	0	1 25.00%	0	2 50.00%	0	1 25.00%	0	0	**4**
PHT Centres	0	2 33.33%	0	3 50.00%	1 16.67%	0	0	0	**6**

Category of institutions	Total number of residents in the institutions								Total N(%)
	No Residence	1-20 n(%)	21-50 n(%)	51-100 n(%)	101-150 n(%)	151-200 n(%)	251-300 n(%)	Over 300 n(%)	
Private orphanage	0	0	4 36.36%	2 18.18%	1 9.09%	3 27.27%	1 9.09%	0	**11**
Public orphanage	0	1 5.88%	2 11.76%	12 70.59%	1 5.88%	1 5.88%	0	0	**17**
Residential Centre for Children with Disabilities	1 4.55%	15 68.18%	1 4.55%	4 18.18%	0	1 4.55%	0	0	**22**
Rehabilitation Centre for Socially Disabled Girls	0	2 50.00%	2 50.00%	0	0	0	0	0	**4**
Safe Home	0	1 16.67%	4 66.67%	1 16.67%	0	0	0	0	**6**
Sheikh Russel Home	0	0	0	2 25.00%	4 50.00%	2 25.00%	0	0	**8**
SUK/CDC	0	0	0	1 33.33%	0	0	0	2 66.67%	**3**

Gender distribution of children across institutions

Analysis of the gender distribution reveals a significant imbalance, with **boys making up 76. 81%** of all children across the surveyed institutions (9, 901 out of 12, 890). This skew is primarily due to the high number of **madrassas** in the sample, which predominantly cater to boys (90. 55%).

Despite this, several public institutions show a more balanced or female-majority demographic:

- **Safe Homes** house **218 girls** and only **7 boys,** meaning **96. 89%** of residents are girls
- **Sheikh Russel Homes** similarly report a female majority, with **69. 35%** of residents being girls (690 girls and 305 boys)
- **Public orphanages** and **PHT Centres** exhibit more balanced ratios. Public orphanages have **56. 77% girls,** while PHT Centres have a near-equal split, with **47. 16% girls** and **52. 84% boys**
- Baby Homes maintain a gender balance, with **58 girls** and **55 boys**, representing **51. 33%** and **48. 67%,** respectively

Conversely, some institution types are almost entirely male-dominated:

- **SUK/CDC** institutions report **93. 96%** boys
- **MOWCA Centres** accommodate 485 boys (82. 91%) and **100 girls** (17. 09%)
- All surveyed **NGOs, private orphanages,** and **madrassas** also reflect this trend, with boys comprising **86. 55%, 89. 33%,** and **90. 55%,** respectively

Institutions exclusively or predominantly serving girls include the **Rehabilitation Centres for Socially Disabled Girls (RCSDG),** which house **63 girls (100%),** and the **Safe Homes,** which, despite hosting a small number of boys under special circumstances, are primarily designed for girls and women in vulnerable situations.

For a complete breakdown of child gender distribution by institution type, refer to **Table 28** below.

Table 28 Total children under 18 years and sibling groups

Category of Institution	Total number of male and female children						Siblings' groups
	Frequency (n)			Percentage (%)			
	Girls	Boys	Total	Girls	Boys	Total	
Baby Home	58	55	**113**	51.33	48.67	**100.00**	3
Madrassa/religious education school	584	5598	**6182**	9.45	90.55	**100.00**	130
MoWCA Centre	100	485	**585**	17.09	82.91	**100.00**	23
NGO (national and international)	39	251	**290**	13.45	86.55	**100.00**	12
PHT Centres	191	214	**405**	47.16	52.84	**100.00**	7
Private orphanage	125	1047	**1172**	10.67	89.33	**100.00**	21
Public orphanage	738	562	**1300**	56.77	43.23	**100.00**	54
Rehabilitation Centre for Socially Disabled Girls	63	0	**63**	100.00	0.00	**100.00**	0
Residential Centre for Children with Disabilities	116	334	**450**	25.78	74.22	**100.00**	4
Safe Home	218	7	**225**	96.89	3.11	**100.00**	1
Sheikh Russel Home	690	305	**995**	69.35	30.65	**100.00**	30
SUK/CDC	67	1043	**1110**	6.04	93.96	**100.00**	3
Total	**2989**	**9901**	**12890**[27]	**23.19**	**76.81**	**100.00**	**288**

Presence of non-staff adult residents in childcare institutions

In addition to children under 18, the study investigated the presence of **non-staff adults** residing in institutions—individuals who live in the facilities but are not employed as caregivers or staff. These include:

- **Youth aged 18–21,** who may still be completing their education or have not transitioned out of institutional care
- **Adults aged 21 and above,** often former residents who remain due to a lack of alternative housing or reintegration options
- **Elderly individuals,** some of whom may belong to the institution's target group (e. g., women in Safe Homes), while others remain due to limited exit pathways

[27]This figure is derived by subtracting the count of 'no responses' (191) from the total number of children (13081).

Except for **Baby Homes,** which house only children under 18, all other institution types reported at least some non-staff adult residents.

Distribution of Female Residents Over 18: According to **Table 26, 13. 19%** of all female residents are over the age of 18. These include:

- **226 young women aged 18–21** (6.56%)
- **35 women above 21 years old** (1.02%)
- **193 elderly women** (5.61%)

The institutions with the highest share of adult female residents are:

- **Rehabilitation Centres for Socially Disabled Girls (RCSDG):** 47.50% of female residents are above 18, with 20 youth, 22 adults, and 15 elderly women (n = 57)
- **Safe Homes:** 46.04% of female residents are over 18, including 52 youth and 134 elderly women (n = 186)
- **PHT Centres:** 23.96% of female residents are adults or elderly women (n = 59)
- **Residential Centres for Children with Disabilities (RCCD)** and **NGOs** also host a notable proportion of young and adult women

Table 29 Total Female Residents

Female residents	Girls 0-18 years old n(%)	Female Youth 18-21 years old n(%)	Female adult above 21 years old n(%)	Elderly female n(%)	Total
Baby Home	58 100%	0	0	0	58
Madrassa/religious education school	584 87.69%	78 11.71%	4 0.60%	0	666
MoWCA Centre	100 99.01%	1 0.99%	0	0	101
NGO (national and international)	39 67.24%	14 24.14%	5 8.62%	0	58
PHT Centres	191 76.40%	47 18.80%	0	12 4.80%	250
Private orphanage	125 99.21%	0	0	1 0.79%	126
Public orphanage	738 96.98%	9 1.18%	0	14 1.84%	761
Rehabilitation Centre for Socially Disabled Girls	63 52.50%	20 16.67%	22 18.33%	15 12.50%	120
Residential Centre for Children with Disabilities	116 87.88%	0	4 3.03%	12 9.09%	132

Female residents	Girls 0-18 years old n(%)	Female Youth 18-21 years old n(%)	Female adult above 21 years old n(%)	Elderly female n(%)	Total
Safe Home	218 53.96%	52 12.87%	0	134 33.17%	404
Sheikh Russel Home	690 98.57%	5 0.71%	0	5 0.71%	700
SUK/CDC	67 100%	0	0	0	67
Total	**2989** **86.81%**	**226** **6.56%**	**35** **1.02%**	**193** **5.61%**	**3443**

Distribution of Male Residents Over 18: As shown in **Table 27, 2. 96%** of male residents are above the age of 18:

- **229 youth aged 18–21** (2.24%)
- **35 adult men** above 21 years (0.34%)
- **39 elderly men** (0.38%)

The majority of male adult residents are concentrated in:

- **Madrassas:** Hosting 149 youth and 24 adult or elderly men
- **Residential Centres for Children with Disabilities (RCCD):** Nearly 10% of residents are over 18, including 11 youth, 13 adults, and 12 elderly men
- **SUK/CDC** and **Public Orphanages** also report small numbers of male youth and elderly residents

Table 30 Total Male Residents

Male Residents	Boys 0-18 years old n(%)	Male youth 18-21 years old n(%)	Male adult above 21 years old n(%)	Elderly Male n(%)	Total
Baby Home	55 100%	0	0	0	55
Madrassa/religious education school	5598 97.07%	149 2.58%	11 0.19%	9 0.16%	5767
MoWCA Centre	485 99.79%	0	1 0.21%	0	486
NGO (national and international)	251 95.08%	12 4.55%	1 0.38%	0	264
PHT Centres	214 98.17%	0	4 1.83%	0	218
Private orphanage	1047 98.31%	10 0.94%	5 0.47%	3 0.28%	1065

Male Residents	Boys 0-18 years old n(%)	Male youth 18-21 years old n(%)	Male adult above 21 years old n(%)	Elderly Male n(%)	Total
Public orphanage	562 95.90%	23 3.92%	0	1 0.17%	586
Rehabilitation Centre for Socially Disabled Girls	0	0	0	0	0
Residential Centre for Children with Disabilities	334 90.27%	11 2.97%	13 3.51%	12 3.24%	370
Safe Home	7 100%	0	0	0	7
Sheikh Russel Home	305 97.44%	0	0	8 2.56%	313
SUK/CDC	1043 97.20%	24 2.24%	0	6 0.56%	1073
Total	**9901** **97.03%**	**229** **2.24%**	**35** **0.34%**	**39** **0.38%**	**10204**

Institutional Implications of Adult Cohabitation: While a small number of older youth may continue residing in institutions due to extended education or protective needs, the presence of large adult populations—especially in **Safe Homes** and **RCSDG**—raises concerns regarding institutional mandates and the adequacy of transition planning. In both facilities, the ratio of children to adults is nearly even:

- **RCSDG:** 63 children under 18 (52.50%) vs. 57 residents over 18 (47. 50%)
- **Safe Homes:** 225 children (53.96%) vs. 186 adults (46. 04%)

This demographic structure may reflect the lack of alternative living arrangements or tailored exit strategies for girls and women, particularly in cases where family reintegration is not feasible.

While the **Safe Homes' broader mission** includes support for women and elderly survivors of violence—which partially explains this age distribution—there is an emerging need to clarify program boundaries and ensure age-appropriate care for all residents. Institutions without a formal mandate to support adults, such as **PHT Centres** and **RCCD**, may face challenges in meeting the distinct needs of mixed-age populations.

Quality of Care Considerations: The cohabitation of children with adults—particularly in the absence of defined caregiving roles or supportive functions—raises questions about the safety, psychosocial wellbeing, and developmental appropriateness of the residential environment. While exposure to older residents can offer children intergenerational interactions, it may also dilute the child-focused mandate of such institutions.

There is a clear need for:

- **Stronger transition planning** for youth nearing 18 years of age
- **Exit strategies** for long-term residents without family-based care options
- **Review of institutional mandates,** especially where significant adult populations are present in facilities intended for children

4.16 Occupancy Rate

Occupancy rate refers to the extent to which an institution's declared capacity is utilized, calculated by comparing the number of resident children to the facility's intended capacity. This metric is crucial in evaluating institutional efficiency, quality of care, and infrastructure strain.

As shown in **Figure 8** (see graph) and **Table 31,** the **average occupancy rate across institutions is 65%,** meaning that on average, institutions are housing approximately one-third fewer children than their designed capacity. However, this average conceals significant variation across facility types:

Overcrowding:

- The **SUK/CDC facilities** have the highest occupancy rate, at **185%**, with child numbers exceeding double the intended capacity
- **Sheikh Russel Homes (SRCHs)** and **RCCDs** also slightly exceed their intended limits (around **102%**), indicating strong demand but also raising concerns about space, staff strain, and risks of neglect or abuse

Underutilization:

- **Baby Homes** and **RCSDGs** are severely underutilized, operating at only **22. 6%** and **15. 75%** occupancy, respectively
- Similarly, **NGO-run homes** and **madrassas** fall below the average, with occupancy rates of **44. 27%** and **56. 38%**

Figure 8: Declared capacity and occupancy in public childcare residential institutions

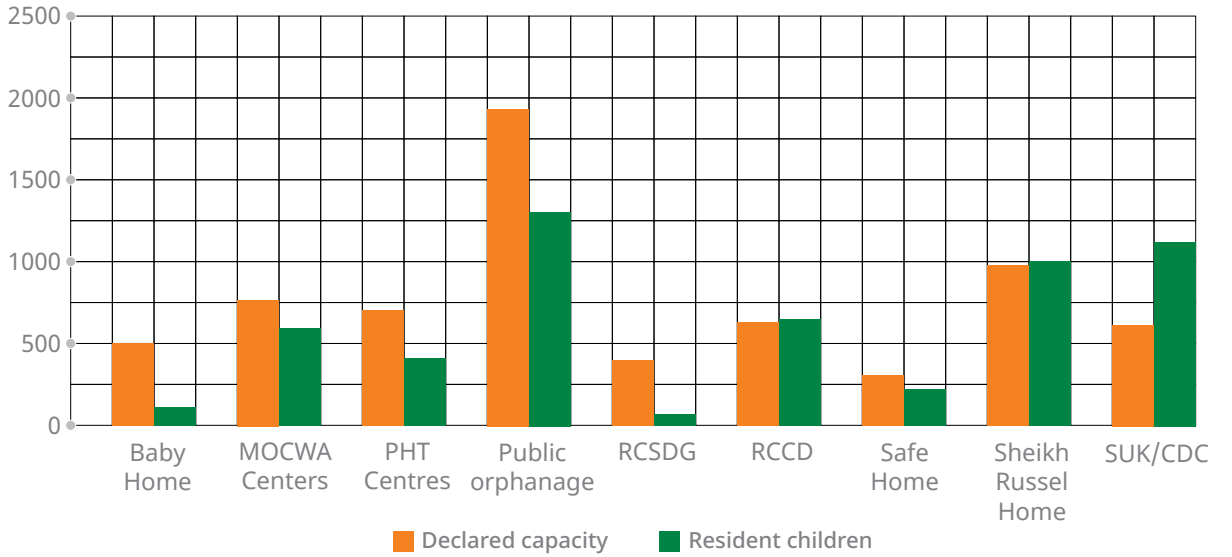


Table 31 Occupancy rate

Category of institution	Number of institutions	Declared Capacity	Total Number of Resident Children	Occupancy Rate
Baby Home	**5** **3.18%**	500	113	22.60
Madrassa/religious education school	**66** **42.04%**	10962	6180	56.38
MoWCA Centre	**5** **3.18%**	760	585	76.97
NGO (national and international)	**4** **2.55%**	655	290	44.27
PHT Centres	**6** **3.82%**	690	405	58.70
Private orphanage	**11** **7.01%**	1730	1172	67.75
Public orphanage	**17** **10.83%**	1925	1300	67.53
Rehabilitation Center for Socially Disabled Girls	**4** **2.55%**	400	63	15.75
Residential Center for Children with Disabilities	**22** **14.01%**	630	643	102.06
Safe Home	**6** **3.82%**	300	225	75.00

Category of institution	Number of institutions	Declared Capacity	Total Number of Resident Children	Occupancy Rate
Sheikh Russel Home	**8** **5.1%**	975	995	102.05
SUK/CDC	**3** **1.91%**	600	1110	185.00
Total	**157** **100%**	**20127**	**13081**	**64.99**

Implications of low and high occupancy rates: The observed low occupancy rates across many institutions suggest an unintended alignment with global care standards, which advocate for small-scale, family-like residential settings that allow for more individualized attention and personalized care. However, this trend also highlights a significant disconnect between the supply of institutional care and the actual demand. A low occupancy rate does not necessarily indicate a failure to meet planned targets; rather, it reflects a mismatch between existing capacity and the real need for residential placements—particularly in a context where institutions are actively recruiting children.

This pattern of under- or overutilization underscores the importance of calibrating institutional capacity to reflect actual care needs, which are influenced by a range of factors. These include the perceived quality of care, the strength of referral and case management systems, and the availability of alternative family-based care options such as kinship or foster care.

Moving forward, this calls for a more deliberate and needs-based approach to residential care admissions. Entry into institutional care should be based on individualized assessments of children's circumstances, with priority given to less restrictive, family-based alternatives wherever possible. This ensures that each child is placed in the most appropriate care setting to support their rights, development, and long-term well-being.

4.17 Children's Admission and Exit

This section provides an overview of the **entry and exit trends of children across different types of residential institutions in 2022,** offering insights into population stability, institutional dynamics, and the flow of care **(Table 32).**

Institutional population dynamics

Facilities where **admissions and exits are relatively balanced** tend to reflect stable resident populations. Institutions such as **Sheikh Russel Homes, SUK, PHT Centres, and Baby Homes** fall into this category, indicating consistent turnover without significant population growth or decline.

In contrast, institutions where **admissions significantly exceed exits**—such as **MOWCA Centres, NGOs, private orphanages,** and **RCCD**s—suggest an increasing resident population. This may be due to growing demand or limited reintegration and discharge mechanisms.

Conversely, where **exits surpass admissions**, it may point to effective reintegration practices or a decline in demand for that care arrangement. Notably, this trend is observed in **Rehabilitation Centres for Socially Disabled Girls (RCSDG)** and, to a lesser extent, **Safe Homes.**

High turnover institutions

A particularly high turnover rate is evident in the **SUK (CDC) centres**, where the number of **admissions (5, 260)** and **exits (5, 026)** far surpasses the **resident population at the time of survey (1, 110).** Of those who exited, **30. 95% were reintegrated with their families,** while **69. 05% were released on court bail.** This reflects a **short-term stay pattern and a continuous influx and outflow,** contributing to persistent overcrowding despite regular exits.

A similar pattern is found in **Safe Homes,** where **875 admissions and 884 exits** occurred in 2022, while the survey recorded only **225 current residents**. Of those who exited, **76. 30% were reintegrated with families, 14. 33% released on bail, 8. 92% transferred to other facilities,** and 0. **45% (4 individuals)** died. This high turnover suggests Safe Homes serve a transitional or emergency care function, with rapid movement through the system.

These findings reflect the varied functions and operational dynamics across different institutional types, and reinforce the need for **strengthened case management, coordinated discharge planning, and expanded family-based care options** to ensure appropriate and sustainable exit pathways for children.

Table 32 Children admission and exit

Children's admissions and exits	Admitted in last 30 Days	Exited in Last 30 Days	Admitted in 2022	Exited in 2022
Baby Home	4	1	39	30
Madrassa/religious education school	106	43	1671	555
MoWCA Centre	2	0	80	16
NGO (national and international)	3	1	42	10
PHT Centres	3	0	332	284
Private orphanage	3	4	126	39
Public orphanage	12	6	183	126
Rehabilitation Centre for Socially Disabled Girls	2	2	28	30
Residential Centre for Children with Disabilities	3	2	107	35
Safe Home	80	52	875	884
Sheikh Russel Home	38	20	452	432
SUK/CDC	550	550	5260	5026
Total	**806**	**681**	**9195**	**7467**

4.18 Children's Transitions Beyond Residential Care: Exit Patterns and Destinations in 2022

To better understand children's pathways beyond institutional care, the study explored the **destinations of children who exited residential facilities during 2022.** These findings provide critical insights into the types of transitions children experienced and whether their exit pathways reflect positive, planned, and rights-based outcomes (see Table 30).

Key findings across institution types

- **Baby Homes** saw equal proportions of children reunified with families (44. 83%) and placed under guardianship (41. 38%). A small number were transferred to other facilities (6. 90%) or died (6. 90%).
- **MOWCA Centres** demonstrated the highest rate of family reintegration (93. 75%), suggesting a strong orientation toward reunification.
- A **majority of children exiting from Sheikh Russel Homes (86. 42%), public orphanages (77. 59%), Safe Homes (76. 30%), and RCCDs (69. 70%)** were also reintegrated with their families.
- Children exiting **NGOs (50%) and private orphanages (41. 67%)** were most commonly reported to have transitioned to independent living, reflecting a trend toward early autonomy for older adolescents.
- **Runaway cases** were highest in **Sheikh Russel Homes (9. 14%)** and **madrassas (4. 66%),** raising concerns about children's safety and the adequacy of care arrangements.
- The highest percentages of children **transferred to other facilities** were observed in **Safe Homes (8. 92%), RCSDGs (7. 41%), and Baby Homes (6. 90%).** While sometimes necessary, such relocations can signal challenges in ensuring stable, long-term care. Frequent transfers may disrupt children's emotional stability and hinder recovery, especially for children with prior experiences of separation or trauma.

Table 33 Destination of children who left residential care in 2022

Category of institutions	Destination of children who left in 2022												
	Family Reintegration n(%)	For Independent Living n(%)	For Marriage n(%)	Place in Guardianship n(%)	Runaway n(%)	Death n(%)	Moved to Another Facility n(%)	Completed Study n(%)	Bailed from court n(%)	Moved for higher Study n(%)	Moved for employment n(%)	Sacked from institution n(%)	Total (N)
Baby Home	13 44.83%	0	0	12 41.38%	0	2 6.90%	2 6.90%	0	0	0	0	0	**29**
Madrassa/ religious education school	233 38.77%	179 29.78%	7 1.16%	0	28 4.66%	1 0.17%	19 3.16%	32 5.32%	0	92 15.31%	8 1.33%	2 0.33%	**601**
MoWCA Centre	15 93.75%	0	0	0	0	1 6.25%	0	0	0	0	0	0	**16**
NGO (national and international)	3 30.00%	5 50.00%	0	0	1 10.00%	1 10.00%	0	0	0	0	0	0	**10**
PHT Centres	103 36.27%	0	2 0.70%	0	0	0	0	0	0	179 63.03%	0	0	**284**
Private orphanage	24 50.00%	20 41.67%	2 4.17%	0	0	0	1 2.08%	0	0	1 2.08%	0	0	**48**
Public orphanage	90 77.59%	16 13.79%	3 2.59%	0	0	0	0	0	0	2 1.72%	0	5 4.31%	**116**
Rehabilitation Centre for Socially Disabled Girls	20 74.07%	5 18.52%	0	0	0	0	2 7.41%	0	0	0	0	0	**27**
Residential Centre for Children with Disabilities	23 69.70%	7 21.21%	0	0	0	0	1 3.03%	0	0	2 6.06%	0	0	**33**
Safe Home	676 76.30%	0	0	0	0	4 0.45%	79 8.92%	0	127 14.33%	0	0	0	**886**
Sheikh Russel Home	350 86.42%	4 0.99%	1 0.25%	0	37 9.14%	0	13 3.21%	0	0	0	0	0	**405**
SUK/CDC	1561 30.95%	0	0	0	0	0	0	0	3483 69.05%	0	0	0	**5044**
Total (n %)	**3111 41.49%**	**236 3.15%**	**15 0.20%**	**12 0.16%**	**66 0.88%**	**9 0.12%**	**117 1.56%**	**32 0.43%**	**3610 48.14%**	**276 3.68%**	**8 0.11%**	**7 0.09%**	**7499[28]**

[28]This total is higher than total number of children reported to exit the facilities in table 26 because it only included the number of children who left through official procedure, excluding instances such as run-aways, etc.

Implications and Reflections: Overall, **family reunification was the most common outcome for children exiting care,** a trend aligned with the principles of the UN Guidelines for the Alternative Care of Children, which emphasize family-based solutions. However, the nature of this reintegration warrants further examination. It is unclear whether these reunifications were the result of **deliberate, planned reintegration processes** supported by case management and family preparation, or if they were **ad hoc returns** without adequate follow-up and support.

Future efforts should focus on strengthening **gatekeeping and reintegration** systems, ensuring that transitions from residential care are **child-centered, individualized,** and part of a broader **continuum of care** that includes preventive and family-based options.

4.19 Availability of Basic Infrastructure and Equipment

This section assesses the availability of key infrastructure across surveyed residential care institutions, including water, electricity, internet connectivity, transport options, and vehicle ownership. These components are essential for ensuring quality care, safety, communication, and accessibility. Table 30 presents a detailed breakdown of basic infrastructure and transport indicators by institution type.

Table 34 Institutions with water, electricity and internet connection, that own a minibus, and are served by public transport

Category of institution	Water connection (n %)		Electricity connection (n%)	Internet (n%)		Own Minibus (n%)		Served by public transport (n%)	
	Yes	No	Yes	Yes	No	Yes	No	Yes	No
Total (n %)	**42 26.75%**	**115 73.25%**	**157 100.00%**	**104 66.24%**	**53 33.76%**	**20 12.74%**	**137 87.26%**	**141 89.81%**	**16 10.19%**
Baby Home	2 40.00%	3 60.00%	5 100.00%	5 100%	0	0	5 100.00%	5 100%	0
Madrassa/ religious education school	11 16.67%	55 83.33%	66 100.00%	26 39.39%	40 60.61%	5 7.58%	61 92.42%	56 84.85%	10 15.15%
MOWCA Centre	3 60.00%	2 40.00%	5 100.00%	3 60.00%	2 40.00%	0	5 100.00%	4 80.00%	1 20.00%
NGO (national and international)	2 50.00%	2 50.00%	4 100.00%	4 100%	0	3 75.00%	1 25.00%	3 75.00%	1 25.00%
PHT Centres	2 33.33%	4 66.67%	6 100.00%	6 100%	0	4 66.67%	2 33.33%	6 100%	0
Private orphanage	2 18.18%	9 81.82%	11 100.00%	7 63.64%	4 36.36%	1 9.09%	10 90.91%	8 72.73%	3 27.27%
Public orphanage	9 52.94%	8 47.06%	17 100.00%	16 94.12%	1 5.88%	0	17 100.00%	17 100%	0
Residential Centre for Children with Disabilities	6 27.27%	16 72.73%	22 100.00%	17 77.27%	5 22.73%	1 4.55%	21 95.45%	22 100%	0

Category of institution	Water connection (n %)		Electricity connection (n%)	Internet (n%)		Own Minibus (n%)		Served by public transport (n%)	
	Yes	No	Yes	Yes	No	Yes	No	Yes	No
Rehabilitation Centre for Socially Disabled Girls	0	4 100%	4 100.00%	4 100%	0	0	4 100.00%	3 75.00%	1 25.00%
Safe Home	2 33.33%	4 66.67%	6 100.00%	5 83.33%	1 16.67%	3 50.00%	3 50.00%	6 100%	0
Sheikh Russel Home			8 100.00%	8 100%	0	0	8 100.00%	8 100%	0
SUK/CDC			3 100.00%	3 100%	0	3 100.00%	0	3 100%	0

Water connection

Only 27% of the institutions surveyed had a functioning water connection. Institutions with the lowest access included SUK/CDC centers, which had no water connection at all, followed by madrassas (83% without), private orphanages (82%), RCCDs (73%), PHT Centers and Safe Homes (67%), and Baby Homes (60%). The few institutions with water access were primarily MoWCA Centres, public orphanages, and NGOs.

Electricity

All 157 institutions included in the study reported having electricity connections, indicating universal access to basic power infrastructure.

Internet access

Internet connectivity was more variable. While most institutions had some form of network access, madrassas were notably under-connected, with only 39% having internet services. Lack of internet can limit opportunities for children's education and social integration, as well as impede administrative efficiency.

Vehicle ownership

Only 13% (20 out of 157) of institutions owned a minibus, which limits their ability to transport children to school, healthcare services, or recreational activities.

Access to public transport

Public transport access is a critical indicator of how socially integrated these institutions are and how easily families and staff can reach the facilities. About 10% of institutions were not served by public transport—most notably madrassas—raising concerns about isolation and limited external engagement.

05

Findings:
Profile of Children in Residential Care

This section provides a detailed analysis of the children residing in institutional care facilities, based on a sample of 10,678 profiled residents as shown in table 31. It examines key demographic characteristics such as age, gender, disability status, and education levels, as well as family background, reasons for admission, and length of stay. It also explores documentation practices related to admission assessments, care orders, and exit planning. These findings shed light on the individual pathways that lead children into institutional care and highlight systemic gaps in gatekeeping, planning, and family-based alternatives.

Table 35 Total Number of Residents vs Profiled Children

Category	Number of facilities in the sample	Number of facilities where Tool 2 was conducted	Total number of residents admitted	Profiled children
Total	**157**	**150**	**12546**	**10143** **80.84%**
Baby Home	5	5	113	113 100%
Madrassa/religious education school	66	66	6431	5,110 79.45%
MoWCA Centre	5	5	587	550 93.69%
NGO (national and international)	4	3	162	108 66.66%
PHT Centres	6	6	468	324 69.23%
Private orphanage	11	11	1191	999 83.87%
Public orphanage	17	16	1250	1,096 87.68%
Rehabilitation Centre for Socially Disabled Girls	4	4	120	43 35.83%
Residential Centre for Children with Disabilities	22	20	493	450 91.27%
Safe Home	6	5	376	210 55.85%
Sheikh Russel Home	8	8	1013	995 98.22%
SUK/CDC	3	1	342	145 42.39%

5.1 Gender

Less than one third of profiled children are girls (28. 27%) while the great majority are boys (71. 73%). The predominance of boys is due to the high numbers of children profiled in madrassas.

Table 36 Gender of Profiled Children

Category	Female Residents n(%)	Male Residents n(%)	Total (N)
Total (n%)	**2867 28.27%**	**7276 71.73%**	**10,143**
Baby Home	58 51.33%	55 48.67%	113
Madrassa/religious education school	787 15.4%	4323 84.6%	5,110
MoWCA Centre	70 12.73%	480 87.27%	550
NGO (national and international)	24 22.22%	84 77.78%	108
PHT Centres	185 57.1%	139 42.9%	324
Private orphanage	86 8.61%	913 91.39%	999
Public orphanage	563 51.37%	533 48.63%	1,096
Rehabilitation Centre for Socially Disabled Girls	43 100%	0	43
Residential Centre for Children with Disabilities	153 34%	297 66%	450
Safe Home	206 98.1%	4 1.9%	210
Sheikh Russel Home	692 69.55%	303 30.45%	995
SUK/CDC	0	145 100%	145

5.2 Age

The majority of profiled children concentrate in the age range between 10 to 16 years of age (72.48%). Children above 16 years of age are numerous in RCSDG (51.16%) and in the SUK (39.31%). Younger children are only more numerous in Baby Homes, where most of them are in the age bracket 3 to 9 years (75.22%). In many cases, the age of children in Baby Homes exceeds the upper limit of the admission criteria (0-7), as children above 7 years of age are present. Further investigation is warranted to understand the reasons behind the extended stays of older children beyond the typical age range.

Table 37 Age bracket of Profiled Children

Category	No Response	0-6 Months	7-12 Months	1-2 years	3-5 Years	6-9 Years	10-13 Years	14-16 years	17-18 Years	Total
Total (n %)	**288 2.84%**	**7 0.07%**	**11 0.11%**	**11 0.11%**	**77 0.76%**	**1457 14.36%**	**4556 44.92%**	**2795 27.56%**	**941 9.28%**	**10,143**
Baby Home	0	7 6.19%	3 2.65%	10 8.85%	45 39.82%	40 35.4%	4 3.54%	3 2.65%	1 0.88%	**113**
Madrassa/religious education school	41 0.8%	0	2 0.04%	0	20 0.39%	756 14.79%	2540 49.71%	1356 26.54%	395 7.73%	**5,110**
MoWCA Centre	1 0.18%	0	0	0	2 0.36%	49 8.91%	272 49.45%	184 33.45%	42 7.64%	**550**
NGO (national and international)	0	0	0	0	0	19 17.59%	43 39.81%	33 30.56%	13 12.04%	**108**
PHT Centres	0	0	0	0	0	29 8.95%	144 44.44%	87 26.85%	64 19.75%	**324**
Private orphanage	13 1.3%	0	0	0	6 0.6%	144 14.41%	409 40.94%	311 31.13%	116 11.61%	**999**
Public orphanage	100 9.12%	0	0	0	0	179 16.33%	420 38.32%	296 27.01%	101 9.22%	**1,096**
Rehabilitation Centre for Socially Disabled Girls	2 4.65%	0	0	0	0	0	3 6.98%	16 37.21%	22 51.16%	**43**
Residential Centre for Children with Disabilities	12 2.67%	0	0	0	0	43 9.56%	220 48.89%	133 29.56%	42 9.33%	**450**
Safe Home	12 5.71%	0	3 1.43%	1 0.48%	2 0.95%	3 1.43%	25 11.9%	111 52.86%	53 25.24%	**210**
Sheikh Russel Home	107 10.75%	0	3 0.3%	0	2 0.2%	195 19.6%	474 47.64%	179 17.99%	35 3.52%	**995**
SUK/CDC	0	0	0	0	0	0	2 1.38%	86 59.31%	57 39.31%	**145**

5.3 Age at Admission

The majority of children were admitted into residential care before they turned 14 (81.16%), and nearly half of the profiled children were found to have been admitted to the facilities between the ages of six to nine years (47.12%). This age bracket could indicate a strong need for supplementing parental education when children enter pre-adolescence and adolescence. For girls, the age of puberty seems to be the critical moment when girls are admitted to residential care, as girls from Safe Homes and RCSDG enter the majority between ages 14-16 (respectively 53.81% and 44.19%) and 10 to 13 years (22.38% for Safe Homes and 37.21% for RCSDG).

Children in Baby Homes were admitted mostly between 3 and 5 years (45.13%). Newborns 0-6 months were admitted in 20. 35%. toddlers 1-2 years of age, 14.16% and 11.5 % between 6 and 9 years.

Table 38 Age at admission

Category	No Response	0-6 Months	7-12 Months	1-2 years	3-5 Years	6-9 Years	10-13 Years	14-16 years	17-18 Years	Total
Total (n %)	**585 5.77%**	**29 0.29%**	**17 0.17%**	**28 0.28%**	**361 3.56%**	**4779 47.12%**	**3453 34.04%**	**769 7.58%**	**122 1.2%**	**10,143**
Baby Home	0	23 20.35%	10 8.85%	16 14.16%	51 45.13%	13 11.5%	0	0	0	**113**
Madrassa/religious education school	215 4.21%	3 0.06%	2 0.04%	5 0.1%	151 2.95%	2222 43.48%	2135 41.78%	357 6.99%	20 0.39%	**5,110**
MoWCA Centre	1 0.18	0	0	0	23 4.18%	295 53.64%	215 39.09%	15 2.73%	1 0.18%	**550**
NGO (national and international)	0	0	0	1 0.93%	6 5.56%	49 45.37%	42 38.89%	6 5.56%	4 3.7%	**108**
PHT Centres	57 17.59%	0	0	0	3 0.93%	97 29.94%	111 34.26%	37 11.42%	19 5.86%	**324**
Private orphanage	33 3.3%	0	1 0.1%	3 0.3%	59 5.91%	583 58.36%	267 26.73%	52 5.21%	1 0.1%	**999**
Public orphanage	142 12.96%	0	1 0.09%	2 0.18%	45 4.11%	805 73.45%	93 8.49%	7 0.64%	1 0.09%	**1096**
Rehabilitation Centre for Socially Disabled Girls	2 4.65%	0	0	0	0	1 2.33%	16 37.21%	19 44.19%	5 11.63%	**43**
Residential Centre for Children with Disabilities	16 3.56%	0	0	0	61.33%	214 47.56%	183 40.67%	30 6.67%	1 0.22%	**450**
Safe Home	12 5.71%	0	3 1.43%	1 0.48%	3 1.43%	7 3.33%	47 22.38%	113 53.81%	24 11.43%	**210**
Sheikh Russel Home	107 10.75%	3 0.3%	0	0	14 1.41%	493 49.55%	338 33.97%	39 3.92%	1 0.1%	**995**
SUK/CDC	0	0	0	0	0	0	6 4.14%	94 64.83%	45 31.03%	**145**

5.4 Admission Modality

Nearly three-quarters of the profiled children were admitted into the facility upon parents' or guardians' application, as reported to be the case for 77.52% of the profiled children. Only a small proportion were admitted into the facility through self-referral (5.39%), recruited by the facility (4.02%), referral from a social worker (1.91%), or from police (1.21%). 100% of children in SUK and shares of children in Safe Homes and Baby Homes were admitted following a care order (see section on Care order for more details).

In the vast majority of cases, children are placed in care following applications from parents, highlighting a substantial demand for assistance within families. This prompts a significant inquiry into whether these families have access to other forms of social and economic support beyond relieving some parental responsibilities or financial burdens. The crucial question emerges: Do support systems exist, and are they adequately communicated and accessible to families to prevent child separation from family? Facilitating referrals to such services forms a crucial component of gatekeeping processes. Expanding on the considerations regarding the communication strategies employed by residential care facilities, it would be pertinent to ensure that there are concerted efforts to align families' perceptions of residential care with the notion that it serves as a measure of last resort and that children are best cared for within family and community environments.

Table 39 Admission modality

Category	Didn't get any Information n(%)	Self-referral n(%)	Admission upon Parents'/ guardian application n(%)	Care order upon parents' application n(%)	Foundling (lost or abandoned) with care order n(%)	Foundling without care or) der n(%)	Referred by social worker (Only govt social worker) n(%)	Referred by Police n(%)	Recruited by facility n(%)	Other (Care order n(%)	Total (N)
Total (n %)	**470 4.63%**	**547 5.39%**	**7863 77.52%**	**52 0.51%**	**85 0.84%**	**5 0.05%**	**194 1.91%**	**123 1.21%**	**408 4.02%**	**396 3.9%**	**10,143**
Baby Home	4 3.54%	19 16.81%	12 10.62%	0	20 17.7%	1 0.88%	12 10.62%	16 14.16%	0	29 25.66%	**113**
Madrassa/religious education school	150 2.94%	193 3.78%	4491 87.89%	19 0.37%	2 0.04%	2 0.04%	1 0.02%	0	223 4.36%	29 0.57%	**5,110**
MoWCA Centre	0	258 46.91%	290 52.73%	0	0	0	0	2 0.36%	0	0	**550**
NGO (national and international)	47 43.52%	1 0.93%	57 52.78%	0	0	0	0	2 1.85%	0	1 0.93%	**108**
PHT Centres	0	29 8.95%	280 86.42%	0	0	0	0	0	15 4.63%	0	**324**
Private orphanage	24 2.4%	0	877 87.79%	0	0	0	0 0%	0	98 9.81%	0	**999**
Public orphanage	73 6.66%	42 3.83%	806 73.54%	30 2.74%	4 0.36%	2 0.18%	30 2.74%	1 0.09%	29 2.65%	79 7.21%	**1,096**
Rehabilitation Centre for Socially Disabled Girls	0	0	421 93.56%	0	0	0	10 2.22%	3 0.67%	14 3.11%	2 0.44%	**450**
Residential Centre for Children with Disabilities	18 41.86%	0	3 6.98%	0 0%	0 0%	0	8 18.6%	8 18.6%	6 13.95%	0 0%	**43**
Safe Home	33 15.71%	0	0	0	43 20.48%	0	0	58 27.62%	0	76 36.19%	**210**
Sheikh Russel Home	121 12.16%	5 0.5%	626 62.91%	3 0.3%	16 1.61%	0	133 13.37%	33 3.32%	23 2.31%	35 3.52%	**995**
SUK/CDC	0	0	0	0	0	0	0	0	0	145 100%	**145**

5.5 Reasons for Admission

Grasping the actual main reason behind children's placement in residential care is not an easy task, as children in need of care and protection often live in complex family situations where identifying a single reason for admission is not an easy job. In addition, the Children's Act considers "children in need of care and protection" to have a broad scope of "categories" and circumstances that can often overlap. This, alongside the lack of standardized and uniform admission criteria in childcare centers, prompts the consideration that the results below as reflecting the respondents' perceptions of the children under their care rather than rigorously applied indicators.

It is striking that in the majority of cases, respondents consistently indicate family poverty as the main (or the main reason behind the actual circumstances of the child) reason for children being admitted in residential care. This is particularly evident for the great majority of the children in MOWCA centers (93.09%), madrassas (75.3%), public orphanages (67.61%), and for approximately half of the children in Sheikh Russel Homes (50.75%) and private orphanages (47.55%).

In this regard, it is important to recall that among the fundamental policy orientations within the UN Guidelines, poverty alone should never justify the admission of a child into formal alternative care. "Financial and material poverty, or conditions directly and uniquely imputable to such poverty, should never be the only justification for the removal of a child from parental care, for receiving a child into alternative care, or for preventing his/her reintegration, but should be seen as a signal for the need to provide appropriate support to the family". These observations call for engaging a broad reflection on the matter, encouraging policy adjustments.

Being deprived of parental care is indicated as the reason for being admitted for a majority of children in private orphanages (46.85%) and in Baby Homes (29.2%).

NGOs indicate that being on the streets and eventually begging is the main reason for 50% of their children being admitted.

Sheikh Russel homes indicate a wide range of reasons for children being in residential care. In addition to family poverty and deprivation of parental care (as already mentioned), these facilities have 11.76% of children considered as victims of neglect and 4.02% of street children.

These results underscore, among others, the need for a robust monitoring system, including standardized reasons for the children's placement in alternative care. This system may seek to establish defined criteria and indicators aligned with national and international best practices. These standardized definitions should guide gatekeeping procedures, ensuring a uniform and consistent assessment to determine the necessity of placement in alternative or residential care.

Table 40 Profiled children's reason for admission

Category of institutions/ Reasons for admission	Baby Home	Madrassa/ religious education school	MOWCA Centre	NGO (national and intl)	PHT Centers	Private orphanage	Public orphanage	Rehabilitation Centre for Socially Disabled Girls	Residential Centre for Children with Disabilities	Safe Home	Sheikh Russel Home	SUK/ CDC	Total (n %)
Anonymous abandonment (for newborns)	14 12.39%	0	0	0	0	1 0.1%	0	0	0	0	0	0	**15** **0.15%**
Child deprived of parental care	33 29.2%	756 14.79%	17 3.09%	1 0.93%	5 1.54%	468 46.85%	192 17.52%	0	5 1.11%	2 0.95%	201 20.2%	0	**1680** **16.56%**
Child in street situation, including begging	6 5.31%	6 0.12%	1 0.18%	46 42.59%	0	0	7 0.64%	2 4.65%	0	14 6.67%	40 4.02%	0	**122** **1.2%**
Child labour and exploitation by work	0	1 0.02%	0	0	0	0	0	0	0	0	28 2.81%	0	**29** **0.29%**
Child with Disability	5 4.42%	9 0.18%	0	54 50%	280 86.42%	3 0.3%	1 0.09%	1 2.33%	441 98%	3 1.43%	15 1.51%	0	**812** **8.01%**
Court Order	26 23.01%	0	0	0	0	0	0	0	0	99 47.14%	4 0.4%	75 51.72%	**204** **2.01%**
Did the criminal offence	0	0	0	0	0	0	0	0	0	27 12.86%	2 0.2%	0	**29** **0.29%**
Didn't get any information	2 1.77%	0	0	0	0	0	76 6.93%	0	0	1 0.48%	33 3.32%	6 4.14%	**118** **1.16%**
Emotional abuse	0	0	1 0.18%	0	0	0	0	0	0	0	0	0	**1** **0.01%**
For Study	0	252 4.93%	0	0	0	0	0	0	0	0	0	0	**252** **2.48%**
Household Economic hardship	15 13.27%	3848 75.3%	512 93.09%	2 1.85%	0	475 47.55%	741 67.61%	0	0	0	505 50.75%	0	**6098** **60.12%**
Inappropriate sexual behaviour	0	0	0	0	0	0	0	4 9.3%	0	0	0	16 11.03%	**20** **0.2%**

Category of institutions/ Reasons for admission	Baby Home	Madrassa/ religious education school	MOWCA Centre	NGO (national and intl)	PHT Centers	Private orphanage	Public orphanage	Rehabilitation Centre for Socially Disabled Girls	Residential Centre for Children with Disabilities	Safe Home	Sheikh Russel Home	SUK/ CDC	Total (n %)
Neglect	1 0.88%	52 1.02%	0	0	0	2 0.2%	7 0.64%	1 2.33%	0	0	117 11.76%	0	**180** **1.77%**
Physical abuse	0	0	0	0	0	0	0	6 13.95%	0	1 0.48%	5 0.5%	0	**12** **0.12%**
Referred from Another Institution	2 1.77%	0	6 1.09%	0	0	0	22 2.01%	0	0	4 1.9%	0	0	**34** **0.34%**
Sexual abuse	1 0.88%	0	0	0	0	0	0	0	0	0	3 0.3%	0	**4** **0.04%**
Sexual exploitation	0	1 0.02%	0	0	0	50 5.01%	0	7 16.28%	0	0	3 0.3%	0	**61** **0.6%**
Socially inappropriate behaviour other than sexual (use of drugs, contact with adult offenders)	0	0	0	0	0	0	0	3 6.98%	0	0	4 0.4%	34 23.45%	**41** **0.4%**
Victim of child marriage	1 0.88%	0	0	0	0	0	0	3 6.98%	0	14 6.67%	7 0.7%	0	**25** **0.25%**
Other	7 6.19%	185 3.62%	13 2.36%	5 4.63%	39 12.04%	0	50 4.56%	16 37.21%	4 0.89%	45 21.43%	28 2.81%	14 9.66%	**406** **4%**
Total (N)	**113**	**5110**	**550**	**108**	**324**	**999**	**1096**	**43**	**450**	**210**	**995**	**145**	**10143**

5.6 Provenance

37.57% of children in residential care come from the same upazila in which they are institutionalized, while 23.06% originated from another upazila within the same district, and 10.1% of the admitted children come from the same district. Additionally, 18.74% of the profiled children were admitted from another district. This may be influenced by the need to provide care for children from neighboring regions where suitable facilities may be limited or absent. Furthermore, the data indicates that 7.39% of profiled children came from a different division within Bangladesh, which could be an indicator of child and family mobility within the country, along with a willingness on the part of these facilities to serve a broader geographic area. Notably, the percentage of residents arriving from an entirely different country is minimal, with only three children. More details show that:

- Children from another division are the majority in SUK (79.31%);
- Children from another division are also particularly numerous in NGOs - notably catering to a majority of street children, who might originate from a different division - as well as for MOWCA centers (23.64%);
- Half of the children in madrassas come from the same upazila, and 14.27% form another district, indicating a degree of mobility among children seeking admission in madrassas;
- Safe Homes (53.81%) and PHT centers (46.3%) draw children from other districts because of their limited availability and the specialized services they provide.

If being from the same district is considered an acceptable distance for allowing trips home by both children and parents/relatives, then the great majority of children have the possibility of maintaining connections with parents and relatives. Conversely, children who live in residential care located at a considerable distance from their former residence, exercising their fundamental right to maintain family ties, unless not in their best interest, might be quite challenging.

Table 41 Provenance of resident children

Category	No Response n(%)	Same upazila n(%)	Another upazila n(%)	Same district n(%)	Another district n(%)	Another division n(%)	Another country n(%)	Total Children
Total (n %)	**315 3.11%**	**3811 37.57%**	**2339 23.06%**	**1024 10.1%**	**1901 18.74%**	**750 7.39%**	**3 0.03%**	**10,143**
Baby Home	8 7.08%	24 21.24%	16 14.16%	26 23.01%	35 30.97%	4 3.54%	0	**113**
Madrassa/religious education school	0	2605 50.98%	1150 22.5%	391 7.65%	729 14.27%	235 4.6%	0	**5,110**
MoWCA Centre	0	20 3.64%	118 21.45%	97 17.64%	185 33.64%	130 23.64%	0	**550**
NGO (national and international)	0	14 12.96%	6 5.56%	28 25.93%	17 15.74%	43 39.81%	0	**108**
PHT Centres	3 0.93%	17 5.25%	54 16.67%	76 23.46%	150 46.3%	24 7.41%	0	**324**
Private orphanage	0	581 58.16%	230 23.02%	15 1.5%	152 15.22%	21 2.1%	0	**999**
Public orphanage	131 11.95%	260 23.72%	360 32.85%	132 12.04%	179 16.33%	33 3.01%	1 0.09%	**1,096**
Rehabilitation Centre for Socially Disabled Girls	10 23.26%	1 2.33%	2 4.65%	16 37.21%	6 13.95%	8 18.6%	0	**43**
Residential Centre for Children with Disabilities	6 1.33%	74 16.44%	138 30.67%	33 7.33%	130 28.89%	69 15.33%	0	**450**
Safe Home	27 12.86%	4 1.9%	19 9.05%	23 10.95%	113 53.81%	24 11.43%	0	**210**
Sheikh Russel Home	130 13.07%	211 21.21%	245 24.62%	185 18.59%	180 18.09%	44 4.42%	0	**995**
SUK/CDC	0	0	1 0.69%	2 1.38%	25 17.24%	115 79.31%	2 1.38%	**145**

5.7 Ethnicity

02.01% of the profiled children, namely 204 children, belong to ethnic minority groups. They are mainly found in MoWCA centers (42.15%), public orphanages (33.33%) and Sheikh Russel Homes (18.13%).

For childcare institutions hosting these children, complying with Article 20 of the CRC, which mandates ensuring the preservation of the child's ethnic, religious, cultural, and linguistic background when in care, could pose major challenges.

Table 42 Ethnicity of resident children

Category	No Response n(%)	Number of children Belongs to Ethnic Minority Group n(%)	Not belonging to Ethnic Minority Group n(%)	Total (N)
Total (n %)	**2 0.02%**	**204 2.01%**	**9937 97.97%**	**10,143**
Baby Home	0	0	113 100%	**113**
Madrassa/religious education school	0	2 0.04%	5108 99.96%%	**5,110**
MoWCA Centre	0	86 15.64%	464 84.36%	**550**
NGO (national and international)	0	0	108 100%	**108**
PHT Centres	0	1 0.31%	323 99.69%	**324**
Private orphanage	0	6 0.6%	993 99.4%	**999**
Public orphanage	0	68 6.2%	1028 93.8%	**1,096**
Rehabilitation Centre for Socially Disabled Girls	0	0	43 100%	**43**
Residential Centre for Children with Disabilities	0	4 0.89%	446 99.11%	**450**
Safe Home	2 0.95%	0	208 99.05%	**210**
Sheikh Russel Home	0	37 3.72%	958 96.28%	**995**
SUK/CDC	0	0	145 100%	**145**

5.8 The Children's Families

The study aimed at exploring the parental status of children, whether their families are known, and their living arrangements before being admitted to residential care. These are key elements for a better comprehension of the underlying dynamics leading to their placement.

Parental status

Most of the children in residential care (89.76%) have at least one parent living.

37.52% of the profiled children in these residential care facilities have both parents living. They are the great majority of children living in RCCD, SUK, PHT, and MoWCA centers.

52.24% have only one parent living, with madrassas standing out as the childcare institutions that have more children with only one parent living.

5.28% of the profiled children are double orphans with no living parent, with half of them living in madrassas.

Equally noteworthy is the fact that for another 5.68% of the profiled children, the parental status is unknown to the facility. For 50.44% of children (57 children) in Baby Homes parental status is not known (Table 40) and for 52.21% of them (59 children) parents or relatives are not identified. (Table 41). Only 14 children have "child anonymous abandonment" as the reason for admission, and therefore, this lack of information on all remaining children underscores potential gaps in family tracking, documentation, or communication between the facility and the families or guardians of these children.

Equally unknown is the parental status of girls in RCSDG, accounting for a significant portion (41. 86%) of residents.

Table 43 Parental status of children

Category	No Response n(%)	Both parents living n(%)	One parent living n(%)	No parents living (Double Orphan) n(%)	Unknown n(%)	Total (N)
Total (n %)	**79 0.78%**	**3806 37.52%**	**5299 52.24%**	**534 5.26%**	**425 4.19%**	**10,143**
Baby Home	0	28 24.78%	26 23.01%	2 1.77%	57 50.44%	**113**
Madrassa/religious education school	0	1458 28.53%	3376 66.07%	265 5.19%	11 0.22%	**5,110**
MoWCA Centre	0	441 80.18%	97 17.64%	6 1.09%	6 1.09%	**550**
NGO (national and international)	0	63 58.33%	21 19.44%	5 4.63%	19 17.59%	**108**

Category	No Response n(%)	Both parents living n(%)	One parent living n(%)	No parents living (Double Orphan) n(%)	Unknown n(%)	Total (N)
PHT Centres	0	274 84.57%	27 8.33%	0	23 7.1%	**324**
Private orphanage	0	341 34.13%	459 45.95%	106 10.61%	93 9.31%	**999**
Public orphanage	72 6.57%	86 7.85%	816 74.45%	73 6.66%	49 4.47%	**1,096**
Rehabilitation Centre for Socially Disabled Girls	0	18 41.86%	6 13.95%	1 2.33%	18 41.86%	**43**
Residential Centre for Children with Disabilities	0	416 92.44%	20 4.44%	6 1.33%	8 1.78%	**450**
Safe Home	1 0.48%%	73 34.76%	74 35.24%	6 2.86%	56 26.67%	**210**
Sheikh Russel Home	6 0.6%	476 47.84%	364 36.58%	64 6.43%	85 8.54%	**995**
SUK/CDC	0	132 91.03%	13 8.97%	0	0	**145**

Children without any identified parent or relative

Children without any identified parent or relative are a substantial portion of children in Baby Homes and RCSDG, as already indicated, and also in NGOs (50.93%) and Safe Homes (34.29%). As mentioned above, this prompts inquiry into whether efforts were undertaken to track the families when the children first interacted with the services, and with what outcome.

Table 44 Have identified parents/relatives

Category	No Response n(%)	Children who have identified parents/ relatives n(%)	Children without any identified parent/ relatives	Total (N)
Total (n %)	**10 0.1%**	**9593 94.58%**	**540 5.32%**	**10,143**
Baby Home	0	54 47.79%	59 52.21%	**113**
Madrassa/religious education school	0	4967 97.2%	143 2.8%	**5,110**
MoWCA Centre	0	544 98.91%	6 1.09%	**550**
NGO (national and international)	0	53 49.07%	55 50.93%	**108**

Category	No Response n(%)	Children who have identified parents/ relatives n(%)	Children without any identified parent/ relatives	Total (N)
PHT Centres	0	302 93.21%	22 6.79%	**324**
Private orphanage	0	994 99.5%	5 0.5%	**999**
Public orphanage	10 0.91%	1040 94.89%	46 4.2%	**1,096**
Rehabilitation Centre for Socially Disabled Girls	0	19 44.19%	24 55.81%	**43**
Residential Centre for Children with Disabilities	0	441 98%	9 2%	**450**
Safe Home	0	138 65.71%	72 34.29%	**210**
Sheikh Russel Home	0	896 90.05%	99 9.95%	**995**
SUK/CDC	0	145 100%	0	**145**

Main caregivers before admission

The data in Table 42 provides compelling insights into the caregiving arrangements that preceded the children's admission into the facilities. Remarkably, a substantial majority, comprising 82.8% of the profiled children, were under the care of single mothers before being admitted. This percentage is higher than the average for boys in SUK (93.1%), which could potentially suggest that single mothers face heightened challenges in managing male children exhibiting problematic behavior, along with the lack of support systems. It is also higher than the average for children in madrassas (91.43%) and for children in RCCD (90%), indicating a possible priority given to children of single mothers, particularly widows.

While for the majority of children in Baby Homes, there is no information regarding the main caregiver before admission, 30.97% of them were living with single mothers. However, from available data, it is not possible to elicit whether these children were born out of wedlock and placed due to adverse social norms surrounding single mothers or not.

Another notable segment of the data reveals that 7.91% of the profiled children – with the majority of them found in private orphanages – were taken care of by other relatives before being placed in residential care.

A relatively small proportion of children, specifically 3.15%, were under the care of single fathers prior to their admission. This finding indicates a less common circumstance leading to residential care placement for their children. These might be widowers.

Also, note that in RCSDGs, 13.95% of girls were living with a non-relative, 16.28% in another institution and 11.63% were living alone (on the streets or other places).

Finally, 23% of children in NGOs were living alone (on the streets or other places). Again, NGOs and Sheikh Russel Homes stand out as institutions especially committed to the plight of street children.

Table 45 Main caregiver before admission

Category	Single Mother n(%)	Single father n(%)	Other relative n(%)	Other non-relative n(%)	Living in another institution n(%)	Living alone (on the streets or Others) n(%)	No information n(%)	Total (N)
Total (n %)	**8398 82.8%**	**320 3.15%**	**802 7.91%**	**18 0.18%**	**160 1.58%**	**58 0.57%**	**387 3.82%**	**10,143**
Baby Home	35 30.97%	0	7 6.19%	1 0.88%	16 14.16%	3 2.65%	51 45.13%	**113**
Madrassa/religious education school	4672 91.43%	111 2.17%	283 5.54%	2 0.04%	1 0.02%	3 0.06%	38 0.74%	**5,110**
MoWCA Centre	448 81.45%	65 11.82%	10 1.82%	0	24 4.36%	1 0.18%	2 0.36%	**550**
NGO (national and international)	62 57.41%	4 3.7%	3 2.78%	0	0	25 23.15%	14 12.96%	**108**
PHT Centres	251 77.47%	0	2 0.62%	0	9 2.78%	0	62 19.14%	**324**
Private orphanage	758 75.88%	18 1.8%	216 21.62%	1 0.1%	0	6 0.6%	0	**999**
Public orphanage	832 75.91%	16 1.46%	100 9.12%	2 0.18%	59 5.38%	1 0.09%	86 7.85%	**1,096**
Residential Centre for Children with Disabilities	405 90%	15 3.33%	20 4.44%	0	5 1.11%	0	5 1.11%	**450**
Rehabilitation Centre for Socially Disabled Girls	6 13.95%	1 2.33%	3 6.98%	6 13.95%	7 16.28%	5 11.63%	15 34.88%	**43**
Safe Home	83 39.52%	54 25.71%	4 1.9%	1 0.48%	1 0.48%	0	67 31.9%	**210**
Sheikh Russel Home	711 71.46%	33 3.32%	148 14.87%	5 0.5%	38 3.82%	14 1.41%	46 4.62%	**995**
SUK/CDC	135 93.1%	3 2.07%	6 4.14%	0	0	0	1 0.69%	**145**

5.9 Health Status

The study inquired into the health status of children to better understand their overall needs. The majority of the profiled children within the care facilities were reported to have good health, while only a mere 1.17% were reported to have, at present, a minor health concern and 0. 25% a major health concern (Table 46).

Young children living in Baby Homes face more health concerns due to their young age and vulnerability, as there are concerns regarding the health of a substantial one-third of the children. There are minor concerns for 21.24% of them and major concerns for 7.08% of them. Girls in the Rehabilitation Centre for Socially Disabled Girls also face some minor concerns (16.28%).

Table 46 Health status of children

Category	Didn't get any Information n(%)	Healthy n(%)	Minor health concern n(%)	Major health concern n(%)	Total (N)
Total (n %)	**27 0.27%**	**9972 98.31%**	**119 1.17%**	**25 0.25%**	**10,143**
Baby Home	0	81 71.68%	24 21.24%	8 7.08%	**113**
Madrassa/religious education school	0	5055 98.92%	46 0.9%	9 0.18%	**5,110**
MoWCA Centre	0	550 100%	0	0	**550**
NGO (national and international)	0	104 96.3%	2 1.85%	2 1.85%	**108**
PHT Centres	0	322 99.38%	2 0.62%	0	**324**
Private orphanage	0	999 100%	0	0	**999**
Public orphanage	10 0.91%	1077 98.27%	7 0.64%	2 0.18%	**1,096**
Residential Centre for Children with Disabilities	0	443 98.44%	6 1.33%	1 0.22%	**450**
Rehabilitation Centre for Socially Disabled Girls	0	36 83.72%	7 16.28%	0	**43**
Safe Home	17 8.1%	184 87.62%	9 4.29%	0	**210**
Sheikh Russel Home	0	977 98.19%	16 1.61%	2 0.2%	**995**
SUK/CDC	0	144 99.31%	0	1 0.69%	**145**

5.10 Disability Status

Having a desire to deepen the knowledge of the links between residential care and disability, which may be one of the factors, which may lead to children being placed in residential care, the study collected individual data on the disability status of children.

Roughly 10% of children in residential care have a form of disability, which amounts to 1005 children. Of these, the majority (8.08%) have a form of sensorial disability, which is not surprising considering that residential facilities for children with sensor disabilities constitute a substantial portion of the sampled facilities.

All the children hosted in RCCDs have a form of disability, standing at 94.22% for sensor disability. In PHT, while the great majority of children have a disability (mostly sensorial), 10.49% of the children have no disability.

Excluding these two types of dedicated facilities, the majority of children hosted in NGO centers live with a disability (60.19%), being again the majority of children with sensor disability (47.22%) and mental disability (11.11%).

Many children in Baby Homes (36.28%) also have a form of disability, with a predominance of mental disability (14.16%), multiple disabilities (12.39%) and around 5% of children with sensor or motor disability. In spite of being only 4.42% of the reasons for being admitted (see 1. 2. 2. 5), disability emerges as a significant factor that increases the vulnerability of young children, whether the disability is apparent from birth or becomes evident as the child grows, leading to a higher likelihood of abandonment/placement in Baby Homes.

Table 47 Disability status of children

Category	Didn't get any Information n(%)	Have no disability n(%)	Sensorial n(%)	Motor n(%)	Mental n(%)	Multiple n(%)	Other n(%)	Total (N)
Total (n %)	**10 0.1%**	**9138 90.09%**	**820 8.08%**	**33 0.33%**	**102 1.01%**	**30 0.3%**	**10 0.1%**	**10,143**
Baby Home	0	72 63.72%	6 5.31%	5 4.42%	16 14.16%	14 12.39%	0	**113**
Madrassa/religious education school	0	5056 98.94%	20 0.39%	19 0.37%	10 0.2%	1 0.02%	4 0.08%	**5,110**
MoWCA Centre	0	543 98.73%	6 1.09%	0	1 0.18%	0 0%	0	**550**
NGO (national and international)	0	43 39.81%	51 47.22%	0	12 11.11%	2 1.85%	0	**108**
PHT Centres	0	34 10.49%	283 87.35%	0	4 1.23%	3 0.93%	0	**324**
Private orphanage	0	999 100%	0	0	0 0%	0	0	**999**
Public orphanage	10 0.91%	1081 98.63%	1 0.09%	1 0.09%	2 0.18%	1 0.09%	0	**1,096**
Residential Centre for Children with Disabilities	0	0	424 94.22%	4 0.89%	18 4%	4 0.89%	0	**450**
Rehabilitation Centre for Socially Disabled Girls	0	34 79.07%	2 4.65%	0	6 13.95%	1 2.33%	0	**43**
Safe Home	0	172 81.9%	11 5.24%	2 0.95%	22 10.48%	2 0.95%	1 0.48%	**210**
Sheikh Russel Home	0	966 97.09%	10 1.01%	2 0.2%	11 1.11%	1 0.1%	5 0.5%	**995**
SUK/CDC	0	138 95.17%	6 4.14%	0	0	1 0.69%	0	**145**

5.11 Educational Status

Having access to an education might be, in some cases, one of the reasons contributing to children being placed in residential care. Moreover, education being a fundamental right, it is important to know if this right is fulfilled while in care.

Among institutionalized children, 1.3% never attended school. While this is acceptable for most of the children in Baby Homes due to their age, 11.63% of girls in RCSDGs and 9.52% of residents in Safe Homes never attended school. Additionally, 7.62% of girls in Safe Homes are out-of-school, and more than half of the girls in Safe Homes and 34.88% in RCSDGs have an unknown educational status, meaning that they are not following any education. For Safe Homes, 5 out of the 6 facilities do not provide any formal education (see section 4.4.6.2). These data together indicate a clear disadvantage for these girls, compromising their development and their future integration into society.

More than half of institutionalized children are at the right age in school (63.55%), especially in madrassa (76.34%), private orphanages (72.67%), MOWCA centres (65.09%) and public orphanages (63.32%).

25% of the children have some form of delay in their education. This average is due to the low percentage of delayed children shown in madrassas as well as public and private orphanages, while the percentage of children delayed in their education is higher than the average in many of the facilities, namely RCCDs (62%). NGOs centers (53.70%), RCSDGs (48.84%), PHT centers (48.15%), in Sheikh Russel Homes (43%) and in MOWCA centers (31.82%) are behind in their education.

0. 41% of the children are in secondary education.

Information on the educational status of children in SUKs was not available/shared.

Table 48 Educational status of children

Category	Didn't get any Information	Right age n(%)	Behind n(%)	Secondary level n(%)	Out of school n(%)	Never attended n(%)	Total (N)
Total (n %)	**990 9.76%**	**6446 63.55%**	**2462 24.27%**	**42 0.41%**	**71 0.7%**	**132 1.3%**	**10,143**
Baby Home	12 10.62%	38 33.63%	6 5.31%	0	0	57 50.44%	**113**
Madrassa/religious education school	343 6.71%	3901 76.34%	860 16.83%	5 0.1%	0	1 0.02%	**5,110**
MoWCA Centre	10 1.82%	358 65.09%	175 31.82%	6 1.09%	1 0.18%	0	**550**
NGO (national and international)	0	50 46.3%	58 53.7%	0	0	0	**108**
PHT Centres	1 0.31%	154 47.53%	156 48.15%	2 0.62%	4 1.23%	7 2.16%	**324**

Category	Didn't get any Information	Right age n(%)	Behind n(%)	Secondary level n(%)	Out of school n(%)	Never attended n(%)	Total (N)
Private orphanage	32 3.2%	726 72.67%	239 23.92%	1 0.1%	0	1 0.1%	**999**
Public orphanage	190 17.34%	694 63.32%	206 18.8%	4 0.36%	0	2 0.18%	**1,096**
Residential Centre for Children with Disabilities	23 5.11%	144 32%	279 62%	1 0.22%	0	3 0.67%	**450**
Rehabilitation Centre for Socially Disabled Girls	15 34.88%	0	21 48.84%	2 4.65%	0	5 11.63%	**43**
Safe Home	112 53.33%	17 8.1%	34 16.19%	11 5.24%	16 7.62%	20 9.52%	**210**
Sheikh Russel Home	107 10.75%	364 36.58%	428 43.02%	10 1.01%	50 5.03%	36 3.62%	**995**
SUK/CDC	145 100%	0	0	0	0	0	**145**

5.12 Length of Stay

Regarding the length of stay, the predominant group – 32.16% of profiled children – were reported to have been placed in the facilities for an extended period exceeding four years. The percentage is above the average for public and private orphanages, and MOWCA centers, suggesting systematic long-term placement for these institutions.

The proportion of children with more than four years in a childcare institution is also concerningly high in Baby Homes (25.66%), considering that it is highly recommended to avoid placement of young children in residential care.

The prolonged stays of a substantial portion of the children in the facilities could prompt inquiries into the reasons behind such extended placements. Factors such as the effectiveness of rehabilitation programs, the availability of suitable permanent living arrangements, and the overall success of the facilities in achieving their intended goals may come into question.

Only a minority of children spent less than six months in these facilities, suggesting a relatively small practice of short-term placement, as already noted in the section "Children's admissions and exits". Notably a high turnover with short placements between 1 to 3 months is noted in SUKs (66.21%) and less frequently for Safe Homes (25.71%).

Table 49 Length of stay

Category	Number of institutes	No Response n(%)	1 to 3 months n(%)	3 to 6 months n(%)	6 to 12 months n(%)	12 to 24 months n(%)	more than 2 years n(%)	More than 3 Years n(%)	More Than 4 Years n(%)	Total (N)
Total (n %)	**150**	**541 5.33%**	**594 5.86%**	**406 4%**	**1505 14.84%**	**1405 13.85%**	**972 9.58%**	**1458 14.37%**	**3262 32.16%**	**10,143**
Baby Home	**5**	0	18 15.93%	2 1.77%	23 20.35%	9 7.96%	19 16.81%	13 11.5%	29 25.66%	113
Madrassa/religious education school	**66**	214 4.19%	245 4.79%	205 4.01%	868 16.99%	742 14.52%	633 12.39%	871 17.05%	1332 26.07%	5,110
MoWCA Centre	**5**	0	19 3.45%	7 1.27%	45 8.18%	102 18.55%	21 3.82%	74 13.45%	282 51.27%	550
NGO (national and international)	**3**	0	11 10.19%	3 2.78%	11 10.19%	22 20.37%	13 12.04%	9 8.33%	39 36.11%	108
PHT Centres	**6**	55 16.98%	37 11.42%	8 2.47%	48 14.81%	32 9.88%	6 1.85%	24 7.41%	114 35.19%	324
Private orphanage	**11**	24 2.4%	8 0.8%	15 1.5%	99 9.91%	136 13.61%	39 3.9%	165 16.52%	513 51.35%	999
Public orphanage	**16**	129 11.77%	23 2.1%	30 2.74%	111 10.13%	54 4.93%	56 5.11%	97 8.85%	596 54.38%	1,096
Residential Centre for Children with Disabilities	**20**	5 1.11%	27 6%	14 3.11%	32 7.11%	80 17.78%	64 14.22%	77 17.11%	151 33.56%	450
Rehabilitation Centre for Socially Disabled Girls	**4**	0	2 4.65%	1 2.33%	9 20.93%	8 18.6%	6 13.95%	6 13.95%	11 25.58%	43
Safe Home	**5**	7 3.33%	54 25.71%	45 21.43%	36 17.14%	28 13.33%	18 8.57%	4 1.9%	18 8.57%	210
Sheikh Russel Home	**8**	107 10.75%	54 5.43%	63 6.33%	192 19.3%	192 19.3%	94 9.45%	117 11.76%	176 17.69%	995
SUK/CDC	**1**	0	96 66.21%	13 8.97%	31 21.38%	0	3 2.07%	1 0.69%	1 0.69%	145

5.13 Children's Regimen

The study investigated the children's regimen within residential care facilities, specifically focusing on the extent of contact these children have with their families and relatives.

Almost half of the institutions practice a boarding regimen for most of their children (46.27%). A boarding regimen typically implies a system or arrangement where children live on the institution's premises during term time and return home during scheduled school holidays. The great majority (above 50%) of children living in madrassas and private orphanages are on a boarding scheme, as well as more than one third of children from PHT centers (49%), MoWCA centers (35%), public orphanages (34%), and 30% of children from RCCDs and Sheikh Russel Homes.

14. 16% children go out of the institution to pay family visits. MoWCA centers and public orphanages have children who go home to pay family visits. For others, these percentages vary. Allowing institutionalized children to visit their families reflects a recognition of the importance of family bonds.

SUKs, Safe Homes, and RCSDGs practice a closed regimen, meaning that they restrict the freedom of movement for their residents in accordance with court orders. These orders prohibit resident children from leaving the facilities or having contact with their families.

Among institutions that practice regular boarding schemes, many of them have among their residents, children who never go home. These are mostly found in NGOs. This may be due to the fact that the family is not known, resides too far, or is unwilling to receive the child.

Table 50 Children's regime

Category of institutions	Children's regime			
	On boarding scheme n(%)	Children who pay family visits n(%)	Children who never leave n(%)	Total n(%)
Baby Home	16 14.16%	16 14.16%	81 71.68%	113 100%
Madrassa/religious education school	4192 62.89%	2115 31.73%	359 5.39%	6666 100%
MoWCA Centre	310 34.64%	566 63.24%	19 2.12%	895 100%
NGO (national and international)	60 20.20%	30 10.10%	207 69.70%	297 100%
PHT Centres	344 49.07%	328 46.79%	29 4.14%	701 100%
Private orphanage	738 62.17%	291 24.52%	158 13.31%	1187 100%
Public orphanage	507 33.75%	809 53.86%	186 12.38%	1502 100%
Residential Centre for Children with Disabilities	369 49.39%	375 50.02%	3 0.40%	747 100%
Rehabilitation Centre for Socially Disabled Girls	0	0	120 100%	120 100%
Safe Home	0	0	334 100%	334 100%
Sheikh Russel Home	368 30.19%	553 45.37%	298 24.45%	1219 100%
SUK/CDC	0	0	1140 100%	1140 100%
Total (n %)	**6904** **46.27%**	**5083** **34.07%**	**2934** **19.66%**	**14921** **100%**

It is interesting to note that some children from Baby Homes are on a boarding scheme or return home at least once a year.

Table 51 Children's regime in Baby Homes

Division	Child residents	On boarding scheme	Go home at least once a year	Never go home
Barishal	12	0	0	12
Chittagong	33	0	0	33
Khulna	19	12	0	7
Raj	15	0	0	15
Sylhet	34	4	16	14
Total	**113**	**16**	**16**	**8**

The practice of children in residential care going home during holidays promotes and maintains family connections, which is crucial for their overall well-being and development and helps create the conditions for family reintegration. For this it is also essential that the child is placed in an alternative care arrangement which is as close as possible to the usual place where the family resides.

However, the existence of this practice also raises questions about the necessity of residential care when a child has a family. If children can safely and positively be integrated into their family environment during holidays without any compromise to their well-being, it does prompt reflection on whether full-time residential care is the most suitable option.

This highlights the importance of assessing the specific needs of each child and their family situation. It might be more beneficial to explore alternative forms of care or support systems that enable children to stay with their families while receiving necessary assistance, guidance, or supervision, if required. This approach aims to strike a balance between maintaining family connections and ensuring the child's safety, development, and well-being.

5.14 Personal File

The UN Guidelines stress the importance of maintaining accurate and updated children's files, including "detailed information on their admission and departure and the form, content, and details of the care placement of each child, together with any

appropriate identity documents and other personal information. Information on the child's family should be included in the child's file as well as in the reports based on regular evaluations".

The facilities have been observed to maintain personal files for a significant number of admitted children. However, it is noteworthy that 24.89% of the profiled children fall outside the scope of this provision, lacking a documented personal file. According to respondents, none of the children in SUKs has a

personal file in the institution's records. This is also the case for a substantial proportion of children in private orphanages (42.34%), in madrassas (31.33%), and PHT centers, among others. The institutions that comprehensively maintain files for all of their children are Baby Homes, MOWCA centers, and NGOs.

Not having properly registered information on their backgrounds, the reasons and circumstances for placement, and personal documents, might jeopardize their right to identity and future integration in society. A sense of self-identity is also essential for the emotional well-being of both the child and the future adult.

Table 52 Personal files

Category	Yes n(%)	No n(%)	Total Children (N)
Total (n %)	**7618 75.11%**	**2525 24.89%**	**10,143**
Baby Home	113 100%	0	**113**
Madrassa/religious education school	3509 68.67%	1601 31.33%	**5,110**
MoWCA Centre	550 100%	0	**550**
NGO (national and international)	108 100%	0	**108**
PHT Centres	232 71.6%	92 28.4%	**324**
Private orphanage	576 57.66%	423 42.34%	**999**
Public orphanage	1020 93.07%	76 6.93%	**1,096**
Residential Centre for Children with Disabilities	397 88.22%	53 11.78%	**450**
Rehabilitation Centre for Socially Disabled Girls	42 97.67%	1 2.33%	**43**
Safe Home	203 96.67%	7 3.33%	**210**
Sheikh Russel Home	868 87.24%	127 12.76%	**995**
SUK/CDC	0	145 100%	**145**

5.15 Birth Certificates

While the presence of a birth certificate could be verified for a majority of the residents, there remains a notable gap in this aspect, as the facilities do not have birth certificates of about 16.19% of the profiled children. All children in Safe Homes and a great majority of girls in RCSDG are deprived of birth certificates (90.7%). Other children without a birth certificate in their files are more than half of the children in SUK (54.48%), almost half of the children in Baby Homes (49.56%), 44.44% of those cared for by NGOS.

It is not clear whether these essential documents are not provided to children in care due to administrative challenges, lack of parental information or any other reason. It is essential to address these challenges while the children are in care to ensure that they have access to their legal documents, including birth certificates, which are essential for their rights and identity.

Table 53 Birth certificates of children (verified)

Category	No response n(%)	Yes n(%)	No n(%)	Total Children (N)
Total (n %)	**12 0.12%**	**8489 83.69%**	**1642 16.19%**	**10,143**
Baby Home	0	57 50.44%	56 49.56%	**113**
Madrassa/religious education school	0	4402 86.14%	708 13.86%	**5,110**
MoWCA Centre	0	539 98%	11 2%	**550**
NGO (national and international)	0	60 55.56%	48 44.44%	**108**
PHT Centres	0	260 80.25%	64 19.75%	**324**
Private orphanage	0	851 85.19%	148 14.81%	**999**
Public orphanage	0	960 87.59%	136 12.41%	**1,096**
Residential Centre for Children with Disabilities	12 2.67%	429 95.33%	9 2%	**450**
Rehabilitation Centre for Socially Disabled Girls	0	4 9.3%	39 90.7%	**43**
Safe Home	0	0	210 100%	**210**
Sheikh Russel Home	0	861 86.53%	134 13.47%	**995**
SUK/CDC	0	66 45.52%	79 54.48%	**145**

5.16 Admission Assessment

There is certainly a wide range of possible understanding of what would be an "admission assessment", from a mere identification form with summary information to a full assessment of the child's circumstances, including justification of the need and suitability of the placement. Unfortunately, it was not feasible to assess the different assessment methods and forms currently in use in the childcare residential facilities. More research is needed for this essential aspect of the alternative care provision.

The majority (94.49%) of the profiled children in the facilities had undergone admission assessment, while only 4.82% did not undergo such assessment (43.52% of children from NGOS, 41.86% of girls from RCSDG and 17.62% of children from Safe Homes).

Table 54 Admission assessment of children

Category	No response n(%)	Undergone admission assessment n(%)	Did not undergo admission assessment n(%)	Total Children (N)
Total (n %)	**73 0.72%**	**9594 94.59%**	**476 4.69%**	**10,143**
Baby Home	0	113 100%	0	**113**
Madrassa/religious education school	0	4956 96.99%	154 3.01%	**5,110**
MoWCA Centre	0	550 100%	0	**550**
NGO (national and international)	0	61 56.48%	47 43.52%	**108**
PHT Centres	0	324 100%	0	**324**
Private orphanage	0	975 97.6%	24 2.4%	**999**
Public orphanage	73 6.66%	947 86.41%	76 6.93%	**1,096**
Residential Centre for Children with Disabilities	0	450 100%	0	**450**
Rehabilitation Centre for Socially Disabled Girls	0	25 58.14%	18 41.86%	**43**
Safe Home	0	173 82.38%	37 17.62%	**210**
Sheikh Russel Home	0	875 87.94%	120 12.06%	**995**
SUK/CDC	0	145 100%	0	**145**

5.17 Children with A Care Order

5.76% of children in residential care have a care order, indicating a legal decision that formalizes and outlines the specific care arrangements for a child's placement. These are the totality of children admitted in the SUK and 92.86% of children living in Safe Homes. However, only a minority of children in Baby Homes (31.86%) and girls living in RCSDG (25.58%), two institutions that are characterized as statutory child protection institutions, have a care order, their placement being fully managed by the administrative authority.

Table 55 Children with a care order

Category	Didn't get any Information n(%)	Yes n(%)	No n(%)	Total Children (N)
Total (n %)	**4 0.04%**	**584 5.76%**	**9555 94.2%**	**10,143**
Baby Home	0	36 31.86%	77 68.14%	**113**
Madrassa/religious education school	0	1 0.02%	5109 99.98%	**5,110**
MoWCA Centre	0	2 0.36%	548 99.64%	**550**
NGO (national and international)	0	7 6.48%	101 93.52%	**108**
PHT Centres	0	0	324 100%	**324**
Private orphanage	0	0	999 100%	**999**
Public orphanage	0	44 4.01%	1052 95.99%	**1,096**
Residential Centre for Children with Disabilities	0	2 0.44%	448 99.56%	**450**
Rehabilitation Centre for Socially Disabled Girls	0	11 25.58%	32 74.42%	**43**
Safe Home	3 1.43%	195 92.86%	12 5.71%	**210**
Sheikh Russel Home	1 0.1%	141 14.17%	853 85.73%	**995**
SUK/CDC	0	145 100%	0	**145**

5.18 Children with A Care Plan

A care plan is a document outlining the main needs of the children as they enter residential care, along with the actions needed to respond to these needs and the timelines for achieving progress. Developing and monitoring the implementation of individual care plans are typically among the main tasks of the authority managing the children's cases.

Only 34.16% of the profiled children within the sampled facilities had explicit care plans documented. A substantial majority, accounting for 65. 83% of the profiled children, did not have care plans in place, signifying a notable gap in a structured and outlined approach to their care.

Table 56 Children having a care plan

Category	No Response n(%)	Yes n(%)	No n(%)	Total Children (N)
Total (n %)	**1 0.01%**	**3465 34.16%**	**6677 65.83%**	**10,143**
Baby Home	0	48 42.48%	65 57.52%	**113**
Madrassa/religious education school	0	1836 35.93%	3274 64.07%	**5,110**
MoWCA Centre	0	199 36.18%	351 63.82%	**550**
NGO (national and international)	0	107 99.07%	1 0.93%	**108**
PHT Centres	0	50 15.43%	274 84.57%	**324**
Private orphanage	0	50 5.01%	949 94.99%	**999**
Public orphanage	0	419 38.23%	677 61.77%	**1,096**
Residential Centre for Children with Disabilities	0	203 45.11%	247 54.89%	**450**
Rehabilitation Centre for Socially Disabled Girls	0	4 9.3%	39 90.7%	**43**
Safe Home	0	141 67.14%	69 32.86%	**210**
Sheikh Russel Home	1 0.1%	408 41.01%	586 58.89%	**995**
SUK/CDC	0	0	145 100%	**145**

5.19 Exit Plan

An exit plan outlining steps for leaving care and indicating aftercare support services is crucial for ensuring a smooth transition and ongoing support for children leaving residential institutions, especially those who spent long years in care. According to data, the care facilities might not have had adequate exit plans in place for the majority of children, as presented in Table 54, with SUK and private orphanages exhibiting the highest rates of lacking exit plans.

Exit plans are reported for 100% of children cared for by NGOs.

Table 57 Children having an exit plan

Category	No Response n(%)	Yes n(%)	No n(%)	Total Children (N)
Total (n%)	**1 0.01%**	**3322 32.75%**	**6820 67.24%**	**10,143**
Baby Home	0	46 40.71%	67 59.29%	**113**
Madrassa/religious education school	0	1759 34.42%	3351 65.58%	**5,110**
MoWCA Centre	0	152 27.64%	398 72.36%	**550**
NGO (national and international)	0	108 100%	0	**108**
PHT Centres	0	135 41.67%	189 58.33%	**324**
Private orphanage	0	174 17.42%	825 82.58%	**999**
Public orphanage	0	328 29.93%	768 70.07%	**1,096**
Residential Centre for Children with Disabilities	0	131 29.11%	319 70.89%	**450**
Rehabilitation Centre for Socially Disabled Girls	0	11 25.58%	32 74.42%	**43**
Safe Home	0	70 33.33%	140 66.67%	**210**
Sheikh Russel Home	1 0.1%	408 41.01%	586 58.89%	**995**
SUK/CDC	0	0	145 100%	**145**

06

Findings:
Children's Lived Experience in Institutional Care

This section takes a closer look at the lived experiences of children residing in institutional care facilities at the time of the survey. It examines how children spend their daily lives—including sleeping arrangements, hygiene practices, nutrition, education, access to health care, recreation, religious activities, and contact with family members. Beyond these core domains, the study also investigated the services available to children within the institutions and assessed whether they were provided on-site or off-site. This distinction helps measure the degree of institutional openness and integration with the surrounding community. Facilities that rely solely on in-house provision tend to be more closed, whereas those that connect children to local education, healthcare, and recreational services foster greater inclusion and normalize daily life. The section also explores whether institutions offer specialized services, such as vocational training, to children from surrounding communities—an indicator of community engagement. Findings are disaggregated by service type and facility category, offering a nuanced view of how different models of care shape the everyday experience of children.

6.1 Sleeping and Hygiene

In seeking to comprehend the living conditions of children in residential care facilities, the study inquired about the planned availability of basic services such as dormitories, washrooms, basins, and showers concerning the planned capacity in terms of resident children. By inquiring about the availability of these essential services, it was also clear to understand the initial intentions or standards that were established when these facilities were designed or organized.

Dormitories

Dormitories hold a significant importance in collective residential facilities. The bed and the surrounding space are often a unique personal space where the children can find a hint of privacy, store their personal belongings, and express their identity through arranging the space, if allowed. Meanwhile, these are often organized as to facilitate supervision rather than fostering a sense of personal space for the children. The number of children sharing a dormitory offers insight into this particular issue, with smaller dormitories allowing for a stronger ownership of the space and offering a better opportunity for children to establish their own identity within the shared space.

On average, facilities are planned to have 14.38 residents sharing a dormitory. For madrassas, private orphanages and MOWCA centers this ratio is higher than the average and stands respectively at 30. 45, 26. 21 and 25. 33 children per dormitory, reflecting a highly dense living environment.

The lowest ratio is found in public orphanages, RCCD, Safe Homes and PHT centers, where the ratio averages six children per dormitory.

The ratio of approximately 15 children per dormitory in Baby Homes seems inappropriately high, as it might strain the ability to ensure proper nurturing, care and supervision for young children, especially knowing that many of children in Baby Homes have disabilities.

Table 58 Number and ratio of bed rooms

Category of institution	Planned number of resident children	Bed Rooms	
		Total number	Ratio per children
Total	**20127**	**1400**	**14.38**
Baby Home	500	34	14.71
Madrassa/religious education school	10962	360	30.45
MoWCA Centre	760	30	25.33
NGO (national and international)	655	39	16.79
PHT Centres	690	100	6.9
Private orphanage	1730	66	26.21
Public orphanage	1925	336	5.73
Rehabilitation Centre for Socially Disabled Girls	400	17	23.53
Residential Centre for Children with Disabilities	630	113	5.58
Safe Home	300	50	6
Sheikh Russel Home	975	116	8.41
SUK/CDC	600	139	4.32

6.2 Staff Present During the Night Shift

Understanding the staffing dynamics and quality during nighttime at a childcare facility is crucial for assessing how childcare facilities ensure comprehensive supervision, prioritizing both the physical and emotional safety of the children. Particularly interesting was the examination of the balance between childcare staff and support staff during the night shift, considering that both are important to ensure both security and well-being.

Our observations reveal that in the majority of facilities, support staff, including guards, constitute the predominant presence during the night shift. However, in specific institutions like Baby Homes, NGOs, public orphanages, RCSDG, and Sheikh Russel Home, childcare staff notably form the majority during nighttime. This prioritization suggests a clear child-centred approach in these particular facilities.

Table 59 Staff present during night shift

Staff Present in the Facility during the night shift	Number of Institution	Manager	Admin	Childcare Staff	Educational Staff	Health Care	Support staff	Therapists and counsellors	Total (N)
Total (n %)	157	31 4.58%	42 6.2%	70 10.34%	315 46.53%	10 1.48%	207 30.58%	2 0.3%	677
Baby Home	**5**	0	1 11.11%	8 88.89%	0	0	0	0	**9**
Madrassa/religious education school	**66**	24 5.71%	30 7.14%	1 0.24%	278 66.19%	2 0.48%	85 20.24%	0	**420**
MoWCA Centre	**5**	0	0	2 18.18%	2 18.18%	0	7 63.64%	0	**11**
NGO (national and international)	**4**	2 12.5%	1 6.25%	7 43.75%	2 12.5%	0	4 25%	0	**16**
PHT Centres	**6**	1 5.56%	2 11.11%	2 11.11%	0	2 11.11%	11 61.11%	0	**18**
Private orphanage	**11**	2 4.17%	0	9 18.75%	25 52.08%	0	12 25%	0	**48**
Public orphanage	**17**	0	7 19.44%	18 50%	3 8.33%	4 11.11%	4 11.11%	0	**36**
Rehabilitation Centre for Socially Disabled Girls	**4**	0	0	6 85.71%	0	0	1 14.29%	0	**7**
Residential Centre for Children with Disabilities	**22**	2 7.41%	0	4 14.81%	1 3.7%	2 7.41%	18 66.67%	0	**27**
Safe Home	**6**	0	0	3 6.67%	0	0	42 93.33%	0	**45**
Sheikh Russel Home	**8**	0	0	10 50%	4 20%	0	4 20%	2 10%	**20**
SUK/CDC	**3**	0	1 5%	0	0	0	19 95%	0%	**20**

6.3 Hygiene

Hygiene facilities in sufficient numbers are essential standards in childcare institutions, as they indicate the resources devoted to maintaining the children's health, preserving their dignity and personal comfort. These facilities are usually assessed based on facility ratios.

The following two tables below indicate respectively the ratio of girls and boys to washrooms based on the actual number of children living in the institutions.

For girls, the ratio is high for MOWCA centers (it stands at 50 girls for one washroom).

Table 60 Washrooms for girls

Category of institution	Number of institutions	Number of Female Children	Number of Washroom	Children to washroom ratio
Total (n %)	**157**	**2989**	**455**	**6.57**
Baby Home	**5**	58	11	5.27
Madrassa/religious education school	**66**	584	52	11.23
MoWCA Centre	**5**	100	2	50.00
NGO (national and international)	**4**	39	12	3.25
PHT Centers	**6**	191	48	3.98
Private orphanage	**11**	125	23	5.43
Public orphanage	**17**	738	125	5.90
Residential Centre for Children with Disabilities	**22**	116	21	5.52
Rehabilitation Centre for Socially Disabled Girls	**4**	63	21	3.00
Safe Home	**6**	218	52	4.19
Sheikh Russel Home	**8**	690	70	9.86
SUK/CDC	**3**	67	18	3.72

For boys, the ratios stay within a reasonable average. Yet it is notably high in SUK with 40 boys per washroom. It is crucial to note that this high ratio in SUK is a result of overcrowding within that specific institution. On the other hand, the other institutions show lower ratios, largely because they have a lower number of children occupying them.

Table 61 Washrooms for boys

Category of institution	Number of institutions	Number of Male Children	Number of Washroom	Children to washroom ratio
Total (n %)	**157**	**9901**	**1036**	**9.56**
Baby Home	**5**	55	18	3.06
Madrassa/religious education school	**66**	5598	510	10.98
MoWCA Centre	**5**	485	44	11.02
NGO (national and international)	**4**	251	108	2.32
PHT Centers	**6**	214	34	6.29
Private orphanage	**11**	1047	70	14.96
Public orphanage	**17**	562	110	5.11
Residential Centre for Children with Disabilities	**22**	334	91	3.67
Rehabilitation Centre for Socially Disabled Girls	**4**	0	0	-
Safe Home	**6**	7	2	3.50
Sheikh Russel Home	**8**	305	23	13.26
SUK/CDC	**3**	1043	26	40.12

Basins

Similarly, the study enquired about the ratio of actual resident girls and boys for basins. While the average number of girls sharing one basin is 8, this ratio is notably high for girls in madrassas, where 45 girls share one basin.

Table 62 Dedicated basins for girls

Category of institution	Number of institutions	Number of Female Children	Number of Basin	Children to basin ratio
Total (n %)	**157**	**2989**	**354**	**8.44**
Baby Home	**5**	58	5	11.60
Madrassa/religious education school	**66**	584	13	44.92
MoWCA Centre	**5**	100	0	-
NGO (national and international)	**4**	39	17	2.29
PHT Centers	**6**	191	44	4.34
Private orphanage	**11**	125	21	5.95
Public orphanage	**17**	738	106	6.96
Residential Centre for Children with Disabilities	**22**	63	18	3.50
Rehabilitation Centre for Socially Disabled Girls	**4**	116	25	4.64
Safe Home	**6**	218	53	4.11
Sheikh Russel Home	**8**	690	44	15.68
SUK/CDC	**3**	67	8	8.38

For boys, the situation of basins appears to be less favorable, with an average of 28 boys sharing one basin. This ratio is considerably higher in madrassas, where 63 children share one basin, and in private orphanages, with 58 boys for one basin.

Table 63 Dedicated basins for boys

Category of institution	Number of institutions	Number of Male Children	Number of Basin	Children to basin ratio
Total (n %)	**157**	**9901**	**358**	**27.66**
Baby Home	**5**	55	9	6.11
Madrassa/religious education school	**66**	5598	89	62.90
MoWCA Centre	**5**	485	21	23.10
NGO (national and international)	**4**	251	58	4.33
PHT Centres	**6**	214	13	16.46
Private orphanage	**11**	1047	18	58.17
Public orphanage	**17**	562	45	12.49

Category of institution	Number of institutions	Number of Male Children	Number of Basin	Children to basin ratio
Residential Centre for Children with Disabilities	**22**	334	85	3.93
Rehabilitation Centre for Socially Disabled Girls	**4**	0	0	-
Safe Home	**6**	7	3	2.33
Sheikh Russel Home	**8**	305	17	17.94
SUK/CDC	**3**	1043	0	-

Showers

Finally, the study enquired about the availability of showers for the children currently living in institutions. For girls the average stands at 8 girls per shower, while on MOWCA Centers, this ratio is notably high and stands at 50 girls for one shower.

Table 64 Dedicated showers for girls

Category of institution	Number of institutions	Number of female Children	Number of Shower	Female Children to shower ratio
Total (n %)	**157**	**2989**	**379**	**7.89**
Baby Home	**5**	58	11	5.27
Madrassa/religious education school	**66**	584	41	14.24
MoWCA Centre	**5**	100	2	50.00
NGO (national and international)	**4**	39	12	3.25
PHT Centres	**6**	191	44	4.34
Private orphanage	**11**	125	12	10.42
Public orphanage	**17**	738	102	7.24
Rehabilitation Centre for Socially Disabled Girls	**4**	63	15	4.20
Residential Centre for Children with Disabilities	**22**	116	30	3.87
Safe Home	**6**	218	37	5.89
Sheikh Russel Home	**8**	690	55	12.55
SUK/CDC	**3**	67	18	3.72

For boys, the average ratio is higher than for girls and stands at 17 boys for one shower. This ratio is extremely high in SUK, where 74 boys share one shower. It is also well above the average in private orphanages (33) and madrassas (24).

Table 65 Dedicated showers for boys

Category of institution	Number of institutions	Number of Male Children	Number of Shower	Male Children to shower ratio
Total (n %)	**157**	**9901**	**595**	**16.64**
Baby Home	**5**	55	15	3.67
Madrassa/religious education school	**66**	5598	231	24.23
MoWCA Centre	**5**	485	43	11.28
NGO (national and international)	**4**	251	68	3.69
PHT Centres	**6**	214	24	8.92
Private orphanage	**11**	1047	32	32.72
Public orphanage	**17**	562	58	9.69
Rehabilitation Centre for Socially Disabled Girls	**4**	0	0	-
Residential Centre for Children with Disabilities	**22**	334	84	3.98
Safe Home	**6**	7	2	3.50
Sheikh Russel Home	**8**	305	24	12.71
SUK/CDC	**3**	1043	14	74.50

Given the lack of national standards for dormitory and hygiene facility ratios, these findings should be viewed in the context of what could be considered acceptable living conditions in present-day Bangladesh.

Establishing agreed-upon standards for childcare institutions would significantly contribute to the definition of adequate living conditions across residential facilities. Defining these standards would play a pivotal role in safeguarding the well-being and fostering the healthy growth of the children in these settings. It would also improve the quality of oversight and monitoring, as there would be parameters to measure the compliance in service provision.

6.4 Food

When it comes to the children's nutrition, all the institutions except one RCCDs and one Safe Home provide three meals per day to the children. One RCCD provides only one meal per day within the premises, and one Safe Home provides two meals per day within the premises. Indeed, every institution is outfitted with kitchens, whether they are situated inside the premises or in an external area. Notably, the presence of kitchens is complemented by a well-staffed contingent of cooks, highlighting the emphasis placed on this essential role within these establishments.

Nevertheless, as shown in section 4.7.2.2. many reported complaints of children are related to food, indicating that there might be restrictions in food quantity, quality and variety.

Table 66 Number of meals provided to children

Category of institution	Number of institutions	One Meal		Two Meals		Three Meals			No Service Provided
		Within the Premise	Outside the Premise	Within the Premise	Outside the Premise	Both	Within the Premises	Outside the Premise	
Total (n %)	**157**	**1 0.64%**	**0**	**1 0.64%**	**0**	**2 1.27%**	**150 95.54%**	**0**	**3 1.91%**
Baby Home	**5**	0	0	0	0	0	5 100%	0	0
Madrassa/religious education school	**66**	0	0	0	0	0	63 95.45%	0	3 4.55%
MoWCA Centre	**5**	0	0	0	0	0	5 100%	0	0
NGO (national and international)	**4**	0	0	0	0	0	4 100%	0	0
PHT Centres	**6**	0	0	0	0	0	6 100%	0	0
Private orphanage	**11**	0	0	0	0	0	11 100%	0	0
Public orphanage	**17**	0	0	0	0	2 11.76%	15 88.24%	0	0
Residential Centre for Children with Disabilities	**22**	1 4.55%	0	0	0	0	21 95.45%	0	0
Rehabilitation Centre for Socially Disabled Girls	**4**	0	0	0	0	0	4 100%	0	0
Safe Home	**6**	0	0	1 16.67%	0	0	5 83.33%	0	0
Sheikh Russel Home	**8**	0	0	0	0	0	8 100%	0	0
SUK/CDC	**3**	0	0	0	0	0	3 100%	0	0

6. 5 Health Care

6.5.1 Common health problems

As indicated in section 4.3.9, in general terms, children living in residential care appear to be in good health.

Enquiring on the most common health problems affecting children, it is clear that health problems vary across different types of childcare institutions (Table 64).

Skin problems and cold and fever (other) are relatively common issues in several institutions, but the prevalence of other health problems varies significantly. Nutritional status and mental health problems are also significant concerns in some institutions.

The most reported common health problem affecting children are skin problems, reported by 79.62 of the institutions. Skin problems are known to be associated with poor hygiene conditions, overcrowding, and inadequate sanitation, among other factors.

The second most common health problem is fever and cough (indicated under "other"), especially during the wet season, with a prevalence of 62.42%%. Some informants reported that children catch a cold sleeping on the floor, especially in the winter season, which might explain the prevalence, among others.

Gastroenteritis and diarrhoea appear to be the third most common health problem (39.49%) followed by ear, eye or mouth infection (27.39%).

All these health problems are a cause for concern in collective living environments due to their rapid spread among children, necessitating significant efforts to control them.

Health problems which seem to be specific to specific target groups of different institutions are:

- Mental health problems are registered in all in RCSDGs and Safe Homes
- The nutritional status of children is reported as a concern by 50% of NGO. In MOWCA centers, ear, eye and mouth infection are quite frequent.)
- In Baby Homes respiratory problems, pneumonia make up a big proportion of health problems affecting young children living in residential care

The following table demonstrates the common health problems among the residents of the facilities.

Table 67 Common health problems in childcare residential facilities

Most Common Health Problem (Could choose more than one response)	Baby Home	Madrassa/ religious education school	MOWCA Centre	NGO (national and international)	PHT Centres	Private orphanage	Public orphanage	Residential Centre for Children with Disabilities	Rehabilitation Centre for Socially Disabled Girls	Safe Home	Sheikh Russel Home	SUK/CDC	Total
Ear, eye, mouth infections	2 40%	14 21.21%	3 60%	2 50%	1 16.67%	3 27.27%	3 17.65%	8 36.36%	2 50%	3 50%	1 12.5%	1 33.33%	43 27.39%
Skin problems	4 80%	56 84.85%	4 80%	4 100%	4 66.67%	10 90.91%	12 70.59%	12 54.55%	2 50%	6 100%	8 100%	3 100%	125 79.62%
Nutritional status	2 40%	17 25.76%	1 20%	2 50%	1 16.67%	2 18.18%	1 5.88%	5 22.73%	1 25%	2 33.33%	1 12.5%	0	35 22.29%
Respiratory, pneumonia	3 60%	7 10.61%	1 20%	2 50%	1 16.67%	3 27.27%	1 5.88%	2 9.09%	0	3 50%	1 12.5%	1 33.33%	25 15.92%
Gastroenteritis, diarrhoea	2 40%	34 51.52%	3 60%	2 50%	2 33.33%	3 27.27%	2 11.76%	6 27.27%	0	3 50%	5 62.5%	0	62 39.49%
Mental health problem	3 60%	7 10.61%	1 20%	3 75%	2 33.33%	1 9.09%	2 11.76%	4 18.18%	4 100%	6 100%	3 37.5%	1 33.33%	37 23.57%
Gynaecological diseases	0	2 3.03%	0	0	0	0	0	0	0	0	0	0	2 1.27%
Tonsil problem	0	0	1 20%	0	0	0	0	0	1 25%	1 16.67%	0	1 33.33%	4 2.55%
Seasonal Flu	3 60%	45 68.18%	3 60%	2 50%	4 66.67%	8 72.73%	11 64.71%	13 59.09%	1 25%	1 16.67%	6 75%	1 33.33%	98 62.42%
Physically injured	0	0	0	0	0	0	0	0	0	1 16.67%	0	0	1 0.64%
Others	0	1 1.52%	0	0	0	0	1 5.88%	1 4.55%	1 25%	0	0	0	4 2.55%
No response	0	0	0	0	0	0	0	1 4.55%	0	0	0	0	1 0.64%

6.5.2 Medical services offer

Medical services in a childcare institution are essential for preventative care such as routine check-ups, vaccinations, and health screenings, and for regularly monitoring children's health and development, enabling early detection and management of any health issues that may arise. This section includes data on medical services and counselling/psychological and mental health services.

The majority (52.22%) of institutions practice health on demand, meaning that they refer to health services only in the event of an illness or an emergency. Those who practice health on demand are the totality of MoWCA centres, a great majority of Safe Homes (83%) and RCCDs (75%) and 50% of PHT Centers. Two out of five Baby Homes practice health on demand, which is concerning considering the importance of medical follow-up for low age children. While health services are provided with varying periodicity, 19 institutions (12.10%) of the total do not provide health services at all. These are 15 madrassas, 3 private orphanages and one SUK.

Table 68 Health care

Institution category	Weekly		Monthly		Everyday	In Every 2 Months	In Every 15 days	Half Yearly	No Specific Time			On Demand			Quarterly	Regularly		No Service	N (%)
	Both	Within the premises	Outside the premises	Within the premises	Within the premises	Within the premises	Both	Both	Both	Outside the premises	Within the premises	Both	Outside the premises	Within the premises	Within the premises	Both	Within the premises		
Total (n %)	**1 0.64%**	**20 12.74%**	**2 1.27%**	**13 8.28%**	**6 3.82%**	**2 1.27%**	**1 0.64%**	**1 0.64%**	**1 0.64%**	**1 0.64%**	**1 0.64%**	**7 4.46%**	**55 35.03%**	**21 13.38%**	**2 1.27%**	**1 0.64%**	**3 1.91%**	**19 12.10%**	**157 100%**
Baby Home	0	2 40.00%	0	1 20.00%	0	0	0	0	0	0	0	0	1 20.00%	1 20.00%	0	0	0	0	5 100%
Madrassa/ religious education school	0	2 3.03%	0	5 7.58%	1 1.52%	2 3.03%	1 1.52%	1 1.52%	0	1 1.52%	1 1.52%	5 7.58%	24 36.36%	6 9.09%	2 3.03%	0	0	15 22.73%	66 100%
MoWCA Centre	0	0	0	0	0	0	0	0	0	0	0	0	5 100%	0	0	0	0	0	5 100%
NGO (national and international)	0	2 50.00%	1 25.00%	1 25.00%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4 100%
PHT Centres	0	0	0	2 33.33%	0	0	0	0	0	0	0	0	3 50.00%	0	0	0	1 16.67%	0	6 100%
Private orphanage	0	1 9.09%	0	2 18.18%	0	0	0	0	1 9.09%	0	0	0	3 27.27%	1 9.09%	0	0	0	3 27.27%	11 100%
Public orphanage	0	6 35.29%	0	0	2 11.76%	0	0	0	0	0	0	2 11.76%	3 17.65%	4 23.53%	0	0	0	0	17 100%
Rehabilitation Centre for Socially Disabled Girls	0	1 25.00%	0	0	0	0	0	0	0	0	0	0	1 25.00%	2 50.00%	0	0	0	0	4 100%
Residential Centre for Children with Disabilities	0	1 4.55%	1 4.55%	2 9.09%	1 4.55%	0	0	0	0	0	0	0	13 59.09%	4 18.18%	0	0	0	0	22 100%
Safe Home	1 16.67%	0	0	0	0	0	0	0	0	0	0	0	2 33.33%	3 50.00%	0	0	0	0	6 100%
Sheikh Russel Home	0	4 50.00%	0	0	1 12.50%	0	0	0	0	0	0	0	0	0	0	1 12.50%	2 25.00%	0	8 100%
SUK/CDC	0	1 33.33%	0	0	1 33.33%	0	0	0	0	0	0	0	0	0	0	0	0	1 33.33%	3 100%

6.5.3 Counselling/psychological/mental health support

For children residing in institutions, prioritizing their psychological and emotional well-being is crucial. These children face exposure to two main distinct forms of emotional stress or trauma:

- The circumstances leading to their institutionalization: These children may have undergone trauma, abuse, or have come from challenging backgrounds. Additionally, many have experienced traumatic separation from their primary caregivers. Some of these children may require trauma-informed care to aid in their recovery and prevent these traumatic experiences from causing enduring mental health issues.
- The environment within institutions, lacking personalized connections and attachment: Living in depersonalized environments often devoid of close, nurturing bonds and attachment relationships can significantly impact these children's emotional development.

It is therefore also reasonable to anticipate that specialized child protection institutions, which have as a primary goal to address the complex needs of children having experienced trauma, abuse and/or challenging backgrounds, prioritize these mental health services more than institutions like madrassas, which typically have broader goals such as offering education and religious teachings.

The great majority of childcare institutions do not provide counselling (57.96%), and this is especially the case in PHT centres (83.33%), Baby Homes (80%), private orphanages (72.73%), RCCDs (68.18%) and madrassas (66.67%).

For those institutions that do provide counselling, they provide this service weekly, monthly or on demand.

It is noticeable that public child protection institutions which should have standardized offerings of specialized services present varying patterns of counselling/psychological and mental health support provision:

- One Baby Home has this service, while four do not;
- One Safe Home provides this service weekly, one monthly, one sometimes/irregularly, one on demand and two do not provide the service;
- The three SUK have one weekly service, one monthly and one on demand.
- One RCSDG provides this service weekly, one monthly, and two do not provide it;
- MoCWA centers equally have varying routines;
- Half of the Sheikh Russel homes have the service, half do not.

These varying patterns of service provision within the same type of public institutions can be concerning as they indicate disparities in access to these services but also inconsistencies in standards or practices within these institutions, raising questions about existence or adherence to established guidelines or regulations.

Providing regular such services is crucial to ensure quality of care and effectiveness of placement within public institutions, guaranteeing that children who need an out-of-home placement do receive the services that justify the existence of such institutions.

Table 69 Counselling/psychological/mental health support

Type of institution	Weekly	Monthly	Everyday/Regularly		Irregular/ Sometimes	On De-mand	Quarterly	Twice a month	Twice a Week	No Service	N (%)
	Within the premises	Within the premises	Outside the premises	Within the premises	Within the premises	Within the premises	Within the premises	Within the premises	Within the premises		
Total (n %)	**23 14.65%**	**20 12.74%**	**1 0.64%**	**4 2.55%**	**2 1.27%**	**12 7.64%**	**2 1.27%**	**1 0.64%**	**1 0.64%**	**91 57.96%**	**157 100.00%**
Baby Home	1 20.00%	0	0	0	0	0	0	0	0	4 80.00%	5 100%
Madrassa/religious education school	6 9.09%	6 9.09%	1 1.52%	0	0	7 10.61%	2 3.03%	0	0	44 66.67%	66 100%
MoWCA Centre	1 20.00%	1 20.00%	0	0	1 20.00%	0	0	0	0	2 40.00%	5 100%
NGO (national and international)	2 50.00%	0	0	0	0	0	0	0	1 25.00%	1 25.00%	4 100%
PHT Centres	0	1 16.67%	0	0	0	0	0	0	0	5 83.33%	6 100%
Private orphanage	0	3 27.27%	0	0	0	0	0	0	0	8 72.73%	11 100%
Public orphanage	6 35.29%	4 23.53%	0	0	0	3 17.65%	0	0	0	4 23.53%	17 100%
Rehabilitation Centre for Socially Disabled Girls	1 25.00%	1 25.00%	0	0	0	0	0	0	0	2 50.00%	4 100%
Residential Centre for Children with Disabilities	3 13.64%	3 13.64%	0	0	0	0	0	1 4.55%	0	15 68.18%	22 100%
Safe Home	1 16.67%	1 16.67%	0	0	1 16.67%	1 16.67%	0	0	0	2 33.33%	6 100%
Sheikh Russel Home	1 12.50%	0	0	3 37.50%	0	0	0	0	0	4 50.00%	8 100%
SUK/CDC	1 12.50%	0	0	1 33.33%	0	1 33.33%	0	0	0	0	3 100%

6.5.4 Availability of medical rooms

The study delved deeper into the accessibility of physical spaces crucial for children's health and well-being, such as medical and counseling rooms. Ensuring dedicated areas for these services is paramount, considering that they are fundamental services to be delivered in safe and private conditions.

Table 70 below reveals a significant shortage of dedicated medical rooms.

- Less than one-third of the facilities are equipped with a medical room
- Two Baby Homes do not have a medical room. This situation requires careful examination, considering the vital need for healthcare for young children and the availability of space in these large facilities
- Out of 66 surveyed madrassas, only five have a medical room, less than 10%. This would give a ratio of 1236 children per medical room, which is quite alarming
- In 11 private orphanages, there are only two medical rooms
- One medical room is available for six PHT centers

Table 70 Medical rooms

Category of institution	Number of institutions	Number of Children	Number of Medical Room	Children to medical room ratio
Total (n %)	**157**	**13081**	**47**	**278.32**
Baby Home	**5**	113	3	37.67
Madrassa/religious education school	**66**	6180	5	1236.00
MoWCA Centre	**5**	585	0	-
NGO (national and international)	**4**	290	2	145.00
PHT Centres	**6**	405	1	405.00
Private orphanage	**11**	1172	2	586.00
Public orphanage	**17**	1300	11	118.18
Rehabilitation Centre for Socially Disabled Girls	**4**	63	4	15.75
Residential Centre for Children with Disabilities	**22**	643	4	160.75
Safe Home	**6**	225	4	56.25
Sheikh Russel Home	**8**	995	7	142.14
SUK/CDC	**3**	1110	4	277.50

As for other types of medical rooms, it is crucial for childcare facilities to have counselling rooms. These are designated spaces where children can interact privately and confidentially with professionals from within or outside the facility, such a social worker or other healthcare provider. This setup is paramount

in ensuring that children can talk freely about their personal issues and feel safe to report their concerns.

There are 40 such rooms for a total of 157 institutions.

- None of the PHT centers has such a room;
- One such room is available across 11 private orphanages;
- Eight counselling rooms are available across 66 madrassas, meaning that less than 10% of madrassas are equipped with a counselling room;
- Five MoWCA centers have one counselling rooms, with a ratio of 585 children;
- SUK have a ratio of 550 children per counseling room, which is a situation that requires careful evaluation given the vital role of counselling/social services for children in conflict with the law;
- Two counselling rooms are available for 63 girls in RCSDGs. Despite the seemingly favorable ratio, it is crucial to take into account the underutilization of the centers (based on their intended capacity).

Table 71 Counselling rooms/rooms for meetings with social workers

Category of institution	Number of institutions	Number of Children	Number of Rooms	Children to rooms ratio
Total (n %)	**157**	**13081**	**40**	**327.03**
Baby Home	**5**	113	2	56.50
Madrassa/religious education school	**66**	6180	8	772.50
MoWCA Centre	**5**	585	1	585.00
NGO (national and international)	**4**	290	3	96.67
PHT Centres	**6**	405	0	-
Private orphanage	**11**	1172	1	1172.00
Public orphanage	**17**	1300	4	325.00
Rehabilitation Centre for Socially Disabled Girls	**4**	63	2in	31.50
Residential Centre for Children with Disabilities	**22**	643	5	128.60
Safe Home	**6**	225	5	45.00
Sheikh Russel Home	**8**	995	7	142.14
SUK/CDC	**3**	1110	2	555.00

6.5.5 Disability rehabilitation

Disability rehabilitation services are essential for institutionalized children living with disabilities as they are needed to enhance their abilities, fully developing their potential, and facilitate adaptation, therefore improving their quality of life.

According to findings, rehabilitation services are limited in the institutions, as they are offered by only 17. 20% of the facilities. Only one third of the institutions that have children with disability as priority target group provide such services. In fact, four out of six PHT centers do not provide such services, and this is also the case for approximately 50% of the RCCDs. Four out of eight Sheikh Russel Homes and two out of five Baby Homes do provide disability rehabilitation services, one inside the premises and one outside.

Table 72 Institutions providing disability rehabilitation

Category of institution	No service provided	Within the premises	Outside the premises	Both	Total (N)
Total (n %)	**123 78.34%**	**27 17.20%**	**6 3.82%**	**1 0.64%**	**157**
Baby Home	3 60.00%	1 20.00%	1 20.00%	0	**5**
Madrassa/religious education school	61 92.42%	5 7.58%	0	0	**66**
MoWCA Centre	5 100.00%	0	0	0	**5**
NGO (national and international)	2 50.00%	1 25.00%	1 25.00%	0	**4**
PHT Centres	4 66.67%	2 33.33%	0	0	**6**
Private orphanage	10 90.91%	1 9.09%	0	0	**11**
Public orphanage	16 94.12%	1 5.88%	0	0	**17**
Residential Centre for Children with Disabilities	10 45.45%	8 36.36%	3 13.64%	1 4.55%	**22**
Rehabilitation Centre for Socially Disabled Girls	2 50.00%	2 50.00%	0	0	**4**
Safe Home	3 50.00%	2 33.33%	1 16.67%	0	**6**
Sheikh Russel Home	4 50.00%	4 50.00%	0	0	**8**
SUK/CDC	3 100.00%	0	0	0	**3**

6.6 Education

6.6.1 Educational status of children

As reported in section 4.3.3.11, approximately a quarter of the profiled children, specifically 24.27%, were reported to be academically delayed, meaning they were not placed in the class corresponding to their

age. In contrast, 63.55% were appropriately enrolled in a class aligned with their age. A small percentage, amounting to 1. 3%, were reported to have never attended school.

6.6.2 Offer of formal and informal education

Formal education is mostly provided inside the premises. This offering is most common in madrassas (50 out of 66) and secondarily in private orphanages. For children residing in these institutions, and for others in similar circumstances, access to formal education might stand as a primary reason for their placement in residential care.

Children who leave the institution to attend school are those residing in Sheikh Russel Homes, MoWCA centers, public orphanages and nearly half of the children living in RCCD. Attending the community school often gives children greater chances to develop social skills and a sense of social integration.

It is extremely concerning that 16% of the institutions do not provide formal education to the children, of which includes all Safe Homes except one. It appears, however, that three Safe Homes not offering formal education attempt to mitigate this shortfall by offering informal educational opportunities to the children in their care (see Table 33). Additionally, informal education is provided in over half of the Sheikh Russel Homes, Baby Homes and PHT centres, further underscoring the efforts made to supplement the absence of formal educational programs.

Table 73 Formal education

Category of institution	No service provided	Within the premises	Outside the premises	Both[29]	Total (N)
Total (n %)	**25** **15.92%**	**86** **54.78%**	**40** **25.48%**	**6** **3.82%**	**157**
Baby Home	2 40.00%	1 20.00%	2 40.00%	0	**5**
Madrassa/religious education school	7 10.61%	50 75.76%	9 13.64%	0	**66**
MoWCA Centre	1 20.00%	0	3 60.00%	1 20.00%	**5**
NGO (national and international)	1 25.00%	2 50.00%	1 25.00%	0	**4**
PHT Centres	2 33.33%	4 66.67%	0	0	**6**
Private orphanage	0	9 81.82%	2 18.18	0	**11**
Public orphanage	3 17.65%	3 17.65%	8 47.06%	3 17.65%	**17**

[29]"Both" refers to both within and outside the premises

Category of institution	No service provided	Within the premises	Outside the premises	Both[29]	Total (N)
Residential Centre for Children with Disabilities	2 9.09%	9 40.91%	10 45.45%	1 4.55%	**22**
Rehabilitation Centre for Socially Disabled Girls	2 50.00%	2 50.00%	0	0	**4**
Safe Home	5 83.33%	1 16.67%	0	0	**6**
Sheikh Russel Home	0	2 25.00%	5 62.50%	1 12.50%	**8**
SUK/CDC	0	3 100.00%	0	0	**3**

Table 74 Informal education

Informal education/literacy	No service provided	Within the premises	Outside the premises	Both	Total (N)
Total (n %)	**67** **42.68%**	**79** **50.32%**	**6** **3.82%**	**5** **3.18%**	**157**
Baby Home	2 40.00%	3 60.00%	0	0	**5**
Madrassa/religious education school	25 37.88%	40 60.61%	1 1.52%	0	**66**
MoWCA Centre	1 20.00%	2 40.00%	1 20.00%	1 20.00%	**5**
NGO (national and international)	1 25.00%	3 75.00%	0	0	**4**
PHT Centres	3 50.00%	3 50.00%	0	0	**6**
Private orphanage	5 45.45%	6 54.55%	0	0	**11**
Public orphanage	7 41.18%	7 41.18%	1 5.88%	2 11.76%	**17**
Residential Centre for Children with Disabilities	15 68.18%	4 18.18%	2 9.09%	1 4.55%	**22**
Rehabilitation Centre for Socially Disabled Girls	2 50.00%	2 50.00%	0	0	**4**
Safe Home	3 50.00%	3 50.00%	0	0	**6**
Sheikh Russel Home	1 12.50%	5 62.50%	1 12.50%	1 12.50%	**8**
SUK/CDC	2 66.67%	1 33.33%	0	0	**3**

6.6.3 Offer of vocational training

Vocational training is crucial for children in residential facilities, especially for those facing difficulties in completing formal education programs. It provides a practical pathway to acquire skills, aiding their integration into the workforce upon leaving the facility and boosting their self-confidence and self-esteem.

However, it is essential to acknowledge that vocational training often faces issues of inadequate funding and low-quality implementation. These shortcomings result in the training failing to deliver the significant benefits essential for these children as they transition into adulthood.

Vocational training includes activities such as stitching, tailoring, computer, boutique crafts, handcraft, animal husbandry, carpentry and others. Most institutions do not provide such a service, which is only implemented in 48 institutions such as madrassas, public orphanages and PHT centres. Institutions that facilitate access to vocational training for their children outside their premises are only seven. The scarcity of vocational training opportunities in the area surrounding the institution could be a contributing factor to this issue.

Table 75 Vocational training

Category of institution	No service provided	Within the premises	Outside the premises	Both	Total
Total (n %)	**97 61.78%**	**48 30.57%**	**7 4.46%**	**5 3.18%**	**157**
Baby Home	5 100%	0	0	0	**5**
Madrassa/religious education school	55 83.33%	10 15.15%	1 1.52%	0	**66**
MoWCA Centre	1 20.00%	4 80.00%	0	0	**5**
NGO (national and international)	4 100%	0	0	0	**4**
PHT Centres	0	6 100%	0	0	**6**
Private orphanage	8 72.73%	2 18.18	1 9.09%	0	**11**
Public orphanage	4 23.53%	7 41.18%	2 11.76%	4 23.53%	**17**
Residential Centre for Children with Disabilities	16 72.73%	4 18.18%	2 9.09%	0	**22**
Rehabilitation Centre for Socially Disabled Girls	0	4 100%	0	0	**4**
Safe Home	2 33.33%	4 66.67%	0	0	**6**
Sheikh Russel Home	2 25.00%	4 50.00%	1 12.50%	1 12.50%	**8**
SUK/CDC	0	3 100%	0	0	**3**

6.6.4 Offer of art and music education

Art and music education offer a holistic approach to learning, nurturing creativity, emotional well-being, social skills, cognitive development and overall child thriving. Unfortunately, art and music education are not provided in almost half of the childcare institutions, in particular madrassas and private orphanages. Those who prize art and music education are PHT centers, public orphanages, Safe Homes, SUK and Baby Homes, where more than half of the institutions provide art and music education to their children.

Table 76 Arts and music education

Category of institution	No service provided	Within the premises	Outside the premises	Both	Total (N)
Total (n %)	**72 45.86%**	**81 51.59%**	**3 1.91%**	**1 0.64%**	**157**
Baby Home	1 20.00%	4 80.00%	0	0	**5**
Madrassa/religious education school	38 57.58%	28 42.42%	0	0	**66**
MoWCA Centre	2 40.00%	2 40.00%	1 20.00%	0	**5**
NGO (national and international)	2 50.00%	2 50.00%	0	0	**4**
PHT Centres	1 16.67%	5 83.33%	0	0	**6**
Private orphanage	6 54.55%	4 36.36%	1 9.09%	0	**11**
Public orphanage	3 17.65%	13 76.47%	1 5.88%	0	**17**
Residential Centre for Children with Disabilities	11 50.00%	11 50.00%	0	0	**22**
Rehabilitation Centre for Socially Disabled Girls	2 50.00%	2 50.00%	0	0	**4**
Safe Home	2 33.33%	4 66.67%	0	0	**6**
Sheikh Russel Home	3 37.50%	4 50.00%	0	1 12.50%	**8**
SUK/CDC	1 33.33%	2 66.67%	0	0	**3**

6.6.5 After school homework help

After-school homework help is a valuable resource for children who have school difficulties and may benefit from extra academic support beyond school hours. This type of service is offered in more than half of the institutions, with a predominance in public orphanages, Sheikh Russel homes, madrassas, MoWCA centers, and RCCDs.

Table 77 After school support

Category of institution	No service provided	Within the premises	Outside the premises	Both	Total
Total (n %)	**66 42.04%**	**82 52.23%**	**7 4.46%**	**2 1.27%**	**157**
Baby Home	2 40.00%	3 60.00%	0	0	**5**
Madrassa/religious education school	28 42.42%	37 56.06%	1 1.52%	0	**66**
MoWCA Centre	1 20.00%	3 60.00%	1 20.00%	0	**5**
NGO (national and international)	1 25.00%	2 50.00%	1 25.00%	0	**4**
PHT Centres	4 66.67%	2 33.33%	0	0	**6**
Private orphanage	8 72.73%	2 18.18%	1 9.09%	0	**11**
Public orphanage	2 11.76%	13 76.47%	0	2 11.76%	**17**
Residential Centre for Children with Disabilities	8 36.36%	12 54.55%	2 9.09%	0	**22**
Rehabilitation Centre for Socially Disabled Girls	4 100.00%	0	0	0	**4**
Safe Home	5 83.33%	1 16.67%	0	0	**6**
Sheikh Russel Home	1 12.50%	6 75.00%	1 12.50%	0	**8**
SUK/CDC	2 66.67%	1 33.33%	0	0	**3**

6.7 Leisure Time

How children employ their leisure time is crucial for their holistic development, as leisure activities contribute to their physical, emotional and social wellbeing. Playing, practicing sport, recreation and picnic and trips activities offer enjoyable experiences that break with the monotony of residential care routines and that provide opportunities for developing physically, emotionally and socially.

Childcare institutions appear to also give a noticeable importance to outdoor life. They are well equipped with playgrounds. Interestingly, institutions that occupy an infrastructure adapted from a different destination are less better off with external areas. This is the case of MoWCA centers, with 0 playgrounds.

Table 78 Playgrounds

Category of institution	Number of institutions	Number of Children	Number of Play-ground	Children to play-ground ratio
Total (n %)	**157**	**13081**	**123**	**106.35**
Baby Home	**5**	113	5	22.60
Madrassa/religious education school	**66**	6180	57	108.42
MoWCA Centre	**5**	585	0	-
NGO (national and international)	**4**	290	3	96.67
PHT Centers	**6**	405	5	81.00
Private orphanage	**11**	1172	12	97.67
Public orphanage	**17**	1300	14	92.86
Rehabilitation Centre for Socially Disabled Girls	**4**	63	1	63.00
Residential Centre for Children with Disabilities	**22**	643	12	53.58
Safe Home	**6**	225	2	112.50
Sheikh Russel Home	**8**	995	6	165.83
SUK/CDC	**3**	1110	6	185.00

Childcare institutions appear also to give a noticeable importance to sports, through availability of dedicated grounds and sports equipment, as shown in the table below.

Table 79 Sports grounds and equipment

Category of institution	Number of institutions	Number of Children	Number of Sports ground and equipment	Children to sports grounds ratio
Total (n %)	**157**	**13081**	**829**	**15.78**
Baby Home	**5**	113	40	2.83
Madrassa/religious education school	**66**	6180	283	21.84
MoWCA Centre	**5**	585	20	29.25
NGO (national and international)	**4**	290	61	4.75
PHT Centres	**6**	405	19	21.32
Private orphanage	**11**	1172	34	34.47
Public orphanage	**17**	1300	92	14.13
Rehabilitation Centre for Socially Disabled Girls	**4**	63	19	3.32
Residential Centre for Children with Disabilities	**22**	643	117	5.50
Safe Home	**6**	225	17	13.24
Sheikh Russel Home	**8**	995	82	12.13
SUK/CDC	**3**	1110	45	24.67

The practice of sports is widely developed in childcare institutions as only 14.65% of the childcare institutions do not provide sports activities. These last are mainly NGOs, MoWCA centers and RCCD.

Table 80 Sports practice

Category of institution	No service provided	Within the premises	Outside the premises	Both	Total (N)
Total (n %)	**23 14.65%**	**112 71.34%**	**13 8.28%**	**9 5.73%**	**157**
Baby Home	0	5 100.00%	0	0	**5**
Madrassa/religious education school	7 10.61%	56 84.85%	2 3.03%	1 1.52%	**66**
MoWCA Centre	2 40.00%	1 20.00%	2 40.00%	0	**5**
NGO (national and international)	2 50.00%	2 50.00%	0	0	**4**
PHT Centres	1 16.67%	4 66.67%	1 16.67%	0	**6**
Private orphanage	2 18.18%	7 63.64%	2 18.18%	0	**11**
Public orphanage	1 5.88%	13 76.47%	0	3 17.65	**17**
Residential Centre for Children with Disabilities	5 22.73%	8 36.36%	6 27.27%	3 13.64%	**22**
Rehabilitation Centre for Socially Disabled Girls	0	4 100.00%	0	0	**4**
Safe Home	1 16.67%	5 83.33%	0	0	**6**
Sheikh Russel Home	2 25.00%	4 50.00%	0	2 25.00%	**8**
SUK/CDC	0	3 100.00%	0	0	**3**

Most of the institutions do give the children opportunities for leisure activities such as picnics and trips, that allow children out of the care setting. Some of the statutory institutions such as SUK (one out of three), Safe Homes (three out of six) and Baby Homes (three out of five) do provide these opportunities to resident children. Recreation, picnic and trips

Table 81

Category of institution	No service provided	Within the premises	Outside the premises	Both	Total (N)
Total (n %)	**44 28.03%**	**39 24.84%**	**65 41.40%**	**9 5.73%**	**157**
Baby Home	2 40.00%	3 60.00%	0	0	**5**
Madrassa/religious education school	21 31.82%	14 21.21%	30 45.45%	1 1.52%	**66**

Category of institution	No service provided	Within the premises	Outside the premises	Both	Total (N)
MoWCA Centre	1 20.00%	1 20.00%	3 60.00%	0	**5**
NGO (national and international)	1 25.00%	0	3 75.00%	0	**4**
PHT Centres	1 16.67%	2 33.33%	3 50.00%	0	**6**
Private orphanage	4 36.36%	0	7 63.64%	0	**11**
Public orphanage	3 17.65%	6 35.29%	4 23.53%	4 23.53%	**17**
Residential Centre for Children with Disabilities	3 13.64%	4 18.18%	14 63.64%	1 4.55%	**22**
Rehabilitation Centre for Socially Disabled Girls	0	3 75.00%	0	1 25.00%	**4**
Safe Home	3 50.00%	3 50.00%	0	0	**6**
Sheikh Russel Home	3 37.50%	2 25.00%	1 12.50%	2 25.00%	**8**
SUK/CDC	2 66.67%	1 33.33%	0	0	**3**

6.8 Religious Education and Practice

Religious education is provided in most of the institutions, among which are all the MoCWA centers, private orphanages, and of SUK. 50% of NGOs, 36% of RCCD, 20% of Baby Homes and 16% of Safe Homes and PHT centers do not provide religious education to the children.

Table 82 Institutions providing religious education

Religious education	No service provided	Within the premises	Outside the premises	Both	Total (N)
Total (n %)	**21 13.88%**	**131 83.44%**	**3 1.91%**	**2 1.27%**	**157**
Baby Home	1 20.00%	4 80.00%	0	0	**5**
Madrassa/religious education school	5 7.58%	60 90.91%	1 1.52%	0	**66**
MoWCA Centre	0	5 100.00%	0	0	**5**
NGO (national and international)	2 50.00%	2 50.00%	0	0	**4**
PHT Centres	1 16.67%	5 83.33%	0	0	**6**

Religious education	No service provided	Within the premises	Outside the premises	Both	Total (N)
Private orphanage	0	11 100.00%	0	0	**11**
Public orphanage	1 5.88%	15 88.24%	0	1 5.88%	**17**
Residential Centre for Children with Disabilities	8 36.36%	11 50.00%	2 9.09%	1 4.55%	**22**
Rehabilitation Centre for Socially Disabled Girls	1 25.00%	3 75.00%	0	0	**4**
Safe Home	1 16.67%	5 83.33%	0	0	**6**
Sheikh Russel Home	1 12.50%	7 87.50%	0	0	**8**
SUK/CDC	0	3 100.00%	0	0	**3**

6.9 Social Worker Assistance

Together with Child Welfare Boards and probation officers, social workers hold a crucial role in the alternative care system. Initially, they contribute to assessing the child's situation and facilitating the child's placement. Once the child is admitted, these professionals contribute to case management, offering continuous support to the child, ensuring a comprehensive care plan is in place, encompassing an exit strategy and access to essential services and collaborating with social welfare authorities. Throughout the child's stay in care, social workers also contribute to maintaining communication with the family and work for family reunification.

The presence of social workers is overall very limited, with a total number of 40 for 157 institutions.

In the public childcare facilities, their presence is as follows:

- Three Baby Homes do not have a social worker; one receives the visit of a social worker on demand and one weekly;
- Three RCSDG do not have a social worker and one receives the social worker's visit weekly;
- Two Safe Homes receive weekly visits by a social worker, one regularly and another three do not have social workers;
- One SUK has weekly visits from a social worker and two do not have such services.

The institutions which have the best relative situation are Sheikh Russel Homes (three out of eight), RCCD, private orphanages, public orphanages, MoWCA centres, NGOs and madrassas, but even in these, only about one quarter of the institutions in each of these types have the services of a social worker.

Unfortunately, the presence of social workers within childcare institutions remains constrained, a situation that underscores the need for investing in universal social work services across all residential institutions. Guaranteeing the availability of social workers in these settings is fundamental to ensuring that the cases of children in alternative care are professionally managed and that children receive adequate support.

Table 83 Social worker follow-up

Type of institution	Weekly			Monthly		Regularly/Daily			Every 2 months	Half Yearly		On Demand		Every 3 months	Quarterly	Yearly		No Specific time to monitor		No service	N (%)
	Within the premises	Outside the premises	Both	Within the premises	Outside the premises	Within the premises	Outside the premises	Both	Outside the premises	Within the premises	Outside the premises	Within the premises	Outside the premises	Outside the premises	Within the premises	Within the premises	Outside the premises	Within the premises	Outside the premises		
Total (n %)	**7 4.46%**	**1 0.64%**	**1 0.64%**	**27 17.20%**	**2 1.27%**	**5 3.18%**	**1 0.64%**	**1 0.64%**	**1 0.64%**	**6 3.82%**	**4 2.55%**	**5 3.18%**	**1 0.64%**	**1 0.64%**	**3 1.91%**	**2 1.27%**	**1 0.64%**	**12 7.64%**	**1 0.64%**	**75 47.77%**	**157 100%**
Baby Home	1 20.00%	0	0	0	0	0	0	0	0	0	0	1 20.00%	0	0	0	0	0	0	0	3 60.00%	**5 100%**
Madrassa/religious education school	0	0	0	13 19.70%	0	0	0	0	0	6 9.09%	4 6.06%	2 3.03%	1 1.52%	1 1.52%	2 3.03%	2 3.03%	1 1.52%	9 13.64%	0	25 37.88%	**66 100%**
MoWCA Centre	0	0	0	1 20.00%	0	0	0	0	1 20.00%	0	0	0	0	0	0	0	0	0	0	3 60.00%	**5 100%**
NGO (national and international)	0	0	0	0	1 25.00%	1 25.00%	1 25.00%	0	0	0	0	0	0	0	1 25.00%	0	0	0	0	0	**4 100%**
PHT Centres	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6 100%	**6 100%**
Private orphanage	0	0	0	3 27.27%	0	0	0	0	0	0	0	0	0	0	0	0	0	2 18.18%	0	6 54.55%	**11 100%**
Public orphanage	0	0	0	4 23.53%	0	1 5.88%	0	0	0	0	0	0	0	0	0	0	0	1 5.88%	0	11 64.71%	**17 100%**
Rehabilitation Centre for Socially Disabled Girls	1 25.00%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3 75.00%	**4 100%**
Residential Centre for Children with Disabilities	0	1 4.55%	0	6 27.27%	1 4.55%	1 4.55%	0	0	0	0	0	0	0	0	0	0	0	0	1 4.55%	12 54.55%	**22 100%**
Safe Home	1 16.67%	0	1 16.67%	0	0	1 16.67%	0	0	0	0	0	0	0	0	0	0	0	0	0	3 50.00%	**6 100%**
Sheikh Russel Home	3 37.50%	0	0	0	0	1 12.50%	0	1 12.50%	0	0	0	2 25.00%	0	0	0	0	0	0	0	1 12.50%	**8 100%**
SUK/CDC	1 33.33%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2 66.67%	**3 100%**

6.10 Contact with Family

Overall, the majority of the children have contact with their families – reportedly 90.03% of profiled children (Table 80). However, important variations exist across the centers. Although most of the children living in RCCD do have a family (92.44% have both parents living), the great majority of them (86.05%) do not have contact with their families. The reasons for this high percentage were not explored. Equally the majority of children from Baby Homes, Safe Homes and NGOs have no contact with family. MoWCA centers and SUKs have the highest percentages of family contact.

Table 84 Children who have contact with family

Category	No Response n(%)	Have contact with Family n(%)	No contact with family n(%)	Total (N)
Total (n %)	**10 0.1%**	**9312 91.81%**	**821 8.09%**	**10,143**
Baby Home	0	39 34.51%	74 65.49%	**113**
Madrassa/religious education school	0	4955 96.97%	155 3.03%	**5,110**
MoWCA Centre	0	545 99.09%	5 0.91%	**550**
NGO (national and international)	0	53 49.07%	55 50.93%	**108**
PHT Centres	0	302 93.21%	22 6.79%	**324**
Private orphanage	0	883 88.39%	116 11.61%	**999**
Public orphanage	10 0.91%	1038 94.71%	48 4.38%	**1,096**
Rehabilitation Centre for Socially Disabled Girls	0	441 98%	9 2%	**450**
Residential Centre for Children with Disabilities	0	6 13.95%	37 86.05%	**43**
Safe Home	0	86 40.95%	124 59.05%	**210**
Sheikh Russel Home	0	821 82.51%	174 17.49%	**995**
SUK/CDC	0	143 98.62%	2 1.38%	**145**

Most of the facilities consider telephone communication as the primary medium of contact, while family visits at the facilities are considered as the second most common medium of contact, followed by children

going home (see Table 81). There might be some restrictions in certain cases for children going home, as the qualitative data indicates (see below section 4.4.11) that children coming back in due time to the facility after a family visit might be very complicated.

Table 85 Medium of contact with family

Category of institution *(Could select more than one choice)*	Didnt get any information n(%)	Tele-phone n(%)	Child receives visit by family member n(%)	Child goes home n(%)	Total (N)
Baby Home	**0**	**13 33.33%**	**37 94.87%**	**31 79.49%**	**39**
Madrassa/religious education school	0	3796 76.61%	3776 76.21%	4273 86.24%	**4955**
MoWCA Centre	0	531 97.43%	398 73.03%	530 97.25%	**545**
NGO (national and international)	0	53 100%	53 100%	53 100%	**53**
PHT Centres	0	208 68.87%	210 69.54%	292 96.69%	**302**
Private orphanage		450 50.96%	610 69.08%	818 92.64%	**883**
Public orphanage	11 1.06%	610 58.77%	746 71.87%	917 88.34%	**1038**
Rehabilitation Centre for Socially Disabled Girls	0	4 66.67%	2 33.33%	0	**6**
Residential Centre for Children with Disabilities	0	123 27.89%	405 91.84%	441 100%	**441**
Safe Home	5 5.81%	37 43.02%	79 91.86%	0	**86**
Sheikh Russel Home	0	593 72.23%	607 73.93%	696 84.77%	**821**
SUK/CDC	0	143 100%	4 2.8%	0	**143**

6.11 Integration of Childcare Facilities within the Community

Childcare facilities should be as much as possible a living part of the social fabric. The idea is that the facilities are as open as possible, that they function as a community resource. On the one side, they should allow resident children to access basic services beyond their walls, in the community. This includes education, healthcare, recreational activities, and cultural experiences available in the wider community. Allowing resident children to access regular community services helps normalize their experiences and promotes their integration into society. It also fosters social skills, and a sense of inclusion and belonging, crucial for their holistic development.

On the other side, well facilities should provide access to equipment or provision of particular services to the children of the community. Moreover, extending services or equipment to the broader community creates a mutually beneficial relationship. It allows the community to benefit from resources available within the facility, potentially filling gaps or enhancing existing services. This integration breaks down barriers and stigmas, promoting understanding and acceptance between the children in care and the community members.

Making residential care facilities open and integrated into the community benefits everyone involved. By functioning as community resources, these facilities not only support the children within but also contribute positively to the surrounding area.

Overall, this approach fosters a more cohesive and supportive environment where resources are shared, and both the children in residential care and the community at large benefit from increased access to services and opportunities.

The study explored the degree of openness and of integration of the institutions within the community through various indicators:

1. The services delivered to institutionalized children outside the premises of the facility
2. The availability of services delivered by the institution to children of the surrounding environment living outside the facility
3. The meetings with the community

Regarding the first indicator, the following emerges:

- The pattern of provision of formal education varies across institutions and within the same category of institutions, with 25.48% of them sending children to school for formal education outside their premises, in particular Sheikh Russel Homes, MoWCA centers, public orphanages and RCCDs (see Table 70).
- For informal education, the use of external services is low, with only 6 institutions doing so (see Table 71)
- For vocational training, sending children in the community is slimly practiced, with only 7 institutions doing so (see Table 72)
- The patterns of provision of health care on demand – meaning when the need arises – is mostly practiced outside the premises, while for those institutions that practice weekly and monthly checks, this is mainly done by medical staff inside the premises (see Table 65).

Regarding the second indicator, the majority of institutions only offer services to resident children. The only institutions that display some degree of openness toward children in the community are the PHT centers, some madrassas, some RCCDs, and some public orphanages. Overall, it appears that these institutions are rather closed off from the external world.

Table 86 Institutions providing services for children living outside the facility

Category of institution	No service provided	Within the premises	Outside the premises	Total (N)
Total (n %)	**131 83.44%**	**21 13.38%**	**5 3.18%**	**157**
Baby Home	5 100%	0	0	**5**
Madrassa/religious education school	51 77.27%	13 19.70%	2 3.03%	**66**
MoWCA Centre	5 100%	0	0	**5**
NGO (national and international)	3 75.00%	0	1 25.00%	**4**
PHT Centres	4 66.67%	2 33.33%	0	**6**
Private orphanage	9 81.82%	0	2 18.18%	**11**
Public orphanage	15 88.24%	2 11.76%	0	**17**
Residential Centre for Children with Disabilities	18 81.82%	4 18.18%	0	**22**
Rehabilitation Centre for Socially Disabled Girls	4 100%	0	0	**4**
Safe Home	6 100%	0	0	**6**
Sheikh Russel Home	8 100%	0	0	**8**
SUK/CDC	3 100%	0	0	**3**

When enquired whether the institutions hold meetings with the community, the responses were mostly positive (70.7%). The majority of the meetings are held inside the facility, indicating that individuals from the outside world do enter the facilities. While the content and objectives of these meeting is not known, it looks like most childcare facilities are open towards the community.

Table 87 Regular meetings with community

Category of institution	No service provided	Within the premises	Outside the premises	Both	Total (N)
Total (n %)	**46 29.30%**	**99 63.06%**	**9 5.73%**	**3 1.91%**	**157**
Baby Home	3 60.00%	1 20.00%	1 20.00%	0	**5**
Madrassa/religious education school	7 10.61%	57 86.36%	1 1.52%	1 1.52%	**66**
MoWCA Centre	3 60.00%	2 40.00%	0	0	**5**

Category of institution	No service provided	Within the premises	Outside the premises	Both	Total (N)
NGO (national and international)	1 25.00%	2 50.00%	1 25.00%	0	**4**
PHT Centres	3 50.00%	3 50.00	0	0	**6**
Private orphanage	2 18.18%	9 81.82%	0	0	**11**
Public orphanage	9 52.94%	7 41.18%	1 5.88%	0	**17**
Residential Centre for Children with Disabilities	7 31.82%	13 59.09%	2 9.09%	0	**22**
Rehabilitation Centre for Socially Disabled Girls	2 50.00%	1 25.00%	1 25.00%	0	**4**
Safe Home	5 83.33%	0	1 16.67%	0	**6**
Sheikh Russel Home	1 12.50%	4 50.00%	1 12.50%	2 25.00%	**8**
SUK/CDC	3 100.00%	0	0	0	**3**

6.12 Legal Assistance

Access to legal aid, counseling or assistance is particularly crucial for statutory childcare institutions. However, e institutions belonging to the same category do not exhibit identical service provision patterns:

- Two Baby Homes provide the service outside the premises, and three do not provide the service;
- One RCSDG provides this service outside the centre;
- Five Safe Homes provide the service, one inside, four outside, and one does not provide the service.
- Two SUK/CDC provide the service, one inside, the other outside the premises, and one does not provide such service.

Table 88 Institutions providing legal assistance

Legal assistance	No service provided	Within the premises	Outside the premises	Both	Total (N)
Total (n %)	**112** **71.34%**	**9** **5.73%**	**34** **21.66%**	**2** **1.27%**	**157**
Baby Home	3 60.00%	0	2 40.00%	0	**5**
Madrassa/religious education school	54 81.82%	3 4.55%	9 13.64%	0	**66**

Legal assistance	No service provided	Within the premises	Outside the premises	Both	Total (N)
MoWCA Centre	3 60.00%	0	2 40.00%	0	**5**
NGO (national and international)	2 50.00%	0	2 50.00%	0	**4**
PHT Centres	6 100.00%	0	0	0	**6**
Private orphanage	9 81.82%	1 9.09%	1 9.09%	0	**11**
Public orphanage	11 64.71%	0	5 29.41%	1 5.88%	**17**
Residential Centre for Children with Disabilities	16 72.73%	2 9.09%	4 18.18%	0	**22**
Rehabilitation Centre for Socially Disabled Girls	3 75.00%	0	1 25.00%	0	**4**
Safe Home	1 16.67%	1 16.67%	4 66.67%	0	**6**
Sheikh Russel Home	3 37.50%	1 12.50%	3 37.50%	1 12.50%	**8**
SUK/CDC	1 33.33%	1 33.33%	1 33.33%	0	**3**

6.13 Documentation

Importance of Documentation in Residential Care Settings: It is essential that the facilities have written documents providing clear information both for registration purposes, policy orientations, and clear guidelines and procedures for day-to-day operations, ensuring everyone involved shares the same knowledge concerning their roles, responsibilities, and the overall functioning of the institution.

The UN Guidelines for the Alternative Care of Children emphasize this requirement: "All agencies and facilities should have written policy and practice statements, consistent with the present Guidelines, setting out clearly their aims, policies, methods and the standards applied for the recruitment, monitoring, supervision and evaluation of qualified and suitable carers to ensure that those aims are met."[30]

In order to apprehend the degree of compliance and internal organization, documents were checked to see if they were physically available in the sampled residential care facilities. This study found high availability of documents such as organization description, program, organogram, registration documents, registers, annual reports, but there was a noticeable unavailability in supervision reports, guidelines for management, child safeguarding policies, staff code of conduct, behavior management policy, internal regulations, and other policies.

[30]UN Guidelines § 106

Table 89 Availability of organization description, program and organogram

Type of document	Availability		
	Yes n(%)	Yes n(%)	Total (N)
Organization description, programme, organogram	93 59.24%	64 40.76%	157
Registration document	82 52.23%	75 47.77%	157
Registers	109 69.43%	48 30.57%	157
Annual reports	81 51.59%	76 48.41%	157
Supervision reports	64 40.76%	93 59.24%	157
Guidelines for management/procedure manual	53 33.76%	104 66.24%	157
Child Safeguarding Policy	16 10.19%	141 89.81%	157
Staff Code of conduct	23 14.65%	134 85.35%	157
Behaviour Management policy	27 17.20%	130 82.80%	157
Internal regulations other than above	4 2.55%	153 97.45%	157
Checklists of documents to be found in the children's files	90 57.32%	67 42.68%	157
Updated and complete staff files	80 50.96%	77 49.04%	157

Visibility of Documents Within Facilities: Some information and/or documents should be known and immediately available for reference to anyone entering the childcare facility. This is specifically the case for documents such as codes of conduct. Both children and staff need to know the rules of conduct, to be able to discern any infringement and react as appropriate within an established and agreed framework. Other documents include daily routine and menu, as children and staff alike might be curious about compliance with timetables or menus. Producing this kind of information, negotiating among the staff and the children and making it visible and easily accessible to visitors, promotes a positive environment, fosters adherence to established norms, and ensures that everyone is aware of and positively respects the rules.

The study therefore observed which documents were posted on the common space of the premise and found a shortcoming in the majority of the facilities in posting necessary documents. While the menu is among the most popularly posted documents, there is a notable shortage of documents concerning

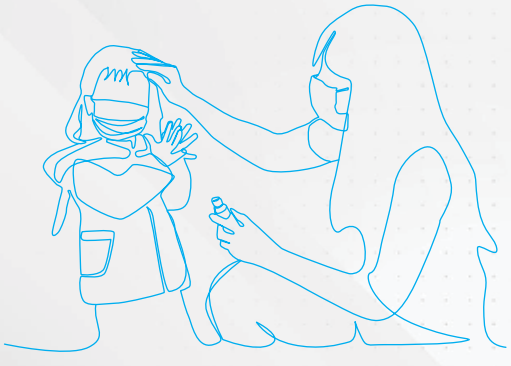
behavior rules – communication about expected and prohibited behavior for both children and staff. More than 90% of institutions don't post this type of document. This represents a serious limitation, as having such a document posted helps create a more predictable and structured environment, reducing the likelihood of unexpected behavior and ensuring cohesive interactions among individuals within the facility. It also diminishes the chances of children receiving arbitrary punishment for rule infractions and enables them to voice complaints about rule breaches by adults.

Table 90 Posted documents

Posted documents	Yes n(%)	No n(%)	Total (N)
Behaviour rules for children	22 14.01%	135 85.99%	157
Behaviour rules for staff	12 7.64%	145 92.36%	157
Behaviour rules for everybody, children and staff alike	4 2.55%	153 97.45%	157
Staff Code of Conduct	12 7.64%	145 92.36%	157
Daily routine	69 43.95%	88 56.05%	157
Weekly menu or menu of the day	103 65.61%	54 34.39%	157
Educational messages	61 38.85%	96 61.15%	157
Visual pleasure – drawings, decoration	59 37.58%	98 62.42%	157

07

Findings:
Workforce Composition and Institutional Capacity



This section presents findings related to the human resources that underpin residential care in Bangladesh—an area that has a direct impact on the safety, quality, and developmental outcomes of children in care. Even more important than infrastructure, the presence of well-trained, adequately supervised staff working under appropriate conditions is a key determinant of care quality. The study began with a comprehensive categorization of staff across different roles—managerial, administrative, teaching, caregiving, and support functions. It then assessed overall staffing levels and distribution, analyzed child-to-staff ratios, and examined the presence or absence of specialized personnel such as social workers. In addition, the section explores staff demographics, including age, gender, educational background, and years of experience, and assesses whether staff had received any relevant training in child protection or residential care. Together, these findings reveal critical workforce gaps that undermine the ability of institutions to provide consistent, child-centred, and developmentally appropriate care, and point to the need for significant investment in workforce development and professionalization.

7.1 Staff Categorization

Our first step was to identify staff categories based on the roles and responsibilities that they cover within the institution. There were a host of g functional roles, each of them covering a wide array of denominations[31]:

- Managerial staff (MAN) – In charge of/Responsible for the institution
- Administrative staff (ADM) – Handle paperwork, record-keeping, and other administrative tasks necessary for the operation of the institution
- Child care workers (CAR)[32] – Responsible for the direct day-to-day care of children (food, clothing, hygiene, emotional support and supervision)
- Educational staff (EDU) – These are in charge of the children's education
- Social workers (SW) – They handle assessments, care plans, communication with family, liaison with authorities and service providers, and assist the Court. These include staff involved in outreach activities
- Therapists and counsellors (TH) – Provide therapeutic interventions and counselling
- Health care professionals (HC) – Provide medical follow-up and care, administer medications, and address any health concerns

[31]For more details, refer to Annex X Staff categories.

[32]In the Children Act Khalamma or BoroBahia or any person engaged in providing care for children are defined as social workers, which is an essential recognition of the importance of their role. Meanwhile, it is important to note that there is a distinction between social workers and caregivers. Caregivers primarily focus on providing direct care and support to children, including meeting their basic needs, offering emotional support, and ensuring their safety and work under the supervision of the Home Manager. On the other hand, social workers possess specialized training in social work, interventions, and case management, link to the child protection and social welfare system and work under the supervision of the Department.

- Support staff (SUP) – In charge of housekeeping and security
- Other – Includes one Bench Assistant and one advocate (in SUK)

These categories are grouped into three main categories[33]:

- Managers and Administrative staff (MAN, ADM)
- Childcare and educational staff (CAR, EDU, SW, TH, HC)
- Support staff (SUP)

7.2 Staffing Levels

Staffing level refers to the number of qualified personnel available to manage the institution and to care for and support the children. Staffing level typically includes:

- The staff number - this refers to having an adequate quantity of staff members to ensure individual supervision and personalized care of children with appropriate workloads
- Staff roles – encompass covering all essential staff roles in order to meet the essential needs of children

The table below provides a general overview of staff numbers in surveyed institutions.

Table 91 Staffing levels: numbers

	# Institutions	Total # staff	Average staff per facility
Baby Home	5	54	10.8
Madrassa/religious education school	66	707	10.7
MoWCA Centre	5	48	9.6
NGO (national and international)	4	56	14
PHT Centres	6	111	18.5
Private orphanage	11	116	10.5
Public orphanage	17	229	13.4
Rehabilitation Centre for Socially Disabled Girls	4	59	14.7
Residential Centre for Children with Disabilities	22	122	5.5
Safe Home	6	77	12.8
Sheikh Russel Home	8	116	14.5
SUK/CDC	3	23	7.6
Grand Total	**157**	**1718**	**10.9**

- PHT Centers, RCSDG, SRCH, NGOs, public orphanages and Safe Homes have an average number of staff above the overall average, indicating a higher staff-to-institution ratio
- SUK and RCCD have the lowest average staff per institution, suggesting few staff members per institution
- The overall average staff per institution across all 157 institutions is 10.9

[33]For more details, see Annex II, Staff Categories.

Our further step was to examine how the staff is distributed across the different categories. This analysis offers a comprehensive understanding of how the different childcare institutions organize their workforce and what is the relative emphasis posed on administrative aspects, childcare aspects or support tasks.

The table below displays how personnel are allocated across different categories within the institutions.

Table 92 Staffing level: Roles

Category of institutions	Staff category									
	Manager	Admin	Childcare staff	Educational Staff	Social Worker	Therapists and counsellors	Health Care	Support Staff	Others	Total staff (N)
Total (n %)	**162 9.43%**	**160 9.31%**	**175 10.19%**	**684 39.81%**	**41 2.39%**	**8 0.47%**	**43 2.50%**	**443 25.79%**	**2 0.12%**	**1718**
Baby Home	5 9.26%	9 16.67%	25 46.30%	5 9.26%	0	0	1 1.85%	9 16.67%	0	**54**
Madrassa/ religious education school	84 11.88%	37 5.23%	7 0.99%	423 59.83%	0	0	2 0.28%	154 21.78%	0	**707**
MoWCA Centre	4 8.33%	0	10 20.83%	12 25%	1 2.08%	0	0	21 43.75%	0	**48**
NGO (national and international)	11 19.64%	1 1.79%	11 19.64%	14 25%	1 1.79%	1 1.79%	1 1.79%	16 28.57%	0	**56**
PHT Centres	7 6.31%	18 16.22%	6 5.41%	34 30.63%	0	0	4 3.60%	42 37.84%	0	**111**
Private orphanage	10 8.62%	3 2.59%	8 6.90%	55 47.41%	2 1.72%	1 0.86%	1 0.86%	35 30.17%	1 0.86%	**116**
Public orphanage	16 6.99%	71 31%	37 16.16%	55 24.02%	2 0.87%	0	17 7.42%	31 13.54%	0	**229**
Rehabilitation Centre for Socially Disabled Girls	3 5.08%	5 8.47%	21 35.59%	12 20.34%	0	0	2 3.39%	16 27.12%	0	**59**
Residential Centre for Children with Disabilities	10 8.20%	8 6.56%	14 11.48%	34 27.87%	2 1.64%	2 1.64%	4 3.28%	48 39.34%	0	**122**
Safe Home	4 5.19%	5 6.49%	8 10.39%	3 3.90%	8 10.39%	0	5 6.49%	44 57.14%	0	**77**
Sheikh Russel Home	7 6.03%	1 0.86%	27 23.28%	28 24.14%	25 21.55%	4 3.45%	6 5.17%	18 15.52%	0	**116**
SUK/CDC	1 4.35$	2 8.70%	1 4.25%	9 39.13%	0	0	0	9 39.13%	1 4.35%	**23**

For a more detailed analysis, separate tables for the main staff categories are presented.

7.3 Childcare and Educational Staff

The majority of staff in all institutions primarily consists of educational and childcare personnel (55.35%), aligning with the core mission of these organizations. However, beneath this overall average, significant disparities exist among institutions. Within the childcare and educational staff category, the following highlights stand out:

- SRCH stands out for its pronounced emphasis on staff directly engaged in the care and education of children, with a substantial 89.1% of staff falling within this category.
- Madrassas, RCSDGs, private orphanages and Baby Homes also have high percentages. In contrast, Safe Homes exhibit the lowest percentage of staff dedicated to care and education, at just 31.16%.
- The predominance of **educational staff** is in madrassas (59.83%). It's worth noting that the high percentage of educational staff in madrassas is consistent with the primary function of these institutions, which is to provide religious and educational instruction to children. This alignment between staff and the institution's core mission is expected. If madrassas are excluded, the percentage of educational staff within the childcare and education staff category falls to 27.44%.
- An extremely low percentage of educational staff in Safe Homes, where it stands at 3.90%, is dramatically below the global average. This situation raises concerns, as the girls residing in these homes are not permitted to exit the facility for external education. Notwithstanding the institution's objective to rehabilitate the girls, they have extremely limited access to education and opportunities for personal development.
- The predominance of **caregivers** in baby homes and RCSDG, and conversely very low scores of caregivers in madrassas (where the central caregiving function is assigned to teachers), SUK, PHT centers and private orphanages.
- Extremely scarce presence of **social workers**, which make up 2.39% of the total staff. Upon excluding Sheikh Russell Homes and Safe Homes, social worker presence is even lower, as social workers make up 21.55% and 10.39% of their staff, respectively.
- **Health care workers** are 2.50% of the total staff. They are much more numerous in public orphanages than in any other institution type. They are above the global average also in Safe Homes, Sheikh Russel Homes, PHT centers, RCSDG and RCCD, indicating the importance given to health in public institutions.
- With regard to **therapists and counsellors** (0.47% of total staff), the Sheikh Russel Homes given importance to this rehabilitative role, with half of all the staff in this category across all institutions (4 staff). This category is absent in Baby Homes, madrassas, MoWCA centers, PHT centers, public orphanages, RCSDG, Safe Homes and SUK.

Table 93 Childcare and educational staff

Category of institution	Childcare staff	Educational Staff	Social Worker	Therapists and counsellors	Health Care	Total childcare and educational staff	Total Staff
Total (n %)	**175 10.19%**	**684 39.81%**	**41 2.39%**	**8 0.47%**	**43 2.50%**	951 55.35%	1718
Baby Home	25 46.30%	5 9.26%	0	0	1 1.85%	31 57.40%	54
Madrassa/ religious education school	7 0.99%	423 59.83%	0	0	2 0.28%	432 61.10%	707
MoWCA Centre	10 20.83%	12 25%	1 2.08%	0	0	23 47.91	48
NGO (national and international)	11 19.64%	14 25%	1 1.79%	1 1.79%	1 1.79%	28 50.00%	56
PHT Centres	6 5.41%	34 30.63%	0	0	4 3.60%	44 39.63%	111
Private orphanage	8 6.90%	55 47.41%	2 1.72%	1 0.86%	1 0.86%	67 75.75%	116
Public orphanage	37 16.16%	55 24.02%	2 0.87%	0	17 7.42%	111 48.47%	229
Rehabilitation Centre for Socially Disabled Girls	21 35.59%	12 20.34%	0	0	2 3.39%	35 59.32%	59
Residential Centre for Children with Disabilities	14 11.48%	34 27.87%	2 1.64%	2 1.64%	4 3.28%	56 45.90%	122
Safe Home	8 10.39%	3 3.90%	8 10.39%	0	5 6.49%	24 31.16%	77
Sheikh Russel Home	27 23.28%	28 24.14%	25 21.55%	4 3.45%	6 5.17%	90 89.17%	89.17%
SUK/CDC	1 4.25%	9 39.13%	0	0	0	10 43.47%	43.47%
Total							

7.4 Support Staff

Support staff is the second most numerous staff category, gathering 25.79%. of staff across all institutions. The percentage of support staff is above the average in Safe Homes and MoWCA centers, RCCD, SUK and PHT centers. Conversely it is lower than the average in public orphanages, Sheikh Russel and Baby Homes.

There is a significant presence of support staff in Safe Homes, comprising 57.14% of their total staff. This means that more than half of the staff within Safe Homes are primarily engaged in roles that are not directly related to the care and well-being of the girls residing there. The substantial share of support and

security personnel may reflect a focus on the safety and operational aspects of Safe Homes. However, it also raises questions about the extent to which the primary mission of rehabilitating the girls and providing them with educational and personal development opportunities is being addressed.

Table 94 Support staff

Category of institution	Total staff	Support staff
Total (n %)	**1718**	**443** **25.79%**
Baby Home	54	9 16.67%
Madrassa/religious education school	707	154 21.78%
MoWCA Centre	48	21 43.75%
NGO (national and international)	56	16 28.57%
PHT Centres	111	42 37.84%
Private orphanage	116	35 30.17%
Public orphanage	229	31 13.54%
Rehabilitation Centre for Socially Disabled Girls	59	16 27.12%
Residential Centre for Children with Disabilities	122	48 39.34%
Safe Home	77	44 57.14%
Sheikh Russel Home	116	18 15.52%
SUK/CDC	23	9 39.13%

7.5 Managers and Administrative Staff

Among surveyed childcare institutions, managers and administrative staff collectively constitute 18.74% of the total staff. Notably, public orphanages exhibit a significantly higher proportion at 37.99%, suggesting a considerable level of bureaucratization in these institutions. Following closely are Baby homes, another long-established public institution, which also shows a high percentage of managers and administrative staff (25.92%)

Table 95 Managers and administrative staff

Category of institution	Manager	Admin	MAN+ADM	TOTAL STAFF
Total (n %)	**162** **9.43%**	**160** **9.31%**	**322** **18.74%**	**1718**
Baby Home	5 9.26%	9 16.67%	14 25.92%	54
Madrassa/religious education school	84 11.88%	37 5.23%	121 17.11%	707
MoWCA Centre	4 8.33%	0	4 8.33%	48
NGO (national and international)	11 19.64%	1 1.79%	12 21.42%	56
PHT Centres	7 6.31%	18 16.22%	25 22.52%	111
Private orphanage	10 8.62%	3 2.59%	13 11.20%	116
Public orphanage	16 6.99%	71 31%	87 37.99%	229
Rehabilitation Centre for Socially Disabled Girls	3 5.08%	5 8.47%	8 13.55%	59
Residential Centre for Children with Disabilities	10 8.20%	8 6.56%	18 14.75%	122
Safe Home	4 5.19%	5 6.49%	9 11.68%	77
Sheikh Russel Home	7 6.03%	1 0.86%	8 6.8%	116
SUK/CDC	1 4.35%	2 8.70%	3 13.04%	23

The study revisited the staff structure in order to provide an overall picture of how the staff are organized within each institution based on the main staff categories, allowing for a better understanding of the overall staff structure and facilitating potential adjustments or improvements as necessary.

As indicated, the main staff categories percentages are as follows:

- Managers and Administrative staff (18.74%)
- Childcare and educational staff (55.35%)
- Support staff (25.78%)

Table 96 Staff structure

Type of institution	Total Staff	Managers and admin	Child care and educational staff	Support staff
Total	**1718**	**322 18.74%**	**951 55.35%**	**443 25,78%**
Baby Home	54	14 25.92%	31 57.40%	9 16.67%
Madrassa/religious education school	707	121 17.11%	432 61.10%	154 21.78%
MoWCA Centre	48	4 8.33%	23 47.91%	21 43.75%
NGO (national and international)	56	12 21.42%	28 50.00%	16 28.57%
PHT Centres	111	25 22.52%	44 39.63%	42 37.84%
Private orphanage	116	13 11.20%	67 57.75%	35 30.17%
Public orphanage	229	87 37.99%	111 48.47%	31 13.54%
Rehabilitation Centre for Socially Disabled Girls	59	8 13.55%	35 59.32%	16 27.12%
Residential Centre for Children with Disabilities	122	18 14.75%	56 45.90%	48 39.34%
Safe Home	77	9 11.68%	24 31.16%	44 57.14%
Sheikh Russel Home	116	8 6.8%	90 89.17%	18 15.52%
SUK/CDC	23	3 13.04%	10 43.47%	9 39.13%

Average percentages of 55.35% for childcare staff, 25.78% for support staff, and 18.74% for administrative staff were used as benchmarks. These figures serve as reference points against which three ranges are established, delineating what might be considered standard or typical within each staff category. Namely:

- With an average standing at 18.74%, a range between 15% and 25% for administrative staff within an organization can be considered acceptable.
    - "Bureaucratic" institutions are defined as having managerial and administrative staff exceeding 25% suggesting an excessive emphasis on administrative functions, potentially leading to bureaucratic tendencies.
    - "Minimalist" institutions are defined as having managerial and administrative staff below 15% indicating a minimalistic approach to administrative staffing, focusing on essential roles only.

- With an average standing at 55%, a range between 50% and 60% for childcare staff within a childcare institution could be considered optimal in many cases. This range suggests an emphasis on the core functions of providing care, education, and support to children within the institution.
    - "Childcare-intensive" is defined as an institution with educational and childcare staff exceeding 60% which means that it has a strong emphasis on childcare, with an abundance of staff dedicated to children's care and education.
    - "Childcare constrained" structures are defined as those where childcare staff is below 50% indicating a staffing structure that is possibly leading to a lower child to childcare staff ratio.
- With an average standing at 25.78%, a range between 15% and 25% for support staff within an organization can be considered within the norm. This range allows for a flexible allocation of support roles while ensuring the smooth functioning of various operational aspects.
    - An institution with support staff exceeding 25% is defined as a "support-driven": institution. This term describes an institution primarily focused on support services, with a substantial allocation of staff towards supporting operational and custodial needs.
    - An institution with support staff under 15% is defined as "support light".

Looking at the data, while most institutions' staff structure falls within the range, some institutions fall outside the proposed parameters:

Table 97 Characterization of staff structures

	Managers and Admin Staff	Childcare and educational staff	Support staff
Above the range	**Bureaucratic**	**Childcare intensive**	**Support driven**
	▪ Public orphanages	▪ Sheikh Russel Homes ▪ Madrassas	▪ Safe Homes ▪ MoWCA centers ▪ RCCD ▪ SUK/CDC ▪ PHT centers ▪ Private orphanages ▪ NGOs ▪ RCSDG
Below the range	**Minimalist**	**Childcare constrained**	**Support light**
▪ RCCD	▪ Sheikh Russel Homes ▪ MoWCA centers ▪ Private orphanages ▪ RCSDG	▪ Safe Homes ▪ PHT centers ▪ SUK/CDC ▪ RCCD ▪ MoCWA centers ▪ Public orphanages	▪ Public orphanages

While Baby Homes staff fall fully within the range for the three staff categories, the other institutions show deviations from the specified average ranges in terms of their percentages for managerial/administrative staff, childcare and educational staff, and support staff.

- Public Orphanages characterize as bureaucratic, childcare understaffed and support light
- Sheikh Russel homes characterize as minimalist and childcare intensive
- MoWCA centers are minimalist, childcare is understaffed and support driven
- Safe Homes, SUK/CDC, PHT centers and RCCD stand as childcare understaffed and support driven
- RCSDG stand as minimalist, and support driven
- Private orphanages stand as minimalist and support driven
- Madrassas seem to be childcare-intensive
- NGOs are support driven

The variations in staff structures across institutions highlight the different operational priorities and resource allocation strategies within each facility. This prompts further examination to ensure that the staff distribution aligns with the core mission and objectives of each institution while optimizing the care and opportunities provided to the children they serve.

7.6 Children-to-Staff Ratios

Another useful method for analyzing the workforce dynamics within a childcare facility involves an analysis of the children-to-staff ratios. This measure refers to the number of children in relation to the number of staff members. Ensuring an appropriate children-to-staff ratio is crucial for maintaining a safe, nurturing environment and providing quality care and supervision tailored to the developmental needs of the children within the specific setting. Lower ratios generally indicate a higher level of individualized attention and supervision for each child. Higher ratios might suggest less individual attention.

Table 94 below presents the actual ratios of children-to-staff. It represents the current situation within each category of childcare institutions. It reflects the number of children present in the facility and the number of staff members responsible for their care at a given point in time, namely the day of the survey. This actual ratio should be compared to the planned ratio that an institution should have - the recommended or required number of staff members per child. The planned ratio takes into account factors such as the age of the children, their specific needs, and the institution's goals for quality of care. It serves as a benchmark for assessing staffing adequacy.

The ratio of children-to-staff encompasses all staff categories: managers and administrators, childcare staff, and support staff. This data is relevant because childcare institutions should be seen as educational collectives, where every adult plays a valuable role in the lives of the children. Beyond caregivers, administrative and support staff also play unique roles in creating a supportive and nurturing environment. The relationships children form with various staff, like a cook, can be equally, if not more, impactful than those with caregivers. Acknowledging the significance of every staff member underscores the holistic nature of quality childcare provision.

In surveyed institutions, there are 1677 staff caring for 12,890 children which gives an overall ratio of 7.61 children per staff. When looking more in detail, it is clear that there are important variations across institutions, varying approximately from 1:48 to 1:1.

The least favorable ratio is observed in SUKs, with an extremely concerning 48.26 children per staff member.

Apart from SUK, the institutions that display a high ratio of children to staff are MOWCA centres (12.19), private orphanages (10.10) and Sheikh Russel Centres (8.58).

Conversely, this ratio is extremely low in RCSDG (1.07), Baby Homes (2.09), Safe Homes (2.92) and PHT Centers (3.65).

Table 98 Overall children-to-staff ratio

Category of institution	Number of Institutions	Number of Children	Number of Staff	Staff ratio
Baby Home	5	113	54	2.09
Madrassa/religious education school	66	6180	707	8.74
MoWCA Centre	5	585	48	12.19
NGO (national and international)	4	290	56	5.18
PHT Centres	6	405	111	3.65
Private orphanage	11	1172	116	10.10
Public orphanage	17	1300	229	5.68
Rehabilitation Centre for Socially Disabled Girls	4	63	59	1.07
Residential Centre for Children with Disabilities	22	643	122	5.27
Safe Home	6	225	77	2.92
Sheikh Russel Home	8	995	116	8.58
SUK/CDC	3	1110	23	48.26
Total	**157**	**13081**	**1718**	**7.61**

Although every staff member holds unique importance in the lives of children living in the institution, childcare and educational staff nonetheless play a central role. This category encompasses childcare workers (or caregivers), social workers, therapists, counsellors, healthcare professionals, and educational staff, including instructors.

These professionals are in direct daily contact with the children and bear explicit nurturing and educational responsibilities. They supervise and care for the children and provide essential services including case management, specific therapy/ies, counselling, healthcare, and education.

The childcare and educational staff ratio to children provides a more detailed view of the staff-to-child relationship, which is often directly related to the quality of care and education provided to children. The child to childcare and educational staff ratio is especially relevant for institutionalized children because personalized attention and supervision are crucial for their development and well-being.

Table 99 Children-to-specific staff ratio (per staff categories)

Category of institutions	Number of Institution	Number of Children	Children-to-Staff Ratio								
			Manager	Admin	Childcare staff	Educational Staff	Social Worker	Therapists and counsellors	Health Care	Support Staff	Others
Baby Home	5	113	22.60	12.56	4.52	22.60	-	-	113.00	12.56	-
Madrassa/religious education school	66	6180	73.57	167.03	882.86	14.61	-	-	3090.00	40.13	-
MoWCA Centre	5	585	146.25	-	58.50	48.75	585.00	-	-	27.86	-
NGO (national and international)	4	290	26.36	290.00	26.36	20.71	290.00	290.00	290.00	18.13	-
PHT Centres	6	405	57.86	22.50	67.50	11.91	-	-	101.25	9.64	-
Private orphanage	11	1172	117.20	390.67	146.50	21.31	586.00	1172.00	1172.00	33.49	1172.00
Public orphanage	17	1300	81.25	18.31	35.14	23.64	650.00	-	76.47	41.94	-
Rehabilitation Centre for Socially Disabled Girls	4	63	21.00	12.60	3.00	5.25	-	-	31.50	3.94	-
Residential Centre for Children with Disabilities	22	643	64.30	80.38	45.93	18.91	321.50	321.50	160.75	13.40	-
Safe Home	6	225	56.25	45.00	28.13	75.00	28.13	-	45.00	5.11	-
Sheikh Russel Home	8	995	142.14	995.00	36.85	35.54	39.80	248.75	165.83	55.28	-
SUK/CDC	3	1110	1110.00	555.00	1110.00	123.33	-	-	-	123.33	1110.00
Total/ Average	**157**	**13081**	**80.75**	**81.76**	**74.75**	**19.12**	**319.05**	**1635.13**	**304.21**	**29.53**	**6540.50**

As it can be observed in Table 95, in many instances, the ratios fall within the typical range of 10 to 15 children per childcare and educational staff member. However, the suitability of these ratios for childcare institutions hinges on several critical parameters, including the age of the children, their health condition, developmental requirements, potential special needs, and levels of trauma experienced, among others.

Madrassas, private orphanages, NGOs, SRCH and public orphanages display ratios of children to childcare and educational not far from the average ratio. However, there are a few outliers:

- The ratio is notably extremely and incomparably high in SUK, where the situation seems to be out of control, with one staff for 111 children
- MoWCA centres have a very high children to childcare staff ratio (1:25.43), indicating a clear difficulty in ensuring personalized attention to children

This ratio is extremely low in RCSDG (1 staff for every 1.8 girls) and Baby Homes (1 staff for every 3.6 children). This situation seems to indicate an excess of staff members relative to the number of children being cared for. While a low ratio of children to childcare staff can enhance the quality of care and supervision, extremely low ratios might indicate an inefficient distribution of resources or staffing

that doesn't align with standard practices or practical necessities within childcare institutions. This situation highlights the complex balance between providing a high level of care and attention to children (favorable for their well-being) and managing resources efficiently (favorable for economic sustainability) in childcare facilities. These findings emphasize the need for further research to clarify the underlying causes of the observed ratios and whether they align with the goals and circumstances of each facility.

In public institutions under DSS supervision, the data show significant variations in the child-to-childcare and educational staff ratios.

As already indicated, the child-to-staff ratios found in Rehabilitation Centers for Girls (1.8) or Baby Homes (3.6) are extremely low. These particularly low ratios of children-to-childcare staff may be favorable for children but might not be economically efficient. This situation might be due to the low occupancy rate of Baby Homes and the standard number of staff required by regulations for this type of facility. In-depth research is needed to clarify this[34].

Conversely, it appears that SUKs are facing significant understaffing issues in terms of childcare and educational staff.

Our analysis of the staff distribution across the different childcare facilities situation suggests that there is room for significant improvement leading to a more balanced and equitable distribution of staff resources, particularly in public institutions. Developing a strategic plan that outlines the allocation of staff members across these facilities seems to be of paramount importance to achieve equitable, effective and efficient service delivery.

7.7 Staff Demographics

Studying staff profiles in childcare institutions helps understand the backgrounds, qualifications, and experience of staff members, which are important factors for assessing whether the staff can provide appropriate guidance, care, and educational support for children at different developmental stages.

The following paragraphs present the gender, age, years of experience, academic background, special training, type of contract and regimen of the staff who are in charge of the institutions. These findings have been presented in line with the staff categories listed in Annex 3: Staff Categories.

7.7.1 Gender of staff

Analyzing the gender distribution across various roles helps determine if there is a balanced representation or noticeable imbalances. It allows us to identify trends indicating gender predominance or bias within these roles.

[34]Upcoming qualitative research within the community will shed light particularly on norms and perceptions linked to these facilities, if they meet community needs and expectations and community assessment o quality of the services they offer

There is a relative gender balance within two staff categories, namely 57.50% females/42.50% males for administrative staff and 48.53% females/51.47% males for support staff. Therapists and counselors are half males and half females.

The other staff categories indicate a more pronounced gender distribution according to roles. The greatest imbalance is found in educational staff, which are mainly males (81.73%). Managers (80.86%) and support roles (51.47%) are in their majority held by males. Females are predominant as childcare staff (66.86%) in health care (65.12%) and as social workers (60.98%).

Table 100 Overall gender of staff as per staff categories

Staff category		Female	Male	Total
Managers		31 19.14%	131 80.86%	**162** **100%**
Admin		92 57.50%	68 42.50%	**160** **100%**
Childcare staff		117 66.86%	58 33.14%	**175** **100%**
Educational staff		125 18.27%	559 81.73%	**684** **100%**
Social workers		25 60.98%	16 39.02%	**41** **100%**
Therapists and counsellors		4 50%	4 50%	**8** **100%**
Health care		28 65.12%	15 34.88%	**43** **100%**
Support staff		215 48.53%	228 51.47%	**443** **100%**

The study further analyzed the gender distribution in the different categories of institutions.

The gender distribution among managers aids in assessing whether women are sufficiently represented in managerial positions, considering the commonly observed trend of fewer women in higher hierarchical roles across organizations. The findings reveal manager roles are mainly covered by men, as 80.86% of the heads of institution are covered by men. Women managing childcare institutions are found mainly in RCCD, MoWCA centers, PHT centers, Sheikh Russel Homes and RCSDG.

Furthermore, the study observed the gender balance among childcare staff, as this is crucial for gauging an institution's adherence to the co-education principle, promoting a diverse mix of male and female staff. This diversity offers children exposure to varied gender roles, positively impacting their understanding of identity and fostering relationships based on comfort and trust. Notably, a skewed representation of only one gender among staff could be influenced by cultural norms or specific preferences tied to caregiver gender.

There is a clear preference or feminization of the caregiving role, with the majority of caregivers being females - 100% of caregivers in Baby homes, MoWCA centers, NGOs and Safe Homes. Females are also more than half of the caregivers in PHT centers, Sheikh Russel homes, and RCSDG. The smallest proportion of female caregivers is found in madrassas, where there is a great majority of male educational staff, which likely relates to the concept of gender segregation in madrassas for boys (that are a large majority of the sample), and a preference for having teachers of the same gender as the students.

Lastly, analyzing the gender distribution among social workers provides insights into gender trends within the profession, offering a glimpse into any prevailing gender patterns or disparities within this field. By now, social workers appear to be 61% females and 40% males. These percentages, however, refer to a limited number of such roles in childcare institutions (40 staff in total).

Table 101 Gender of staff per selected staff categories

Manager	Number of Institutions	Number of Children	Female	Male	Total
Baby Home	5	113	3 60%	2 40%	**5** **100%**
Madrassa/religious education school	66	6180	4 4.76%	80 95.24%	**84** **100%**
MoWCA Centre	5	585	1 25%	3 75%	**4** **100%**
NGO (national and international)	4	290	4 36.36%	7 63.64%	**11** **100%**
PHT Centres	6	405	2 28.57%	5 71.43%	**7** **100%**
Private orphanage	11	1172	1 10%	9 90%	**10** **100%**
Public orphanage	17	1300	8 50%	8 50%	**16** **100%**
Rehabilitation Centre for Socially Disabled Girls	4	63	1 33.33%	2 66.67%	**3** **100%**
Residential Centre for Children with Disabilities	22	643	2 20%	8 80%	**10** **100%**
Safe Home	6	225	3 75%	1 25%	**4** **100%**
Sheikh Russel Home	8	995	2 28.57%	5 71.43%	**7** **100%**
SUK/CDC	3	1110	 0%	1 100%	**1** **100%**
Total	**157**	**13081**	**31** **19.14%**	**131** **80.86%**	**162** **100%**

Childcare staff	Number of Institution	Number of Children	Female	Male	Total
Baby Home	5	113	25 100%	0	**25** **100%**
Madrassa/religious education school	66	6180	1 14.29%	6 85.71%	**7** **100%**
MoWCA Centre	5	585	10 100%	0	**10** **100%**
NGO (national and international)	4	290	11 100%	0	**11** **100%**
PHT Centres	6	405	5 83.33%	1 16.67%	**6** **100%**
Private orphanage	11	1172	3 37.5%	5 62.5%	**8** **100%**
Public orphanage	17	1300	18 48.65%	19 51.35%	**37** **100%**
Rehabilitation Centre for Socially Disabled Girls	4	63	11 52.38%	10 47.62%	**21** **100%**
Residential Centre for Children with Disabilities	22	643	4 28.57%	10 71.43%	**14** **100%**
Safe Home	6	225	8 100%	0	**8** **100%**
Sheikh Russel Home	8	995	21 77.78%	6 22.22%	**27** **100%**
SUK/CDC	3	1110	 0%	1 100%	**1** **100%**
Total	**157**	**13081**	**117** **66.86%**	**58** **33.14%**	**175** **100%**
Baby Home	5	113	2 40%	3 60%	**5** **100%**
Madrassa/religious education school	66	6180	34 8.04%	389 91.96%	**423** **100%**
MoWCA Centre	5	585	2 16.67%	10 83.33%	**12** **100%**
NGO (national and international)	4	290	7 50%	7 50%	**14** **100%**
PHT Centres	6	405	11 32.35%	23 67.65%	**34** **100%**
Private orphanage	11	1172	13 23.64%	42 76.36%	**55** **100%**
Public orphanage	17	1300	28 50.91%	27 49.09%	**55** **100%**
Rehabilitation Centre for Socially Disabled Girls	4	63	6 50%	6 50%	**12** **100%**

Childcare staff	Number of Institution	Number of Children	Female	Male	Total
Residential Centre for Children with Disabilities	22	643	8 23.53%	26 76.47%	**34** **100%**
Safe Home	6	225	3 100%	 0%	**3** **100%**
Sheikh Russel Home	8	995	8 28.57%	20 71.43%	**28** **100%**
SUK/CDC	3	1110	3 33.33%	6 66.67%	**9** **100%**
Total	**157**	**13081**	**125** **18.27%**	**559** **81.73%**	**684** **100%**
Baby Home	5	113	0	0	**0**
Madrassa/religious education school	66	6180	0	0	**0**
MoWCA Centre	5	585	1 100%	 0%	**1** **100%**
NGO (national and international)	4	290	 0%	1 100%	**1** **100%**
PHT Centres	6	405	0	0	**0**
Private orphanage	11	1172	1 50%	1 50%	**2** **100%**
Public orphanage	17	1300	2 100%	 0%	**2** **100%**
Rehabilitation Centre for Socially Disabled Girls	4	63	0	0	**0**
Residential Centre for Children with Disabilities	22	643	 0%	2 100%	**2** **100%**
Safe Home	6	225	8 100%	 0%	**8** **100%**
Sheikh Russel Home	8	995	13 52%	12 48%	**25** **100%**
SUK/CDC	3	1110	0	0	**0**
Total	**157**	**13081**	**25** **60.98%**	**16** **39.02%**	**41** **100%**
Baby Home	5	113	0	0	**0**
Madrassa/religious education school	66	6180	0	0	**0**
MoWCA Centre	5	585	0	0	**0**
NGO (national and international)	4	290	1 100%	 0%	**1** **100%**
PHT Centres	6	405	0	0	**0**
Private orphanage	11	1172	1 100%	 0%	**1** **100%**
Public orphanage	17	1300	0	0	**0**
Rehabilitation Centre for Socially Disabled Girls	4	63	0	0	**0**

Childcare staff	Number of Institution	Number of Children	Female	Male	Total
Residential Centre for Children with Disabilities	22	643	0%	2 100%	**2** **100%**
Safe Home	6	225	0	0	**0**
Sheikh Russel Home	8	995	2 50%	2 50%	**4** **100%**
SUK/CDC	3	1110	0	0	**0**
Total	**157**	**13081**	**4** **50%**	**4** **50%**	**8** **100%**

7.7.2 Age of staff

Ensuring a balance of ages among staff members can facilitate a diverse range of skills and knowledge. While older staff may possess extensive experience and expertise gained over years of service that enables them to handle complex situations and provide guidance, younger staff with fresh perspectives introduce the latest developments within the profession and can enhance the practices within the institutions.

The majority of managers (57.41%), childcare (63.43%) staff are in the 35 to 54 age brackets, while educational staff are mostly in the 25-44 range

As shown in the below table, SUK staff are in general older, while madrassas have the lowest staff average age.

Table 102 Age of staff

Staff roles	Number of Institution	Number of Children	Number of Staff	Below 18 years	18-24 Years	25-34 Years	35-44 Years	45-54 Years	55-64 Years	65 Years or More	Didn't get any information
Manager	157	13081	162 100%	0	1 0.62%	22 13.58%	39 24.07%	54 33.33%	31 19.14%	13 8.02%	2 1.23%
Childcare staff	157	13081	175 100%	0	4 2.29%	32 18.29%	72 41.14%	39 22.29%	22 12.57%	1 0.57%	5 2.86%
Educational staff	157	13081	684 100%	1 0.15%	54 7.89%	214 31.29%	201 29.39%	138 20.18%	47 6.87%	10 1.46%	19 2.78%
Social worker	157	13081	41 100%	0	0	12 29.27%	20 48.78%	7 17.07%	2 4.88%	0	0
Therapists and counsellors	157	13081	8 100%	0	0	0	6 75.00%	2 25.00%	0	0	0
Health care	157	13081	43 100%	0	0	23 53.49%	5 11.63%	9 20.93%	3 6.98%	3 6.98%	0
Support staff	157	13081	443 100%	1 0.23%	18 4.06%	132 29.80%	132 29.80%	98 22.12%	50 11.29%	6 1.35%	6 1.35%

7.7.3 Years of experience

The majority of managers (24.69%) have above 20 years of experience, while a good portion of them (22.22%) have much less experience, namely between 2-4 years. The third most numerous group of managers are new to the profession. One fourth of childcare staff have between 5 and 9 years of experience, and almost another fourth are old in the profession, with more than 20 years of experience. The great majority of social workers (80.49%) have a maximum of 9 years of experience, while therapists and counsellors are split across the different ranges.

Table 103 Years of experience

Staff category	Number of Institution	Number of Children	Number of Staff	0-1 Years	2-4 Years	5-9 Years	10-14 Years	15-19 Years	20 years or above	Didn't get any information
Manager	157	13081	162 100.00%	29 17.90%	36 22.22%	26 16.05%	17 10.49%	12 7.41%	40 24.69%	2 1.23%
Admin	157	13081	160 100.00%	38 23.75%	57 35.63%	26 16.25%	11 6.88%	10 6.25%	16 10.00%	2 1.25%
Childcare staff	157	13081	175 100.00%	23 13.14%	32 18.29%	45 25.71%	19 10.86%	13 7.43%	41 23.43%	2 1.14%
Educational staff	157	13081	684 100.00%	95 13.89%	167 24.42%	170 24.85%	92 13.45%	60 8.77%	84 12.28%	16 2.34%
Social Worker	157	13081	41 100.00%	3 7.32%	17 41.46%	13 31.71%	6 14.63%	0	2 4.88%	0
Therapists and counsellors	157	13081	8 100.00%	2 25.00%	1 12.50%	0	2 25.00%	1 12.50%	2 25.00%	0
Health care	157	13081	43 100.00%	5 11.63%	9 20.93%	20 46.51%	3 6.98%	2 4.65%	4 9.30%	0
Support staff	157	13081	443 100.00%	66 14.90%	129 29.12%	106 23.93%	60 13.54%	19 4.29%	58 13.09%	5 1.13%

7.7.4 Staff academic background

Educational qualifications are relevant within residential childcare institutions to ensure that staff have the appropriate qualifications to implement their role. In particular, academic background can be more relevant for certain roles that might require specialized knowledge or training. For instance, educators, social workers, psychologists, and therapists working within these institutions might need specific academic backgrounds or certifications to provide specialized care and support to children with diverse needs. Equally, staff involved in managerial and other administrative tasks might benefit from an appropriate educational background.

Conversely, academic qualifications might be less relevant for caregiving roles. In fact, the quality of attention, maintenance of positive relationships, and being good role models might be more related to the interpersonal skills, empathy, and relational abilities of staff rather than their academic background.

As shown in the table below, primary level education is more frequent for support staff (55.76%) and childcare staff (18.29%). For this last category, the majority of staff have a secondary level of instruction (41.71%), a degree in fields other than social science (25.14%), or a degree in social sciences (13.71%).

Most of the staff have a degree other than social sciences, and these are mainly found among educational staff (77.34%), managers (76.54%), therapists and counsellors (75%), health care workers (62.79%), and social workers (65.85%). It is concerning to note that 14.63% of social workers do not have a degree and that two individuals in healthcare positions have primary level education.

Table 104 Academic background of staff

Staff category	Number of Institution	Number of Children	Number of Staff	Uneducated	Primary	Secondary	Degree in Social Science	Degree Other	Above	Didn't get any information
Managers	157	13081	162 100%	1 0.62%	0	15 9.26%	17 10.49%	124 76.54%	4 2.47%	1 0.62%
Admin	157	13081	160 100%	0	14 8.75%	62 38.75%	21 13.13%	63 39.38%	0	0
Childcare staff	157	13081	175 100%	0	32 18.29%	73 41.71%	24 13.71%	44 25.14%	1 0.57%	1 0.57%
Educational staff	157	13081	684 100%	0	2 0.29%	92 13.45%	59 8.63%	529 77.34%	2 0.29%	0
Social Worker	157	13081	41 100%	0	0	6 14.63%	8 19.51%	27 65.85%	0	0
Therapists and counsellors	157	13081	8 100%	0	0	0	0	6 75.00%	2 25.00%	0
Health care	157	13081	43 100%	0	2 4.65%	8 18.60%	0	27 62.79%	6 13.95%	0
Support staff	157	13081	443 100%	1 0.23%	247 55.76%	167 37.70%	5 1.13%	22 4.97%	0	1 0.23%

7.7.5 Staff with special training in childcare

The UN Guidelines place significant emphasis on the importance of ensuring that staff working with children in alternative care settings possess the qualifications and training essential for delivering appropriate high-quality care. The Guidelines advocate for staff members to possess the necessary skills

to understand and address the needs of children in residential care, knowledge of child development, trauma-informed care, culturally sensitive practices, and ethical conduct.[35] For the purposes of this study, training on these topics is called "special training in childcare".

In essence, it is broadly agreed that, regardless of one's specific role and academic qualifications, specialized training in childcare for children facing various forms of disadvantage is an imperative requirement for those working within residential care institutions. This knowledge enables the staff to understand the needs, behaviors, and challenges children may face at different ages, engage effectively in behavior management, conflict resolution, and recognizing and responding to signs of distress or abuse.

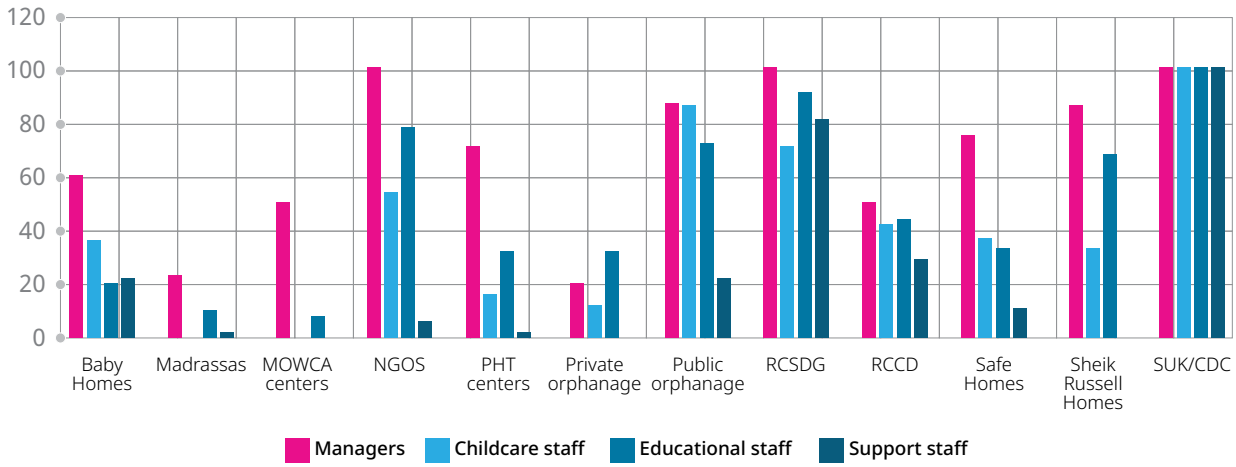
The table and figure below provide numbers and percentages pertaining to the distribution of staff with training in childcare across different categories within the surveyed childcare institutions.

Table 105 Staff with special training in childcare

Staff category	Number of Institutions	Number of Children	Number of Staff	Has special training in childcare	Doesn't have special training in childcare	Didn't Get any information
Managers	157	13081	162 100%	74 45.68%	87 53.70%	1 0.62%
Admin	157	13081	160 100%	54 33.75%	106 66.25%	0
Childcare staff	157	13081	175 100%	83 47.43%	90 51.43%	2 1.14%
Educational staff	157	13081	684 100%	179 26.17%	503 73.54%	1 0.15%
Social worker	157	13081	41 100%	33 80.49%	8 19.51%	0
Therapists and counsellors	157	13081	41 100%	33 80.49%	8 19.51%	0
Health care	157	13081	43 100%	23 53.49%	20 46.51%	0
Support staff	157	13081	443 100%	55 12.42%	387 87.36%	1 0.23%
TOTAL				**534**	**1209**	**5**

[35]UN Guidelines §115. Training should be provided to all carers on the rights of children without parental care and on the specific vulnerability of children, in particularly difficult situations, such as emergency placements or placements outside their area of habitual residence. Cultural, social, gender and religious sensitization should also be assured. States should also provide adequate resources and channels for the recognition of these professionals in order to favour the implementation of these provisions.
§ 116. Training in dealing appropriately with challenging behaviour, including conflict resolution techniques and means to prevent acts of harm or self-harm, should be provided to all care staff employed by agencies and facilities. 117. Agencies and facilities should ensure that, wherever appropriate, carers are prepared to respond to children with special needs, notably those living with HIV/AIDS or other chronic physical or mental illnesses, and children with physical or mental disabilities.

Figure 9: Staff with special training in childcare



SUKs have the highest average percentage of staff with childcare training, with 100% of its staff trained in childcare. However, in numerical terms, this translates to only 21 staff members across three facilities, despite the presence of several hundred children in conflict with the law and facing various serious family and personal issues. SUKs face challenges such as overcrowding, an exceptionally high child-to-staff ratio, and a deficiency in different categories of staff, including social workers, therapists, counsellors, and healthcare professionals. As a consequence, the 100% staff training rate, while notable, does not guarantee quality care.

Conversely, madrassas have the lowest average percentage of staff with childcare training, with only 10% of their staff trained in childcare, with a higher percentage for their managers, of whom 22% have childcare training. This situation can be attributed to a variety of factors, including a strong emphasis on religious studies and educational qualifications for their staff. Additionally, adherence to traditional community cultural practices that may not align with modern childcare concepts could contribute to this low rate of childcare training. It is also essential to acknowledge that the prioritization of childcare training varies significantly from one madrassa to another, and some may indeed value and provide more extensive training in this area.

When assessing the overall scenario across staff categories, other several significant points stand out:

- Social workers, therapists, and counselors, who play pivotal roles in managing children in alternative care, show the highest percentages of trained staff. However, it is concerning that 20% lack this specialized training, given the critical nature of their responsibilities.
- Nearly half of childcare staff and managers lack essential childcare training, indicating a significant gap in their preparedness for their roles.
- Educational staff exhibit a low percentage (26%) in childcare training, which highlights an area for potential improvement.

- Support staff display a notably low percentage (12%) in childcare training, signaling an area requiring attention and development considering their daily and overnight interactions with children.

The figure below summarizes the situation indicating staff categories with high, moderate and low training rates. The breakdown provides insights into the diverse levels of preparedness among various staff categories. Attending to these training differences is important in ensuring that all staff members receive the training required to effectively provide quality care to the children in childcare residential facilities.

Table 106 Staff categories with high, moderate and low training rates in childcare

Categories with Medium-High Training Rates in childcare	Categories with Moderate Training Rates in childcare	Categories with Low Training Rates in childcare
▪ **Social workers.** 78% of staff have childcare training, and they are primarily employed in MOWCA centers, NGOs, and public orphanages. ▪ **Therapists and counselors.** 71% of staff have childcare training, and they are mainly found in NGOs, private orphanages, and SRCH. ▪ **Other professionals** (bench assistant, advocate): 100% of staff in this category have training in childcare.	▪ **Health care workers.** 55% of staff in this category have childcare training. They are primarily found in private orphanages, RCSDG and to a lesser extent in public orphanages, SRCH, Safe Homes, and RCCD ▪ **Caregivers.** Slightly less than half (49%) of the global workforce of caregivers have undergone training in childcare.	▪ **Educational staff:** Only 26% of educational staff have received training in childcare. ▪ **Administrative staff:** 32% of administrative staff have childcare training. ▪ **Support staff.** The lowest percentage, with only 14% having training in childcare.

Despite significant efforts to specialize the staff, the overall average of 30% of childcare institutions' staff with specialized training in childcare indicates the ongoing need for further improvements in qualification levels.

This analysis accentuates the disparities in training rates across various staff categories, emphasizing the requirement for more comprehensive training to enhance the overall quality of care within childcare institutions.

Particularly, there is a clear need to gradually increase the percentage of caregivers and educational staff with specialization in childcare to reach an optimal 100%. The training for these two categories, who are in direct contact with children, can have lasting impacts by enabling them to better understand and address the care and educational needs of disadvantaged and traumatized children.

Lastly, it is crucial to emphasize that while staff skills are essential, delivering quality service involves more than just training. Providing quality care to children requires a holistic approach, encompassing favorable organizational environments, motivational factors, and other global conditions that contribute to the overall quality of service delivery.

7.7.6 Type of contract

The study aimed to understand whether individuals working in childcare institutions are engaged through regular contracts or volunteer work. Our findings revealed that only 44 staff members, a minimal proportion (2.5%) of the total workforce, engage in voluntary work in childcare institutions. Among these volunteers, the majority hold managerial positions in madrassas (15 or 34%) or private orphanages (4), followed by educational staff (9, including 5 in madrassas), 6 in administrative roles (4 in madrassas), 6 in support roles (4 in private orphanages), 2 in childcare (one each in a madrassa and private orphanage), and 2 in healthcare (one in a public orphanage and one in a Safe home). These volunteers are predominantly female, encompassing individuals with varying levels of experience, from novices to seasoned professionals.

While voluntary work can signify community commitment, its prevalence in healthcare roles raises concerns, considering the critical nature of this work.

Table 107 Type of contract per staff category

Manager	Number of Institution	Number of Children	Number of Staff	Paid	Voluntary	Didn't Get any information
Madrassa/religious education school	66	6180	84 100%	69 82.14%	15 17.86%	0
Private orphanage	11	1172	10 100%	6 60.00%	4 40.00%	0
Total	**157**	**13081**	**162 100%**	**142 87.65%**	**19 11.73%**	**1 0.62%**
Admin	**Number of Institution**	**Number of Children**	**Number of Staff**	**Paid**	**Voluntary**	**Didn't Get any information**
Madrassa/religious education school	66	6180	37 100%	33 89.19%	4 10.81%	0
Public orphanage	17	1300	71 100%	69 97.18%	2 2.82%	0
Total	**157**	**13081**	**160 100%**	**154 96.25%**	**6 3.75%**	**0**
Childcare staff	**Number of Institution**	**Number of Children**	**Number of Staff**	**Paid**	**Voluntary**	**Didn't Get any information**
Madrassa/religious education school	66	6180	7 100%	6 85.71%	1 14.29%	0

Private orphanage	11	1172	8 100%	7 87.50%	1 12.50%	0
Total	**157**	**13081**	**175 100%**	**173 98.86%**	**2 1.14%**	**0**
Educational staff	**Number of Institution**	**Number of Children**	**Number of Staff**	**Paid**	**Voluntary**	**Didn't Get any information**
Madrassa/religious education school	66	6180	423 100%	418 98.82%	5 1.18%	0
Private orphanage	11	1172	55 100%	53 96.36%	2 3.64%	0
Public orphanage	17	1300	55 100%	54 98.18%	1 1.82%	0
Safe Home	6	225	3 100%	2 66.67%	1 33.33%	0
Total	**157**	**13081**	**684 100%**	**675 98.68%**	**9 1.32%**	**0**
Social Worker	**Number of Institution**	**Number of Children**	**Number of Staff**	**Paid**	**Voluntary**	**Didn't Get any information**
Total	**157**	**13081**	**41 100%**	**41 100%**	**0**	**0**
Therapists and counsellors	**Number of Institution**	**Number of Children**	**Number of Staff**	**Paid**	**Voluntary**	**Didn't Get any information**
Total	**157**	**13081**	**8 100%**	**8 100%**	**0**	**0**
Health Care	**Number of Institution**	**Number of Children**	**Number of Staff**	**Paid**	**Voluntary**	**Didn't Get any information**
Public orphanage	17	1300	17 100%	16 94.12%	1 5.88%	0
Safe Home	6	225	5 100%	4 80.00%	1 20.00%	0
Total	**157**	**13081**	**43 100%**	**41 95.35%**	**2 4.65%**	**0**
Support Staff	**Number of Institution**	**Number of Children**	**Number of Staff**	**Paid**	**Voluntary**	**Didn't Get any information**
Madrassa/religious education school	66	6180	154 100%	152 98.70%	2 1.30%	0
Private orphanage	11	1172	35 100%	31 88.57%	4 11.43%	0
Total	**157**	**13081**	**443 100%**	**437 98.65%**	**6 1.35%**	**0**

7.7.7 Staff regimen

Four types of work regimens exist within the institutions, residential, full-time, part time and visiting:

- **Residential:** These staff members reside in the facilities for extended periods.
  - The majority of staff working in childcare institution work on a residential basis (47%) or full-time (45%)
  - The main category of residential staff is support staff (55%). Educational (52%), childcare (49%) health care (37%), managers (37%) and admin (32%). It is not clear where and why admin staff reside in the institutions.
- **Full-time:** These staff work full-time but do not reside on-site.
  - Full-time is the second most important regime for childcare staff, including 45% of the workforce.
  - 40 out of 41 social workers and more than half of therapists and counsellors, admin ad managers work full-time.
- **Part-time:** These individuals work half-periods, whether in the morning, afternoon, or evening-night.
  - This category comprises 16% of health care staff and 7% of support staff, 6% of education staff and 6% of managers.
- **Visiting:** This refers to professionals who periodically visit the facility to carry out their tasks.
  - There are 14 staff members working on a visiting basis, predominantly health care staff and managers.

Table 108 Staff regimen per category

Staff category	Number of Staff	Full Time	Part Time	Residential	Visiting	Didn't Get any information
Manager	162 100%	85 52.47%	9 5.56%	60 37.04%	6 3.70%	2 1.23%
Admin	160 100%	98 61.25%	3 1.88%	52 32.50%	1 0.63%	6 3.75%
Childcare staff	175 100%	83 47.43%	4 2.29%	86 49.14%	0	2 1.14%
Educational staff	684 100%	287 41.96%	39 5.70%	354 51.75%	2 0.29%	2 0.29%
Social Worker	41 100%	40 97.56%	0	0	1 2.44%	0
Therapists and counsellors	8 100%	7 87.50%	0	1 12.50%	0	0

Staff category	Number of Staff	Full Time	Part Time	Residential	Visiting	Didn't Get any information
Health care staff	43 100%	13 30.23%	7 16.28%	16 37.21%	4 9.30%	3 6.98%
Support staff	443 100%	167 37.70%	31 7.00%	244 55.08%	0	1 0.23%
TOTAL	**1716**	**780**	**93**	**813**	**14**	**16**

This comprehensive analysis of staff profiles encompassed an examination of demographic data, qualifications, training, experience, and work conditions. It aims to provide decision-makers with useful information to make informed choices. By leveraging this information, decision-makers can better optimize staff distribution, enhance their performance, and ultimately elevate the quality of care delivered to children. This concerted effort supports the ongoing endeavor to ensure the best possible outcomes for the children in residential institutions.

7.8 Police Clearance

The final aspect in this quantitative assessment of childcare institutions revolves around a key requirement advocated within a comprehensive child safeguarding policy: the mandatory procurement of a police clearance prior to the recruitment of staff working with children. This crucial step is indispensable as it validates that the individual seeking employment in a childcare facility possesses no criminal record or history that could potentially endanger the well-being and safety of the children in care. This stringent measure ensures a protective environment, upholding the paramount importance of safeguarding children within these institutions.

The data from respondents indicates that 44.59% of institutions implement the requirement for a police clearance during staff recruitment, maintaining a consistent application within Baby Homes, PHT centers, public orphanages and SUKs. However, significant variability exists among other categories of institutions. The institutions displaying the lowest adherence to this requirement are madrassas and private orphanages. Divergent practices, as observed in other centers such as RCSDGs, indicate a potential disparity in the adoption of police clearance protocols during the hiring process within these specific types of institutions.

Table 109 Institutions that require police clearance of staff prior to staff recruitment

Category of institutions	Whether institution require police clearance prior to staff recruitment?		
	Yes (n %)	No (n %)	Total (N)
Total (n %)	**70 44.59%**	**87 55.41%**	**157**
Baby Home	5 100%	0	**5**

Category of institutions	Whether institution require police clearance prior to staff recruitment?		
	Yes (n %)	No (n %)	Total (N)
Madrassa/religious education school	3 4.55%	63 95.45%	**66**
MoWCA Centre	4 80.00%	1 20.00%	**5**
NGO (national and international)	0	4 100%	**4**
PHT Centres	6 100%	0	**6**
Private orphanage	1 9.09%	10 90.91%	**11**
Public orphanage	17 100%	0	**17**
Residential Centre for Children with Disabilities	19 86.36%	3 13.64%	**22**
Rehabilitation Centre for Socially Disabled Girls	2 50.00%	2 50.00%	**4**
Safe Home	5 83.33%	1 16.67%	**6**
Sheikh Russel Home	5 62.50%	3 37.50%	**8**
SUK/CDC	3 100%	0	**3**

08

Findings:

Safeguarding, Oversight, and Adherence to Standards

This section explores how well residential childcare institutions uphold essential safeguarding practices and comply with national care standards. It reviews the presence of staff vetting procedures, written child safeguarding policies, and mechanisms for child participation. It also assesses whether institutions maintain documented rules and protocols aligned with national guidelines. These safeguards are critical to ensuring children's safety, well-being, and right to be heard. The findings point to significant gaps in adherence—particularly among non-state institutions—underscoring the need for stronger oversight, regulatory enforcement, and consistent implementation of care standards across all facility types.

8.1 Child Participation

Child participation is a fundamental right, enshrined in the **UN Convention on the Rights of the Child (UNCRC)**, particularly Article 12, which **affirms children's right to express their views freely in all matters affecting them and to have those views given due weight in accordance with their age and maturity.** Participation is not only a right but also a key element in fostering children's development as active citizens.

The UN Guidelines for the Alternative Care of Children reinforce this principle, integrating participation throughout key provisions (e.g., paragraphs 40, 57, 65, 67)[36]. In the context of alternative care, children should be consulted prior to placement, throughout their stay in care, and before any transitions or discharge. Bangladesh's national framework also emphasizes this right. The Children Act 2013 calls for children to express their views and participate in judicial proceedings (Sections 22 and 30)[37]. The National Children Policy 2011 underscores the importance of involving children in programmes, particularly those with disabilities and neurodevelopmental conditions (Sections 6.13, 6.8.2, 6.9.1).[38] The DSS Guidelines for the Management of State Children's Homes identify "listening to the child's views and active participation" as a core principle of state-run care (p.9).[39]

Findings: The study explored how participation is practiced within childcare institutions through real-life examples provided by respondents. Most institutions reported some form of child participation, although 12 institutions (7 public, 5 private) provided no examples at all.

The most frequently cited form of participation (63 institutions – 34 public, 29 private) involved children helping plan and organize activities, particularly sports, competitions, national celebrations (e.g., Independence Day, Eid), and cultural events. Children often choose which events they participate in, and some even initiate requests for sports areas or equipment (e.g., BAR10, KHU22). In certain facilities,

[36]United Nations General Assembly. (2010). Guidelines for the Alternative Care of Children (A/RES/64/142). https://digitallibrary.un.org/record/673583

[37]Government of Bangladesh. (2013). Children Act, 2013 (Act No. XXIV of 2013). Ministry of Law, Justice and Parliamentary Affairs

[38]Government of Bangladesh. (2011). National Children Policy 2011. Ministry of Women and Children Affairs.

[39]Department of Social Services (DSS). (2015). Guidelines for the Management of State Children's Homes. Ministry of Social Welfare, Government of Bangladesh.

children also contribute to decorating shared spaces during festivals or special occasions and, less commonly, take part in shaping daily routines.

Another widely reported domain of participation was related to food and clothing choices. In 62 institutions (31 public, 31 private), respondents shared that children are involved in selecting meals—either proactively or by voicing complaints that lead to menu changes. Children also participate in choosing clothing, particularly for special occasions. One respondent noted a shift toward greater inclusiveness: *"Previously, opinions were not taken and a specific uniform was provided. Now, if someone wants a Punjabi, they get a Punjabi; if they want a jama, they get a jama; if they want a ganji, they get a ganji. Now, the boys' opinions are taken into account in all areas" (KHU05).*

Participation in daily chores was also cited by 31 institutions (11 public, 20 private), including tasks like room cleaning, meal preparation, shopping, gardening, sweeping, and occasionally fundraising. While participation in chores can promote responsibility and belonging, the extent to which this replaces formal staff roles (e.g., cooks or cleaners) remains unclear. In some institutions, older children also help care for younger residents.

A smaller number of respondents (14 total—7 public, 7 private) reported involving children in decisions around education and training. Children were encouraged to express preferences for subjects or training areas, and some institutions supported them in planning future academic or vocational pathways: *"We try to ensure child participation by hearing where the children want to study, their future plan" (RAJ14). "Children can make their own education decisions. They can decide on what subject they will build their future" (CTG34).*

More structured, regular opportunities for participation—such as scheduled group meetings—were mentioned by a minority. Some institutions reported monthly or weekly feedback sessions where children could voice opinions or concerns:

"We usually hold a weekly meeting with the residents where we ask them to update us on their activities and encourage their participation in the discussions" (DHA13). "Meetings are held on the last Friday of every month with resident sons and daughters. Their advantages and disadvantages are known from the children's mouth there" (SYL18).

For children with disabilities, participation remains more limited. Barriers include staff capacity, communication needs, and assumptions about children's ability to contribute. Some institutions reported excluding children from decision-making due to perceived limitations:

"As institutionalized children are deaf and dumb, they cannot participate in most important decisions or activities, or it can be said their opinion is not sought" (SYL09). "Authorities make decisions on behalf of children because they have mental or multiple disabilities" (CTG33). However, one institution working with visually impaired children emphasized the positive impact of participation on wellbeing and confidence (RAJ09).

In 13 institutions (7 public, 6 private), respondents said child participation was not practiced due to age, behavioural concerns, overcrowding, or institutional policy. Comments included:

"Children don't understand anything" (CTG27, BAR15, SYL04, RAJ06). "Asking their opinion creates a problem" (SYL07). "The decisions of the institutions regarding students' food, education and accommodation are final. No input from students is taken" (KHU04).

Overall, most institutions appear to support participation in routine aspects of daily life such as food, events, chores, and clothing. However, more structured or meaningful opportunities—especially those related to care planning, education, and future decision-making—are much less common.

Notably, two key aspects of child participation were entirely absent from respondents' examples:

- **Participation in placement or discharge decisions**: No institutions reported involving children in decisions about entering or leaving care
- **Family and guardian participation**: There were no references to involving family members in a child's life within the institution, suggesting a gap in holistic, family-centered care

Child participation is essential for children's wellbeing and for the development of rights-based, child-centred care systems. While many institutions demonstrate efforts to involve children in everyday activities, deeper and more structured participation—especially in decisions that shape children's lives—is still lacking. Developing and institutionalizing national guidelines for child participation in residential care could help ensure regular, meaningful engagement of children in all aspects of their care, including their placement and eventual reintegration. Such practices would not only affirm children's rights but also contribute to improved care outcomes and more responsive service delivery.

8.2 Child Safeguarding Policy and Code of Conduct

The protection of children from abuse, neglect, and exploitation is a core obligation under the UN Convention on the Rights of the Child (CRC). Article 19 specifically requires States to take all appropriate measures to safeguard children from "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse."[40] The UN Guidelines for the Alternative Care of Children further affirm that children in care must be protected from abuse, stating that "States must ensure… that accommodation provided to children in alternative care, and their supervision in such placements, enable them to be effectively protected against abuse."

Child safeguarding refers to the policies, procedures, and practices that ensure children's safety and well-being in any organizational setting. These measures are designed not only to respond to incidents of harm but also to proactively prevent them from occurring. International best practice emphasizes that any organization working with or for children must have a comprehensive Child Safeguarding Policy that is fully implemented in both routine and emergency operations.[41]

[40]United Nations General Assembly. (1989). Convention on the Rights of the Child (CRC), Article 19

[41]Keeping Children Safe. (2014). Child Safeguarding Standards and How to Implement Them. https://www.keepingchildrensafe.global/

A robust Child Safeguarding Policy typically includes three essential components:

- A written safeguarding policy document, which includes a clear Code of Conduct for staff
- Mandatory training for staff on the policy and procedures, along with formal commitment to the Code of Conduct
- A child-friendly reporting mechanism through which children can safely raise concerns, and raise awareness among children about how to use it

Together, these elements ensure that the institutional environment is safe, accountable, and responsive to the protection needs of children in care.

The prevalence of written child safeguarding policy and staff code of conduct in institutions

A written Child Safeguarding Policy is a critical tool for protecting children from harm within institutional settings. Such a policy outlines explicit rules, standards, and procedures designed to prevent and respond to abuse, neglect, and exploitation. A core component of any safeguarding policy is a **Staff Code of Conduct**, which establishes expected behaviours and boundaries for those working directly with children.

According to the **Guidelines for the Management of State Children's Homes** (GMO), all public orphanages are required to establish a **Grievance Redressal Committee**, chaired by the Assistant Director of the District Social Services Office. This committee is tasked with conducting monthly discussions with children about the Code of Conduct and grievance procedures.[1] However, the current GMO document does not include the Staff Code of Conduct or the grievance procedure itself—highlighting a major gap between policy mandates and operational clarity.

Findings: Respondents were asked whether their institution had a written Child Safeguarding Policy or Staff Code of Conduct. The majority—**122 out of 156 institutions (78%)**—reported **not having** a written document. Among the **37 institutions** that claimed to have such documentation, **14** noted that it was **not physically available at the facility**.

There are considerable discrepancies across different types of institutions. The lack of standardization suggests that there is **no universally applied safeguarding policy** across residential care institutions, or that **awareness and implementation remain inconsistent**. This gap poses significant risks to children's safety and well-being, especially in settings where oversight is limited.

When asked whether staff were trained on safeguarding policies or codes of conduct, **70% of institutions reported that no such training is provided**. Public sector institutions fared slightly better: nearly **half of the public facilities** reported offering some form of staff training. In the private sector, **four madrassas and all international NGOs** reported that they train staff on safeguarding.

Some institutions—like RAJ19, a madrassa receiving state support—reported implementing informal safeguarding expectations:

"Employees are told before hiring that they will be fired immediately if they are found to be involved in child abuse." (RAJ19)

Similar statements were echoed in other madrassas (e.g., CTG39). However, in these cases, there was **no accompanying documentation or written safeguarding policy**, making it difficult to assess the consistency or quality of the training and enforcement mechanisms.

These findings point to the **urgent need** for:

- Development and dissemination of a **standardized written Child Safeguarding Policy** for all institutions;
- Inclusion of a clearly articulated **Staff Code of Conduct**;
- **Mandatory and regular staff training** on safeguarding principles and response mechanisms.

Such measures are essential for ensuring a consistent, protective environment for all children in residential care, regardless of the type of institution or its management structure.

8.3 Complaint Mechanism for Children

An essential component of any child safeguarding policy is the establishment of accessible, confidential, and child-friendly complaint mechanisms. The **UN Guidelines for the Alternative Care of Children** emphasize the need for such mechanisms within alternative care settings to ensure that children can raise concerns about their treatment or living conditions without fear of retaliation or harm (para. 99). These systems are particularly critical in institutional care environments, where children face heightened power imbalances and potential attitudinal barriers to self-expression.

To be effective, complaint procedures must allow children to report concerns **safely and without fear of retaliation**. Effective complaint systems should include clear procedures for submitting complaints, explain the process in child-appropriate language, and ensure that children are informed about how their concerns will be handled. **Children should be encouraged to express their grievances freely and be updated on the progress and resolution of their complaints.**

In Bangladesh, the **Guidelines for the Management of State Children's Homes** (GMO) mandate that public orphanages establish **Grievance Redressal Committees**, which are expected to meet monthly with children, discuss the Code of Conduct, and support children in raising concerns.[42] However, the procedures and protocols for complaint handling are not explicitly outlined in the GMO itself, leaving implementation inconsistent and often unclear.

[42]Department of Social Services (DSS). (2015). Guidelines for the Management of State Children's Homes. Ministry of Social Welfare, Government of Bangladesh.

Findings: Respondents were asked whether their institution had a written complaint mechanism, whether children are informed of how to file complaints, and to provide examples of complaints received and how they were addressed.

- Out of 158 respondents, **142 (90%) reported that their institution does not have a written complaint procedure**. Of the **16 who claimed to have one**, **six stated the document was not available** at the facility.
- Nevertheless, **almost all institutions (except nine: four public and five private)** indicated that **children are verbally informed** upon entry about whom they should approach if they have a complaint. These points of contact range from caregivers and teachers to the head of the institution. In some cases, children are advised to tell their parents, who would then escalate the concern.
- **Notably, none of the respondents from public orphanages mentioned the Grievance Redressal Committee**, despite its prescribed role in supporting complaints.

A few institutions reported having **physical complaint boxes** (e.g., RAJ15, SYL10, RAJ14, DHA18—all INGOs), although their management and follow-up processes were unclear. In one Safe Home (BAR06), children are instructed to report directly to the Social Welfare Officer. In contrast, **DHA15**, also a Safe Home, **does not inform children of any complaint mechanism**.

A more positive example came from **RANG16**, where children are routinely encouraged to voice concerns:

"There is a meeting every evening where they are given the opportunity to share any issues or concerns they may have and resolve them."

Types of complaints reported

When asked to give examples of child complaints, the most frequently mentioned issues involved interpersonal conflict, infrastructure, or basic services. The table below summarizes the types of complaints received across institutions:

Table 110

	Public institutions	Private institutions	TOTAL
Complaints by children about other children's behaviour	30	40	70
Complaints by children about the quality of food	14	9	23
Complaints by children about adult's behaviour	8	7	15
Children don't have complaints	11	3	14
No example has been given	5	1	6
Complaints about infrastructure and equipment	1	3	4
Total	**69**	**63**	**131**

- Following the **Most frequent complaints** involved **peer conflict**, including quarrels, bullying, physical aggression, and theft of personal items. In one public institution, a case of **sexual assault by older boys against younger residents** was reported.
- **Food-related complaints** (monotony, poor quality) and **infrastructure issues** (e.g., broken fans, taps, lack of hygiene supplies) were also cited, especially in public facilities.
- In **15 of 131 cases**, children reportedly raised complaints about **adults' behaviour**, including **staff misconduct**.

Response to complaints

Institutions reported a range of responses to complaints:

- **Peer conflicts** are generally managed through counselling; in more serious cases, parents are contacted or disciplinary measures (including dismissal) are taken.
- **Staff misconduct**—such as physical abuse or neglect of duties—may lead to **transfer or dismissal** of the staff member.
- **Complaints about food or equipment** reportedly result in efforts to improve menus or repair facilities, though resource constraints may limit responsiveness.

While most institutions report that children are verbally informed of whom to approach with complaints, the **absence of formal written procedures**, lack of child-friendly reporting mechanisms, and **inconsistent follow-up** are significant gaps. Furthermore, few institutions offered concrete examples of structured feedback systems or independent complaint channels. Notably, the mandated **Grievance Redressal Committees in public orphanages appear largely non-functional** in practice.

To ensure meaningful child protection, institutions must:

- Establish **clear written complaint procedures** accessible to children of different ages and abilities.
- Provide **confidential and safe channels** for children to report concerns.
- Ensure that **children are informed, empowered, and supported** throughout the complaint process.
- Monitor and evaluate the effectiveness of these mechanisms to **promote a culture of accountability and care**.

8.4 Child Abuse

Child abuse in residential care settings—whether physical, emotional, sexual, or through neglect—constitutes a serious violation of children's rights and safety. While child protection frameworks, such as the **UNCRC** (Article 19) and the **UN Guidelines for the Alternative Care of Children**, require that children be protected from all forms of abuse and maltreatment, the actual detection, reporting, and management of abuse within institutional settings remain complex and often underreported due to stigma, fear of repercussions, and social norms.

Findings: Respondents were asked to provide examples of any incidents involving abuse by adults toward children in their institution and how these incidents were managed.

- **The overwhelming majority of respondents stated that no such incidents had occurred** in their institutions. Only **11 respondents**—from **seven public and four private institutions**—shared examples of adult-perpetrated abuse.

This is notably lower than the **15 cases reported in Section 8.4** where children reportedly lodged complaints about adult behavior, suggesting possible **variations in how 'abuse' is perceived** by staff. What may be seen by a child as harmful or inappropriate may not be interpreted as abuse by the institution.

Public Institutions: Among the seven examples reported by public institutions:

- One case (CTG33) involved a **suspected sexual abuse** resulting in a **girl's pregnancy**. The child gave birth and the baby was adopted, but no further detail was provided regarding investigation or accountability
- The remaining cases involved **staff shouting at or physically disciplining children**, generally through slapping or beating. These were often downplayed or normalized

A respondent from a **Baby Home in Khulna (KHU08)** acknowledged the **prevalence of abuse in residential care**, stating:

"It is inevitable for abuse issues to arise where children are present."

Others highlighted the **structural challenges** in preventing or responding to abuse. For instance, inadequate staffing levels were mentioned as a barrier to timely and appropriate action when staff misconduct occurred.

A respondent from Sylhet (SYL09) described a lack of institutional accountability and enforcement:

"Staff staying in hostels sometimes misbehave with children. In this regard, the authorities did not give any clear answer whether they have taken any affirmative action... Little attention is paid to their care. Hence, when any maltreatment of children occurs, there is little interest on the part of the authorities in taking proper investigation and taking further action."

Private Institutions: In four private institutions, **staff were reported to have physically abused children**:

- **Three staff members were dismissed**, and one received a **verbal warning**
- In Barishal division, there were also reports of a **cook asking a child to complete their duties**, and another **scolding a child**—both examples of misuse of power

Some informants **normalized harsh disciplinary practices**, especially in madrassa or Hefz Khana settings. One such example from **RANG05** noted:

"Flogging by stick is still commonly practiced in the Hefz Khana. Flogging by stick or intimidation for the purpose of learning is normalized and no one sees it as abuse."

This illustrates how **cultural acceptance of corporal punishment** can blur the lines between discipline and abuse, and hinder protective responses.

Interpretation and Limitations: This section revealed a striking discrepancy between:

- The number of actual abuse cases reported, and
- The expectation that **abuse—particularly physical and psychological—would be more prevalent**, given the inherent vulnerabilities of institutional care environments

This discrepancy may stem from:

- **Social desirability bias**: Respondents might have withheld information to avoid institutional scrutiny
- **Differing thresholds** for what qualifies as "abuse" versus "discipline" or "misbehavior"
- **Fear of consequences** or a belief that certain forms of mistreatment are acceptable or necessary

Prior global research has documented that **closed institutional settings**—including **prisons, hospitals, and childcare facilities**—are **inherently prone to abuse** due to power imbalances, lack of oversight, and isolation from external scrutiny.

Thus, while only a few examples were provided, it would be reasonable to assume that many more incidents may go **undisclosed or undocumented.**

An example of desirability bias on reporting child abuse in institutions

One enumerator reported the following observation. *«The informant claimed that there was never an incident of abuse by the staff and had not heard of it happening before. However, while waiting in the office room to receive the information, the sound of screaming and crying was heard from the children's bathroom next to the office room. At that point, a male worker angrily entered the room and came out with a cane and then the child's screams from the bathroom got louder and the worker was also heard screaming. Then the informant said to the worker before leaving the room "Why the beating again?" After some more conversation between them, the informant returned to the room. It was understood that the child did not want to bathe on time which is why he was treated like this. But he was not willing to talk about it » CTG 19*

The findings reveal critical gaps in **recognition, prevention, and response** to child abuse in residential institutions. Abuse is likely **underreported**, and the **normalization of corporal punishment** further obscures accountability.

To strengthen child protection, the following actions are recommended:

- **Strengthen enforcement of national laws and policies** banning corporal punishment and ensuring accountability for abuse
- **Standardize staff training** on identifying and reporting abuse, distinguishing between discipline and maltreatment
- **Strengthen independent monitoring mechanisms** to regularly assess safety and wellbeing in residential care settings
- **Foster a culture of zero tolerance** toward abuse—ensuring that all staff recognize the rights of children to dignity, safety, and care free from fear or harm

8.5 Child Discipline and Behaviour Management

In a collective environment, it is crucial to have clear behaviour rules not only for adults but also for children. Clear rules of behaviour for children serve as a vital framework for their safety, socialization and education. These rules help create a positive environment for children where they are encouraged to be responsible for their behaviour and are knowledgeable about the possible consequences of rules breaking. Clear behaviour rules for children are an essential part of a positive discipline approach. They provide a framework and guidance for both adults and children while fostering positive relationships between adults and children.

The Guidelines for the Management of State Orphanages provide among others, "instructions to residents" in public orphanages (page 41) where in 19 points the expected behaviour is declined, ranging

from gentle advise "do not bite nails with the teeth" to more stringent rules like "not going out after evening". There is no mention of any type of sanctions.

Findings: Respondents were asked if they have written child behaviour rules, whether children are informed about them, if staff is trained to deal with challenging behaviour and to provide an example of a situation in which a child broke the rules of the institution and to explain how that case was managed.

The great majority of respondents (114 responses out of 158, namely 72%) indicated that the institutions do not have written behaviour rules for children. Those who said that they have such a document, in half of cases the document was not available at the facility.

Respondents also reported that, in the majority of instances, staff members are not trained to address challenging behaviour. Given the prevalence of challenging behaviour in residential institutions, providing staff with training in positive discipline techniques could be very useful as, as reported by one respondent, *"Basically, there are so many kids, and every day there is some sort of fight."*

Respondents were asked to provide examples of situations in which a child broke the rules and how it was managed.

"File Case. The guardians are informed. Long term vacation. If repeat the incident again, the child will be fired". (CTG 36, Rehab. Centre). *"If any of the residents break any rule, they are given a warning. In case of severe misconduct, we invite their guardians and may cancel their admission"* (DHA21). Some rules are mentioned more frequently than others to provide an example of children's misconduct. These are *"it is prohibited to go out without permission" or "it is prohibited to use cell phones".*

Running away from the institution to go home is the most cited example of child misconduct (17 in public and 39 in private). In less cases, children go out of the institutions to roam about. Most of the examples from madrassas are about children leaving the institution without permission to go home:

"There are many cases of children running away from the madrassa and going home. A few days ago, a child studying in class 5 ran away. Later his mother brought him back. As the mother is unable to support the orphaned child, he is put back in the hostel and strictly told not to do this again" (CTG24)

The second most frequent answer is that children do not break the rules and that they don't have an example (12 in public and 8 in private institutions).

Another behavioural problem is violence amongst children and children stealing other children's belongings or food: *"Institutions house many children in small spaces and are comparatively understaffed. So, it is not possible to give attention to all the children at once. Chaos, fights violation of rules happens constantly" (CTG 19).*

In public institutions, respondents mentioned attempted suicide and self-harm as a problematic behaviour by girls (4 cases, CTG34, SYL5 both Sheikh Russel Homes, BAR4 socially disabled). In one

public orphanage, the example was given of a sexual assault by two boys aged twelve and thirteen on a ten-year boy. (KHU5)

The most common ways of managing these types of problems are:

- Children are called by supervisor and counselled. In cases considered as serious, parents or guardian are called and usually they are threatened that the child will be expelled from the institution.
- Physical punishment is not mentioned in public institutions *"it is prohibited by the government to punish or harm the children", "we certainly do not punish physically",* while in private institutions, respondents referred to physical punishment such us ear catching for children who break the rules.
- Other punishment in private institutions include sweeping the floor, extra study hours, food deprivation;
- Children are sometimes sent back home, in particular when they show no positive change in their behaviour.
- In some cases, children are scolded and threatened of discharge or even worse *"They are also told that if they do not follow rule they would be sent to Doudkandi Technical Centre" (CTG 36)*
- In private institutions, frequent ways of dealing with rules breaking is counselling, ear catching, sitting, extra study, memorization, cleaning, call parents, discharge from institution - canes and sticks were seen on the desks of the respondents.

> *One of the rules of the institution is to perform the five daily prayers with the congregation. Once, a child was unable to wake up from sleep to perform the prayer, which resulted in a major violation of the institution's rules. Usually, children do not violate this rule. Due to the rule violation, the child was beaten and made to stand with ears held for 100 times. (KHU14)*

This analysis showed a multitude of practice related to the different aspects of child safeguarding in an institutional setting. There is a clear need for child protection authorities to prioritize the development and implementation of comprehensive Child Safeguarding Policies to be implemented in residential settings. Standardization across all types of child care institutions seems essential to ensure the safety and well-being of all children in institutional care.

8.6 Quality of Care

The concept of "quality of care" in residential childcare is multi-faceted, as outlined in the CRC and in the Guidelines. Quality of care can be assessed based on several key aspects:

- General principles of childcare. Ensuring the best interests of the child, non-discrimination, child participation, and respecting the child's opinion form the foundational principles of quality care.
- Principles related to alternative care encompass the necessity and suitability of providing such care, maintaining family ties for the child, ensuring culturally appropriate care, and fostering positive relationships between caregivers, children, and their families.
- Efficiency of the child protection system. Managing the relationship between alternative care service providers and child protection authorities is crucial to ensure that the care provided aligns with legal and regulatory standards.
- Living conditions. Adequate infrastructure, favourable working conditions for staff, and proper training and supervision are also essential components of quality care.

Informants were asked to report initiatives taken during the last two years or so to improve the quality of care in their respective institutions. In analysing improvements made in private institutions over the previous two years, approximately, it was noted that respondents primarily focused on aspects related to living conditions. The other components received less attention in terms of reported improvement initiatives.

8.7 Public Institutions

The analysis of initiatives and actions taken in the last two years in view of enhancing the quality of care in public institutions indicated several key areas of focus:

- Quality of food and water (30 responses): a significant number of institutions prioritized improving the quality of food and water provided to the children.
- Diversification of activities (19 responses): many institutions focused on diversifying activities for the children, including cultural, sports, recreational, and special events.
- Infrastructure enhancements (14 responses): investments in infrastructure improvements, such as renovations, painting, constructing new buildings, and maintaining gardens, were also mentioned.
- Additional learning opportunities (8 responses): some institutions introduced new regular activities, such as vocational training, computing, and sewing, to provide valuable skills and opportunities for personal development to the children.
- Areas of quality improvement less frequently mentioned include:
  - Hygiene and health care provision (6)
  - Increasing the number of staff (6 responses)
  - Staff training (4 responses)

- Procuring new equipment such as computers, beds, books, (4 responses)
- Enhancing the provision of formal education (4 responses)
- Making improvements in the daily routine (3 responses)
- Developing exit strategies for children leaving the institutions (1 response)
- Introducing provision of counselling (1 response)

It is important to note that not all institutions reported positive changes. Eight respondents expressed concerns about the lack of initiatives, stagnant or declining quality, and worrying issues related to funding and staff. Quality has worsened in this Baby Home according to the respondent: *"the environment here is unhealthy for children. At the same time, the presence of small, large, disabled (physical and mental) children, the development of normal children is also being disturbed".*

It's worth mentioning that in all these eight cases where a decline in quality was reported, the respondent was not the institution's manager and there may have been gaps in communication or understanding of the institution's efforts.

8.8 Private Institutions

Respondents from private institutions shared several initiatives undertaken over the past two years to improve the quality of care. These efforts can be grouped into the following areas:ccording to respondents from private institutions, initiatives taken over the two previous years to improve the quality, were the following:

- **Infrastructure Development (44 responses):** Many institutions have prioritized infrastructure upgrades to expand capacity and improve living conditions. Reported improvements include constructing new buildings or adding floors, tiling floors, upgrading sanitation facilities, installing deep tube wells for clean water, expanding kitchen spaces, introducing or improving bathing areas and ponds, and increasing the number of toilets.
- **Food, Water, and Clothing (42 responses):** Ensuring the quality and quantity of food and drinking water was cited as a top concern. In addition, 11 respondents noted efforts to improve clothing quality for the children.
- **Provision of Essential Equipment (23 responses):** Investments have been made in bedding and related supplies—mats, mattresses, blankets, and sheets—to improve sleep quality and hygiene and prevent children from sleeping on the floor.
- **Increased Staffing (6 responses):** A small number of institutions reported hiring additional staff and teachers to improve supervision and overall care.
- **Diversified Activities and Enhanced Education (6 responses): Some** institutions introduced new activities and learning opportunities to improve the children's overall development.

- **Regular Supervision (1 response):** One institution highlighted the establishment of regular supervision mechanisms as a recent positive development..
- Overall, all private institutions surveyed appeared to be actively engaged in efforts to enhance both the capacity and quality of their services, reflecting a strong commitment to continuous improvement.

The challenge of quality improvement in a Rehabilitation Centre for Socially Disabled Girls:

"Most of the women in the institution worked as prostitutes in various hotels, on the street and at home before coming to the institution. Apart from this, some children have been subjected to child rape and other physical and mental abuse. As a result of such incidents, many of them become pregnant and give birth in the institution. The informant thinks that the environment of this institution is not suitable for any child to grow up. He personally arranges for the transfer of such children to other baby home, children's families. So that those children can grow up in a suitable environment. Apart from this, he applied to the MSW several times. So that psychological counselling can be arranged for women, and for this, skilled psychologists are appointed by the government. Although it has been tried many times, it has not worked until now. He has made a big garden inside the institution on his own initiative so that the resident women can take part in the maintenance of garden plants" (SYL10)

Among private institutions—primarily madrassas—quality of care is often perceived through the lens of physical living conditions, such as shelter, food, and hygiene. In contrast, respondents from public institutions were more likely to identify children's activities and learning opportunities as key indicators of quality, alongside basic needs like food.

In summary, while the quality of residential childcare is inherently multifaceted, encompassing material conditions, care practices, and developmental opportunities, the improvements noted across private institutions mainly emphasize basic living standards. Establishing minimum national care standards—both for residential care and alternative care more broadly—could offer a structured approach to quality assurance, helping to:

- Prevent substandard care
- Identify priority areas for improvement
- Guide institutional development plans, and
- Strengthen accountability among service providers

Such standards would serve as a critical benchmark for ensuring safe, appropriate, and child-centered care across all types of institutions.

09

Key Conclusions: Lessons from the Residential Care Assessment

9.1 Discrepancy Between Policy and Regulatory Intent

Legal and Policy Commitments to Family-Based Care: Bangladesh has demonstrated a strong normative commitment to children's rights by ratifying the Convention on the Rights of the Child (CRC) in 1990 and enacting the Children Act 2013. These frameworks emphasize that children have the right to grow up in a family environment and that institutional care should be used only as a last resort. The UN Guidelines for the Alternative Care of Children (2009) further reinforce this principle, calling for preventive family support and formal alternatives like kinship or foster care before resorting to institutional placement.

Implementation Gaps and Policy Contradictions: Despite these legal safeguards, policy implementation remains misaligned. The National Social Security Strategy – Action Plan Phase II (2021–2026) outlines broad child protection goals but fails to prioritize or finance the development of formal alternative care systems, such as foster care or structured kinship care. As a result, residential care continues to expand, often by default, rather than through evidence-based assessment of children's protection needs**.**

Absence of Formalized Family and Community-Based Alternatives Care Systems: Although the Children Act promotes family- and community-based care, **Bangladesh lacks a national system for foster care or formalized kinship care.** In the absence of these options, children requiring care outside of their families are routinely referred to residential institutions, even in cases where family-based alternatives could be viable with adequate support.

Unintended Effects of Institutional Funding Models: The **Capitation Grant Programme**, intended to support private childcare institutions, operates on a **per-capita funding model**. While it seeks to improve service coverage, it may inadvertently incentivize **over-enrolment** and **unnecessary institutionalization**. Some institutions actively **advertise their services** or distribute leaflets to attract children from low-income families—practices that violate the principle of "necessity" in care placement and risk promoting separation driven by poverty, not protection concerns.

Operational Practices That Undermine Policy and Legislative Intent: The study highlights how **day-to-day operational practices**—such as **open admission processes**, **lack of gatekeeping**, and **informal recruitment of children**—further distance implementation from the policy goal of family preservation. This reflects an underlying **paternalistic welfare model**, where the State and charitable actors substitute family care rather than supporting families to fulfill their caregiving role.

There is a growing gap between **the rights-based vision articulated in Bangladesh's laws and commitments**, and the **actual structure of care provision**. Without a formal system for alternative care, dedicated investment in family support, and reform of funding mechanisms, **residential care will remain the default option**. A deliberate shift is required to align implementation with legal intent—one that prioritizes **family strengthening, formalizes alternative care options**, and reorients the system toward the **best interests of the child**.

9.2 Overreliance on Institutional Care

Despite global and national emphasis on family-based solutions, Bangladesh has seen consistent growth in institutional care. **Today, over 110,000 children reside in residential facilities, supported by hundreds of government-run institutions and thousands of private organizations—many of them faith-based**. The expansion of residential care infrastructure—much of it occurring after the ratification of the CRC—reflects a systemic reliance on institutionalization, often in response to poverty, not protection risks..

This reflects a paternalistic welfare model, where the State substitutes the role of the family rather than supporting it. Such practices contradict both children's right to family life and caregivers' right to receive support in fulfilling their parental responsibilities. In many cases, family separation could have been avoided through targeted social protection, economic strengthening, and community-based services.

Drivers of institutionalization: socioeconomic pressures and systemic incentives:

The findings of this study reveal that most children in residential care have not been admitted due to abuse, neglect, or abandonment, but rather due to underlying **socioeconomic hardship**, **service exclusion**, and **structural incentives that promote institutionalization**.

- **Poverty and Lack of Access to Basic Services:** Many families place children in institutions so they can access food, shelter, education, and clothing—services that should be accessible in their communities. These placements are not based on child protection concerns but on survival needs. As one respondent, A facility manager stated, "Most of the children are not orphans. They are here because their parents cannot afford to feed or educate them."
- **A majority of admissions occur without formal gatekeeping — 65% of children are placed based on family application, not care orders or formal assessments.**
- **Children with Disabilities:** The study finds that **a significant number of children with disabilities** are institutionalized, often not because they lack parental care, but because families are unable to provide adequate care due to poverty, stigma, and lack of community-based services. These placements often reflect desperation in the absence of inclusive education, health care, and respite services. Children with disabilities are present in many facilities but **specialized care and rehabilitation services are limited**.
- **Service Substitution Effect:** This situation reflects a clear **"service substitution" effect**, where residential care becomes the default provider of basic needs, functioning as a de facto social safety net—contrary to legal and international guidance that institutional care should be a last resort.

Structural factors contributing to institutionalization

- **Admission Campaigns and Public Outreach**: The study documents that **private and faith-based institutions often engage in community outreach and informal referrals** to increase enrolment. These well-meaning campaigns, however, directly conflict with the Children Act 2013 and UN Guidelines, which stress that children should only be placed in institutional care when all family- and community-based options have been exhausted.
- **Infrastructure Expansion as a Pull Factor**: Approximately **60% of surveyed institutions reported infrastructure expansion** over the past two years, largely aimed at increasing intake. However, this expansion was rarely accompanied by increased staff, quality-of-care investments, or individualized reintegration planning—suggesting that **expansion prioritizes quantity over quality**.
- **Capitation Grant Model**: In private institutions receiving government support, the **Capitation Grant** provides per-child funding. While designed to sustain operations, this model may unintentionally **incentivize higher enrolment**, regardless of whether residential care is the most appropriate solution for a child.

Misconceptions About Orphanhood: A critical misconception underpinning institutionalization in Bangladesh is the **overuse of the term "orphan"**. Many children in residential care who are labelled as orphans actually have **one or both parents alive.** The findings show that **only 4% had lost both parents**. Even in cases where both parents are deceased, most children have **extended family or community members willing to care for them** if appropriate **financial, practical, and psychosocial support** were made available.

Research from global care reform initiatives shows that **an estimated 80–90% of children living in orphanages worldwide are not orphans** in the strict sense, and the same pattern holds true in Bangladesh. These findings reinforce the need to shift away from institutionalization as a default response and invest instead in **family preservation**, **kinship care**, and **community-based support**.

A Missed Opportunity for Family Strengthening: The current reliance on institutional care reflects a missed opportunity to invest in **preventive and family-strengthening services**. With appropriate reforms, Bangladesh can shift away from institutionalization toward a **rights-based and family-centred care system** by:

- Expanding and formalizing **kinship care and foster care** options;
- Providing **cash transfers and social protection** to vulnerable families to prevent unnecessary separation;
- Ensuring access to inclusive **education, health, and disability services** within communities;

- Developing a system of **gatekeeping and case management** to assess and monitor institutional placements as a last resort.
- Tackling **harmful social norms, practices, and stigma** that lead to family separation—such as children not being accepted by a mother's new family after remarriage, stigma and barriers associated with disability, and discriminatory attitudes toward girls and women.

Such a shift would not only uphold children's rights under the CRC and Children Act 2013, but also create a more **cost-effective, culturally grounded, and sustainable** care system in line with international best practice.

9.3 Challenges in State-Run Institutions

For children who genuinely require out-of-home care and family or community-based care is not an option, the State has a legal and moral obligation to provide placements that are **safe, specialized, and rehabilitative**. In practice, however, institutions such as Baby Homes, Safe Homes, Child Development Centres (CDCs), and Rehabilitation Centres for Socially Disabled Girls (RCSDGs) often fall short of fulfilling their statutory mandates. **These institutions were originally designed for specialized and time-bound interventions but are instead operating as long-term custodial facilities.**

Key Gaps in Practice: The study highlights several systemic shortcomings in State-run institutions:

- **Limited Specialized Staff:** Few staff are trained in **child protection**, **psychosocial care**, or **trauma-informed practices**.
- **Absence of Individualized Care:** Processes such as **individual care planning**, **risk assessments**, and **case management** are either **non-existent** or inconsistently applied. **Less than 30% of children had a documented care plan**, and exit planning is rare.
- **Low Standards of Care:** Overcrowding, poor sanitation, inadequate supervision, and a lack of structured educational and recreational activities were commonly reported.
- **Punitive Care Approaches:** In some institutions, particularly CDCs and Safe Homes, the care model is based on a **punitive or disciplinary framework**—more akin to correctional settings than protective environments. This includes rigid routines, restricted freedom of movement, and an emphasis on control over rehabilitation.

Rights Implications and Long-Term Risks: This custodial model **undermines children's rights**, as outlined in the **CRC** and **Children Act 2013**, particularly the right to **participation**, **protection from harm**, and **reintegration** into society. Children placed in such environments are at increased risk of:

- **Psychosocial harm** due to institutionalization;
- **Stigmatization** and barriers to reintegration;
- **Delayed or blocked transitions** to family- or community-based care.

The findings call for **Urgent Reforms** to ensure that **State-run institutions move away from a detention-oriented or custodial logic** toward a model that is **therapeutic, rights-based, and community-connected**. This includes:

- Expanding the **professionalization** of the social service workforce;
- Strengthening **gatekeeping mechanisms** to prevent unnecessary placements;
- Embedding **individualized care planning and case management** into standard practice;
- Investing in **rehabilitative and reintegration pathways**, particularly for older children and children in conflict with the law.

9.4 and Faith-Based Facilities: Gaps in Oversight and Quality

The The majority of children in institutional care in Bangladesh reside in private facilities, many of which are faith-based and supported through mechanisms like the Capitation Grant Programme. These institutions are often grounded in longstanding traditions of charity, religious obligation, and social solidarity. While they provide an important safety net for some vulnerable children, the study identifies several systemic concerns that impact the quality of care and child protection outcomes.

Key challenges identified:

- **Limited Individualized Care**: Many private institutions operate large group settings where children receive limited personal attention or emotional support, undermining their psychological and social development. **Less than 30% of children had a documented care plan**, and exit planning is rare.
- **Weak Case Management and Reintegration Planning**: There is a general absence—or highly inconsistent application—of case management processes and individualized reintegration plans. Children often remain in institutions without structured efforts to assess their needs or support their safe return to families or communities.
- **Lack of Standardized Services**: Services such as food provision, education, and healthcare are inconsistent across institutions, with no uniform standards to ensure minimum quality of care. Safeguarding mechanisms are particularly weak or absent.
- **Poor Monitoring and Recordkeeping**: Oversight mechanisms are minimal, and documentation of admissions, discharges, case histories, and financial accounts is often lacking. This compromises accountability and follow-up care.
- **Funding Model Risks**: The per-capita Capitation Grant model, while aimed at supporting care provision, may inadvertently incentivize higher enrolment over necessity. In the absence of strong gatekeeping mechanisms, this increases the risk of unnecessary institutionalization.

Implications: These gaps risk reinforcing the systemic overreliance on institutional care, rather than shifting towards family- and community-based alternatives. Without comprehensive reforms to the regulatory framework, oversight, standard-setting, and support to transition children safely out of institutions, the current model may expose children to avoidable harm and long-term developmental consequences.

9.5 Gaps in the Professional Workforce

A foundational weakness in the current residential care system is the limited presence of a professional, multidisciplinary workforce capable of delivering individualized, rights-based care for children. The study highlights critical gaps in staffing, training, and oversight that undermine the quality and safety of care across both government and private institutions.

- **Professional social workers**, who are central to case management, family tracing and reintegration (FTR), risk and needs informed care planning, are rarely present or adequately trained;
- **Psychosocial counsellors** and staff trained in child mental health and trauma-informed support are largely absent, despite children's exposure to loss, separation, and adversity;
- There is an absence of **early childhood development (ECD) specialists**, **inclusive education personnel**, and professionals trained to work with children with disabilities;
- Institutions often lack trained **health workers**, **recreational facilitators**, and **educational support staff**, which limits holistic care;
- **Support personnel** such as child care workers, caregivers, security guards, and volunteers are frequently unvetted, under-supervised, and without child safeguarding training.

This lack of professionalization contributes to inconsistent or absent care planning, weak safeguarding systems, and a custodial approach to care rather than developmental or rehabilitative.

In addition, there is a limited presence of statutory oversight actors. **Probation officers**, who should play a critical role in ensuring that placements align with the best interests of the child and are regularly reviewed, are not consistently engaged in institutional care cases. Likewise, the absence of social workers specifically mandated to prioritize **family tracing and reintegration (FTR)** has led to prolonged and unnecessary stays for many children, especially girls and children in Safe Homes.

Without a trained, accountable, and child-focused workforce, the system cannot ensure safe, nurturing environments or facilitate timely and appropriate transitions back to family- or community-based care. Strengthening the professional child protection workforce must therefore be a core pillar of any reform to the alternative care system.

9.6 Gaps in Child Protection Reporting and Safeguarding Practices

Robust child protection (CP) systems are essential in any residential care setting. However, the study highlights significant gaps in institutional safeguarding frameworks, reporting practices, and staff preparedness—placing children at continued risk of harm and rights violations.

Lack of Institutional Safeguarding Frameworks: The majority of surveyed institutions do not have a written child safeguarding policy or a clearly defined Code of Conduct for staff. Even where such documents were reported, many were not physically available at the facility or shared with staff. This absence of formal safeguarding measures contributes to:

- Inconsistent standards of care and behavioral expectations;
- Weak institutional accountability and supervision;
- Limited staff understanding of child protection roles and responsibilities.

Inadequate Training and Accountability of Staff: Only a minority of institutions provide structured training on child safeguarding, abuse prevention, or ethical conduct. Most facilities rely on informal orientation processes—if any—leaving staff unequipped to identify, prevent, or respond to abuse. Specific concerns include:

- No regular refresher training or supervision to reinforce safeguarding principles;
- No designated safeguarding focal point to guide or oversee institutional practices;
- Inadequate staff vetting processes, especially in private institutions, which increases the risk of recruitment of unqualified or unsafe individuals.

Underreporting and Misclassification of Abuse: The findings point to a widespread underreporting of abuse:

- Only 11 of 158 respondents could provide examples of adult-to-child abuse, despite other responses indicating complaints against staff;
- Abuse is often narrowly interpreted—limited to extreme cases—while neglect, corporal punishment, and psychological harm are overlooked;
- Social desirability bias and fear of reputational damage likely contribute to institutional silence or minimization of incidents.

This underreporting hinders early detection, prevention, and response, allowing patterns of harm to go unchecked.

Weak Oversight and Monitoring: There is no centralized mechanism for documenting, tracking, or responding to child protection concerns in institutional care. The absence of such systems results in:

- No standardized reporting or referral procedures for incidents;
- Limited external monitoring or inspection;
- No data collection on the prevalence or trends of CP violations across institutions.

In many facilities, safeguarding concerns are managed informally, if at all, with no linkages to statutory child protection services or formal accountability mechanisms.

Without these foundational safeguards, the care system will continue to expose children to preventable risks—undermining national child protection commitments and global obligations under the CRC.

9.7 Limited Child Participation and Inadequate Complaint Mechanisms

The participation of children in decisions that affect their lives is a cornerstone of child rights-based care. However, the study revealed that:

- Most institutions do not have accessible, child-friendly complaint procedures;
- Children often rely on informal channels, such as speaking to staff, rather than structured mechanisms;
- In public institutions, mandated grievance redress mechanisms are largely unknown or unused by children and staff.

In addition, very few institutions involve children in their care planning or day-to-day decision-making. Without meaningful participation, children's voices go unheard, and their ability to report abuse or suggest improvements is limited—leaving them vulnerable and disempowered within care settings.

9.8 Call for Reform

The current supply of residential care does not correspond to actual protection needs. The study identified:

- Underutilized facilities (e.g., Baby Homes, RCSDGs);
- Overcrowded centres (e.g., SUK, Safe Homes);
- Unregulated admission practices;
- Prolonged stays without exit options, particularly for girls in Safe Homes.

These findings suggest an urgent need to reform the national alternative care system, ensuring alignment with the Children Act 2013, CRC, and UN Guidelines.

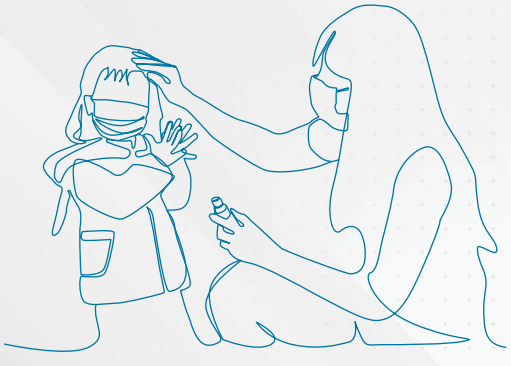
A strategic, phased reform approach is recommended, with immediate priorities including:

- Standardization of care provision across all residential facilities;
- Systematic reassessment of current care models, with a gradual shift toward family-based and community-based alternatives;
- Establishment of a professional child protection workforce with specialized training in social work, case management, and child mental health;
- Revision of funding models, to discourage institutional expansion and incentivize family preservation.

Only through such a transition can Bangladesh move toward a rights-based, responsive, and sustainable alternative care system that truly serves the best interests of children and upholds the State's obligations under national and international law.

10

Recommendations: Shifting Toward a Family-Based Care System



The following recommendations, drawn from the findings of this national assessment, are directed to the **Government of Bangladesh** and its **development partners**. They aim to strengthen the national child protection and alternative care system in line with the **CRC**, **Children Act 2013**, and **UN Guidelines for the Alternative Care of Children**.

10.1 Strengthen Child Welfare, Protection, and Alternative Care Policy by Operationalizing a National Action Plan to Transition Toward Family-Based Care

Finalize and adopt the National Plan of Action (NPA) for Alternative Care of Children (2026–2030), building on evidence-based findings from national studies such as this Residential Case Assessment, the provisions of the Children Act 2013, CRC, and UN Guidelines.

Ensure the NPA includes:

- A **clear vision and roadmap** for transitioning from institutional to family-based care.
- A **continuum of care options** including kinship care, foster care, supported independent living, and emergency family-based placements.
- Gatekeeping mechanisms to ensure separation from families occurs **only when necessary**, based on formal assessment and in the best interests of the child.
- A phased strategy for the **regulated use and reduction of institutional care**, with time-bound reintegration and placement review processes.

Review and update the national Child Protection Policy to strengthen linkages with the NPA and embed alternative care priorities across the broader child protection system.

10.2 Adopt Measures to Prevent Family Separation and Institutionalization where Possible

Adopt a **comprehensive prevention strategy that addresses the root causes of institutionalization—poverty, disability, exclusion from services, stigma**, and harmful social norms—while building systems that strengthen families and communities.

Develop **preventive responses** that do not rely on forced institutionalization for children and adolescents subject to high-risk situations (e.g., substance use, street involvement, sexual exploitation).

Invest in preventive and early intervention measures

- Expand **cash transfer and social protection schemes** targeted at families at risk of separation.
- Scale up **community-based support services**, including for children with disabilities, to address care needs within the family.
- Improve access to **inclusive education, healthcare, disability, and mental health services** to reduce reliance on institutional care as a substitute for basic services.
- Promote **family support programs** that address violence, conflict, and other drivers of breakdown, including parenting support and psychosocial interventions.

Develop robust gatekeeping and placement oversight systems

- Establish **standardized screening, referral, and assessment procedures** at the point of potential separation to ensure children are placed in care only when necessary and appropriate.
- Require all placement decisions to be guided by a **best interests determination**, with documentation of the child's background, family capacity, and care needs.
- Develop and operationalize **Child Welfare Boards and Probation Officers' roles** in placement oversight, including regular case reviews.

Reform admission and funding practices

- **Prohibit the admission of children into institutions** without a formal gatekeeping process or care order issued by an authorized body.
- Ban **active recruitment or promotional campaigns** by institutions aimed at attracting children from low-income families.
- Reform the **Capitation Grant or other per-capita funding models** to remove financial incentives that encourage unnecessary or prolonged institutionalization. Introduce funding mechanisms that prioritize family-based alternatives.

Strengthen registration and accountability of care providers

- Require all residential care providers, especially private institutions, to undergo a **licensing and quality assurance process** that assesses their capacity to deliver individualized care and follow national care standards.
- Ensure that all **Private Institutes are** registered and regularly monitored by national safeguarding authorities.
- Ensure ongoing **monitoring of provider practices**, including sanctions for facilities violating admission protocols or safeguarding responsibilities.

10.3 Improve the Quality of Residential Care by Developing Care Standards

Develop and strengthen the care provided in residential institutions by establishing and enforcing a comprehensive **National Framework and Minimum Standards for Residential Care**, aligned with the Children Act 2013, CRC, and the UN Guidelines for the Alternative Care of Children.

Establish and enforce minimum standards for residential care

- Develop and implement **national minimum standards** that are legally binding and applicable to all government and non-government child care facilities and institutions.
- Ensure standards address **quality of care, infrastructure, staffing, child protection, care planning, child participation, and access to services.**

Ensure a family-like and dignified living environment

- Reduce the size of institutions to promote **individualized attention** and **small-group or family-like settings.**
- Provide **adequate and age-appropriate sleeping arrangements**, bathrooms, and recreational areas.
- Foster **inclusive, co-educational environments** that model healthy gender and social norms, with appropriate adult guidance and supervision.
- Ensure institutions are **open and integrated into the community**, supporting:
- Access to public services (education, health, recreation);
- Participation of the community in institutional activities;
- Encourage use of spaces and services frequented by non-resident children where appropriate.

Implement rigorous admission and case management procedures

- Require that children be admitted **only through a care order** or **administrative placement decision**, based on a comprehensive best interest assessment.
- Ensure that each child has:
- A **designated case worker** responsible for care planning, ongoing supervision, and exit planning;
- A **personal file** that includes background information, placement justification, progress notes, and service records;
- An **individual care plan** is developed and reviewed periodically in **coordination with Probation Officers and Child Welfare Boards.**

Guarantee full access to essential services

- Facilitate access to **formal education and healthcare**, including referral and accompaniment when needed.
- Promote **safe and regular contact with families**, unless contrary to the child's best interests, as part of reintegration planning.
- Provide **targeted support for children with disabilities or complex needs**, including access to therapeutic, rehabilitative, and assistive services.

Strengthen safeguarding and child participation

- Establish **institution-wide safeguarding protocols**, including:
  - A **staff code of conduct**;
  - Prohibition of all forms of violence, exploitation, neglect, and inappropriate discipline;
  - Clear guidance on positive behavior management.
- Promote **meaningful child participation**, including:
  - Regular opportunities for children to express views on their care and daily life;
  - Involvement in key decisions related to their placement and future.
- Operationalize **child-friendly, confidential complaint mechanisms** that are well-publicized, safe, and supported by trusted adults.

10.4 Develop a Qualified and Skilled, and Accountable Workforce

Ensure the care and protection of children in residential institutions through the **professionalization and capacity-building of the workforce**, including social service professionals, support staff, and volunteers.

Establish a strategic workforce development plan

- Develop and implement a **National Social Work Policy** and a **National Plan of Action (NPA) for Social Service Workforce (SSWF) Strengthening through Professionalization**, which:a **national strategic plan** for workforce development that:
  - Define clear **competency frameworks, accreditation systems, and career pathways** for social workers, para-social workers, and child protection professionals;
  - Ensure **equitable and needs-based deployment** of staff across all care settings;
  - Promote a **multidisciplinary team approach**, including qualified social workers, psychosocial counsellors, educators, and care staff;

- Are **aligned with international best practices for workforce roles in alternative care settings**, including the UN Guidelines for the Alternative Care of Children, Global Social Service Workforce Alliance guidance, and UNICEF's SSWF Strengthening Framework.

Set and enforce professional standards

- Define and enforce **minimum competency standards** for all categories of personnel, including:
  - Residential caregivers and care workers;
  - Social Workers and Psychosocial Counsellors;
  - Administrative and security personnel (e.g., guards, watch staff);
  - Educators, vocational teachers, health workers
  - Activity and recreation facilitators
  - Volunteers and activity/recreation facilitators.
- Ensure adequate **child-to-staff ratios** to facilitate individualized care and supervision.

Provide specialized, continuous training

- Deliver **standardized pre-service and in-service training** covering:
  - Child development and age-appropriate care;
  - Trauma-informed practice and psychosocial support;
  - Disability inclusion, Early Childhood Development (ECD), and MHPSS;
  - Children's rights, safeguarding, gender, and positive discipline;
  - Family tracing and reintegration, exit planning, and aftercare support.
- Introduce **refresher courses**, mentoring, and clinical supervision, particularly for frontline social workers and counsellors.

Strengthen roles of key professional staff

- Ensure each facility is supported by **qualified social workers** who lead on:
  - Case management, including care planning, placement reviews, and reintegration;
  - Regular interaction with Child Welfare Boards and Probation Officers to uphold best interest determinations.
- Deploy **psychosocial counsellors** to provide structured support to children experiencing distress, trauma, or behavioural challenges.
- Prioritize recruitment of **specialists for children with disabilities**, including rehabilitation staff and inclusive education personnel

Ensure safe recruitment and accountability

- Implement mandatory **background checks and police clearance** for all staff prior to recruitment.
- Develop and enforce **codes of conduct**, including accountability mechanisms for violations.
- Create clear roles, supervision lines, and performance monitoring systems to ensure **accountability, transparency, and ongoing quality improvement**.

10.5 Review and Reform Institutional Care Models

Review Undertake a comprehensive review and reform of existing institutional care models being used in Bangladesh to ensure they are child-centred, rehabilitative, and aligned with the UN Guidelines for the Alternative Care of Children, the Children Act 2013, and principles of continuity of care and reintegration.

Reform the baby home model

- Redesign Baby Homes to reflect **family-based care principles**, ensuring:
  - **One primary caregiver per child or small group of children**, to foster stable attachment and development;
  - A **home-like, nurturing environment**, with consistent routines, play-based stimulation, and age-appropriate interaction;
  - Integration of **Early Childhood Development (ECD)** and **healthcare services**, with regular developmental monitoring;
  - Strong focus on **reunification with biological family** or **placement into family-based care** (e.g., kinship or foster care) at the earliest possible stage.

Systematically review specialized institutions

- Conduct a **comprehensive evaluation** of:
  - **Safe Homes**, especially for girls and women survivors of violence;
  - **Rehabilitation Centres for Socially Disabled Girls (RCSDGs)**;
  - **Child Development Centres (CDCs)** for children in conflict with the law.
- Ensure that each care model:
  - Clearly defines its **mandate, entry/exit criteria, and length of stay**;
  - Provides **individualized care, case planning, and psychosocial support**;
  - Avoids prolonged institutionalization and promotes **timely reintegration** into family or community-based care settings;

- Incorporates **rehabilitation, life skills, and education services**, especially for older children and adolescents;
- Ensures **multisectoral support**, including legal, health, education, and livelihood interventions.

Ensure oversight and transition planning

- Establish clear **oversight mechanisms and accountability frameworks** for each type of institution, led by the relevant line ministry (e.g., MoSW, MoWCA).
- Embed requirements for **care planning, reintegration preparation**, and follow-up support post-discharge.
- Include voices of **children and young people** in the redesign of services, particularly those with lived experience in institutional care.

10.6 Establish a Dedicated Alternative Care Information System

Enhancement: Develop and operationalize a **centralized digital database for Alternative Care (AC)**, housed within the **Alternative Care Sub-Unit** and operating under the strategic oversight of the **Child Protection Unit of the Department of Social Services (DSS)**. This system will serve as the backbone for registration, monitoring, and case management of all children in formal alternative care settings across Bangladesh.

Core functions of the AC information system

- **Institutional Registration**: Maintain a complete national registry of all residential care facilities (government, private, and faith-based), including licensing status and compliance history.
- **Caregiver and Staff Registry**: Record the deployment, professional background, qualifications, and police clearance of all staff working in each institution—including caregivers, administrators, psychosocial staff, and guards.
- **Foster and Kinship Care Registry**: Include an updated list of all approved foster and kinship carers, with relevant background checks and training history.

Child-level case management integration

- Ensure that **every child in institutional care has an active digital case file**, linked to:
  - Individual **care plans** and **exit strategies**;
  - Relevant **legal mandates**, such as court orders or Child Welfare Board reports;

- Ongoing **Family Tracing and Reunification (FTR)** efforts.
- All children in institutional care must be **actively case-managed** by designated social workers and reviewed periodically for quality assurance and placement appropriateness.

System interoperability

- Design the AC database to be **interoperable with the national child protection information systems**, including **OCMS** and **CPIMS+**, enabling:
  - Cross-referral and tracking across programs;
  - Integrated service provision;
  - Consistent child protection case oversight.

Strengthen institutional capacity for implementation

- Build internal capacity by:
  - **Training government and NGO staff** on system use, data entry, and analysis;
  - Establishing clear **protocols for data privacy, child safeguarding**, and information sharing;
  - Appointing dedicated national help desk and focal points at the DSS and divisional levels to support system rollout and troubleshooting.

10.7 Develop a National Transition Strategy for Deinstitutionalization

Develop and implement a clear, government-led strategy to safely transition children out of institutional care and into appropriate family-based alternatives, aligned with the NPA for Alternative Care. The strategy should:

- Establish time-bound targets for reducing reliance on institutional care across all types of facilities;
- Map children currently in institutions and assess their reintegration potential;
- Develop specialized reintegration support packages, including FTR, economic assistance, and psychosocial follow-up;
- Provide transition funding and technical support to institutions that shift toward family and community-based services;
- Ensure that no new large-scale residential facilities are constructed or expanded unless in line with time-limited emergency needs;
- Engage civil society, faith-based actors, and private institutions in the transition process, through awareness, retraining, and incentives.

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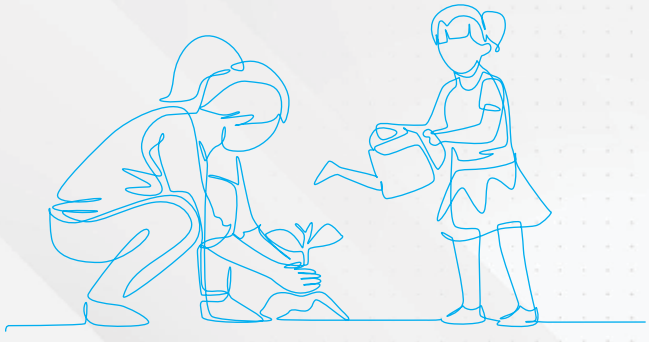

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Annex

Annex I: Facility Type Profiles (One-Pagers)

Baby homes

Category:	Baby home	
Type (public, private)	Public	
Geographic location	Chittagong (01) Khulna (01) Barisal (01) Rajshahi (01) Sylhet (01)	
Funding sources	Fully state-funded	
Number of surveyed facilities and % of existing facilities	▪ 05 facilities surveyed ▪ 3.18% of sample ▪ 100% of existing facilities	
Total Number of Residents 0-18	113	
Sex	Girls: 58 (51.33%)	Boys: 55 (48.67%)
Age group	0-7	
Child categories admitted	Orphans: 4 (80%) Disadvantaged children: 3 (60%) Abandoned Children: 4 (80%) Street children: 3 (60%) Vagrants: 3 (40%) Children with disability: 3 (60%)	
Total occupancy rate	22.60%	
Regime	On-boarding scheme: 16 (14.16%) Family visits: 16 (14.16%) Never leave: 81 (71.68%)	
Health problems (rank based on most common responses)	Respirator & pneumonia, mental health problems, seasonal flu, skin problems	
Disability status (inclusiveness)	41 (36.28%) children have disability	
Average # of (total) staff per facility	54	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	01	
Resident-to-Total Staff ratio	2.09	
Resident-to-Practitioner ratio	113	

Madrassas

Category:	Madrassas	
Type (public, private)	Private	
If private, capitation grant:	55 facilities receive capitation grant	
Geographic location	▪ Dhaka (08) ▪ Chittagong (07) ▪ Khulna (12) ▪ Rajshahi (08) ▪ Barisal (07) ▪ Sylhet (06) ▪ Rangpur (10) ▪ Mymensingh (08)	
Funding sources	Private & capitation grant	
Number of surveyed facilities and % of existing facilities	▪ 66 facilities surveyed ▪ 42.04% of the sample	
Total Number of Residents 0-18	6180	
Sex	Girls: 584 (9.45%)	Boys: 5596 (90.55%)
Total number of residents between 18-21 years	227	
Sex	Female: 78	Male: 149
Total number of residents above 21 years	15	
Sex	Female: 04	Male: 11
Total number of elderly residents	09	
Sex	Female: 0	Male: 09
Age group	0-22 years	
Child categories admitted	Orphans: 65 (98.48%) Disadvantaged children: 20 (30.3%) Abandoned Children: 19 (28.79%) Street children: 15 (22.73%) Vagrants: 2 (3.03%) Children with disability: 14 (21.21%)	
Total occupancy rate	56.38%	
Regime	On-boarding scheme: 4192 (62.89%) Family visits: 2115 (31.73%) Never leave: 359 (5.39%)	
Health problems (rank based on most common responses)	Skin problems, seasonal flue, gastroenteritis & diarrhoea, ear, eye and mouth infection, nutritional disease.	
Disability status (inclusiveness)	57 (1.09%) children have disability	
Average # of (total) staff per facility	707	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	19	
Resident-to-Total Staff ratio	8.74	
Resident-to-Practitioner ratio	325.26	

MoWCA centers

Category:	MOWCA Centers	
Type	Public	
Geographic location	▪ Dhaka (03) ▪ Khulna (01) ▪ Rajshahi (01)	
Funding sources	Fully state funded	
Number of surveyed facilities and % of existing facilities	▪ 05 facilities surveyed ▪ 3.18% of sample ▪ 83% of existing facilities	
Total Number of Residents 0-18	585	
Sex	Girls: 100 (17.09%)	Boys: 485 (82.74%)
Total number of residents between 18-21 years	01	
Sex	Female: 01	Male: 0
Total number of residents above 21 years	01	
Sex	Female: 0	Male: 1
Age group	4-18 years	
Child categories admitted	Orphans: 5 (100%) Disadvantaged children: 5 (100%) Abandoned Children: 4 (80%) Street children: 4 (80%) Vagrants: 1 (20%) Children with disability: 2 (40%)	
Total occupancy rate	76.97%	
Regime	On-boarding scheme: 310 (34.64%) Family visits: 566 (63.24%) Never leave: 19 (2.12%)	
Health problems (rank based on most common responses)	Skin problems, seasonal flu, gastroenteritis and diarrhoea	
Disability status (inclusiveness)	7 (1.26%) children have disability	
Average # of (total) staff per facility	48	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	04	
Resident-to-Total Staff ratio	12.19	
Resident-to-Practitioner ratio	146.25	

NGOs (national and international)

Category:	NGOs	
Type (public, private)	Private	
If private, a capitation grant:	02 facilities receive a capitation grant	
Geographic location	▪ Dhaka (02) ▪ Rajshahi (01) ▪ Rangpur (01)	
Funding sources	Private & capitation grant	
Number of surveyed facilities and % of existing facilities	▪ 04 facilities surveyed ▪ 2.55% of the sample	
Total Number of Residents 0-18	290	
Sex	Girls: 39 (13.45%)	Boys: 251 (86.45%)
Total number of residents between 18-21 years	26	
Sex	Female: 14	Male: 12
Total number of residents above 21 years	06	
	Female: 05	Male: 01
Age group	6-18 years	
Child categories admitted	Orphans: 2 (50%) Disadvantaged children: 3 (75%) Abandoned Children: 3 (75%) Street children: 2 (50%) Vagrants: 1 (25%) Children with disability: 2 (50%)	
Total occupancy rate	44.27%	
Regime	On-boarding scheme: 60 (20.20%) Family visits: 30 (10.10%) Never leave: 207 (69.70%)	
Health problems (rank based on most common responses)	Skin problems, seasonal flu, gastroenteritis, diarrhoea	
Disability status (inclusiveness)	72 (62.60%) children have disability	
Average # of (total) staff per facility	56	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	0	
Resident-to-Total Staff ratio	5.18	
Resident-to-Practitioner ratio	-	

PHT centers

Category:	PHT centers	
Type (public, private)	Public	
Geographic location	▪ Dhaka (01) ▪ Chittagong (01) ▪ Khulna (01) ▪ Barisal (01) ▪ Sylhet (01) ▪ Rajshahi (01)	
Funding sources	Fully state funded	
Number of surveyed facilities and % of existing facilities	▪ 06 facilities surveyed ▪ 3.82% of sample ▪ 50% of existing facilities	
Total Number of Residents 0-18	405	
Sex	Girls: 191 (47.16%)	Boys: 214 (52.84%)
Total number of residents between 18-21 years	47	
Sex	Female: 47	Male: 0
Total number of residents above 21 years	04	
Sex	Female: 0	Male: 04
Total number of elderly residents	12	
Sex	Female: 12	Male: 0
Age group	6-25 years	
Child categories admitted	Orphans: 2 (33.33%) Disadvantaged children: 2 (33.33%) Abandoned Children: 1 (16.67%) Street children: 1 (16.67%) Vagrants: 0 Children with disability: 6 (100%)	
Total occupancy rate	58.70%	
Regime	On-boarding scheme: 344 (49.07%) Family visits: 328 (46.79%) Never leave: 29 (4.14%)	
Health problems (rank based on most common responses)	Skin problems, seasonal flu, gastroenteritis, diarrhoea	
Disability status (inclusiveness)	301 (80.06%) children have disability	
Average # of (total) staff per facility	111	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	04	
Resident-to-Total Staff ratio	3.65	
Resident-to-Practitioner ratio	101.25	

Private orphanages

Category:	Private orphanages	
Type	Private	
If private, capitation grant:	07 facilities receive capitation grant	
Geographic location	▪ Dhaka (01) ▪ Chittagong (05) ▪ Rajshahi (02) ▪ Barisal (01) ▪ Sylhet (01)	
Funding sources	Private & capitation grant	
Number of surveyed facilities and % of existing facilities	▪ 11 facilities surveyed ▪ 7.10% of sample	
Total Number of Residents 0-18	1172	
Sex	Girls: 125 (10.67%)	Boys: 1047 (89.33%)
Total number of residents between 18-21 years	10	
Sex	Female: 0	Male: 10
Total number of residents above 21 years	05	
Sex	Female: 0	Male: 05
Total number of elderly residents	04	
Sex	Female: 01	Male: 03
Age group	3-18 years	
Child categories admitted	Orphans: 10 (90.91%) Disadvantaged children: 2 (18.18%) Abandoned Children: 3 (27.27%) Street children: 0 Vagrants: 0 Children with disability: 3 (27.27%)	
Total occupancy rate	67.75%	
Regime	On-boarding scheme: 738 (62.17%) Family visits: 291 (24.52%) Never leave: 158 (13.31%)	
Health problems (rank based on most common responses)	Skin problems, seasonal flu, nutritional disease, gastroenteritis, diarrhoea	
Disability status (inclusiveness)	None of the children have disability	
Average # of (total) staff per facility	116	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	03	
Resident-to-Total Staff ratio	10.10	
Resident-to-Practitioner ratio	390.67	

Public orphanages

Category:	Public orphanages	
Type	Public	
Geographic location	▪ Dhaka (02) ▪ Chittagong (03) ▪ Khulna (02) ▪ Rajshahi (02) ▪ Barisal (02) ▪ Sylhet (02) ▪ Rangpur (02) ▪ Mymensingh (02)	
Funding sources	Fully state funded	
Number of surveyed facilities and % of existing facilities	▪ 17 facilities surveyed ▪ 10.83% of sample ▪ 20% of existing facilities	
Total Number of Residents 0-18	1300	
Sex	Girls: 738 (56.77%)	Boys: 562 (43.23%)
Total number of residents between 18-21 years	32	
Sex	Female: 09	Male: 23
Total number of elderly residents	15	
Sex	Female: 14	Male: 01
Age group	6-18 years	
Child categories admitted	Orphans: 16 (94.12%) Disadvantaged children: 10 (58.82%) Abandoned Children: 8 (47.06%) Street children: 4 (23.53%) Vagrants: 0 Children with disability: 1 (5.88%)	
Total occupancy rate	67.53%	
Regime	On-boarding scheme: 507 (33.75%) Family visits: 809 (53.86%) Never leave: 186 (12.38%)	
Health problems (rank based on most common responses)	Seasonal flu, skin problems, nutritional disease, gastroenteritis, diarrhoea	
Disability status (inclusiveness)	5 (0.44%) children have disability	
Average # of (total) staff per facility	229	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	06	
Resident-to-Total Staff ratio	5.68	
Resident-to-Practitioner ratio	216.67	

Residential Centers for children with disabilities

Category:	Residential Centers for children with disabilities	
Type (public, private)	Public	
Geographic location	▪ Dhaka (04) ▪ Chittagong (04) ▪ Khulna (03) ▪ Rajshahi (02) ▪ Barisal (02) ▪ Sylhet (03) ▪ Rangpur (02) ▪ Mymensingh (02)	
Funding sources	Fully state funded	
Number of surveyed facilities and % of existing facilities	▪ 22 facilities surveyed ▪ 14.01% of sample ▪ 30.56% of existing facilities	
Total Number of Residents between 0-18 years	450	
Sex	Girls: 116 (25.78%)	Boys: 334 (75.22%%)
Total Number of Residents between 18-21 years	11	
Sex	Female: 0	Male: 11
Total number of residents above 21 years:	17	
	Female: 04	Male: 13
Total number of elderly residents	24	
Sex	Female: 12	Male: 12
Age group	0-18	
Child categories admitted	Orphans: 0 Disadvantaged children: 3 (13.64%) Abandoned Children: 0 Street children: 0 Vagrants: 0 Children with disability: 17 (77.27%)	
Total occupancy rate	15.75%	
Regime	On-boarding scheme: 0 Family visits: 0 Never leave: 120 (100%)	
Health problems (rank based on most common responses)	Seasonal flu, skin problems, ear, eye and mouth infection, mental health problems	
Disability status (inclusiveness)	100% children have disability	
Average # of (total) staff per facility	122	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	18	
Resident-to-Total Staff ratio	5.27	
Resident-to-Practitioner ratio	35.72	

Rehabilitation centre for socially disabled girls

Category:	Rehabilitation Centre for Socially Disabled Girls	
Type (public, private)	Public	
Geographic location	▪ Dhaka (01) ▪ Khulna (01) ▪ Barisal (01) ▪ Sylhet (01)	
Funding sources	Fully state funded	
Number of surveyed facilities and % of existing facilities	▪ 04 facilities surveyed ▪ 2.55% of sample ▪ 66.67% of existing facilities	
Total Number of Residents 0-18	63	
Sex	Girls: 63 (100%)	Boys: 0
Total number of residents between 18-21 years	20	
Sex	Female: 20	Male: 0
Total number of residents above 18 years	22	
Sex	Female: 22	Male: 0
Total number of elderly residents	15	
Sex	Female: 15	Male: 0
Age group	6-18	
Child categories admitted [n(%) of facilities]	Orphans: 1 (25%) Disadvantaged children: 2 (50%) Abandoned Children: 2 (50%) Street children: 4 (100%) Vagrants: 2 (50%) Children with disability: 2 (50%)	
Total occupancy rate	102.06%	
Regime	On-boarding scheme: 369 (49.40%) Family visits: 375 (50.20%) Never leave: 3 (0.4%)	
Health problems (rank based on most common responses)	Skin problems, nutritional disease, mental health problems, gynaecological problem	
Disability status (inclusiveness)	45 (37.51%) children have disability	
Average # of (total) staff per facility	59	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	01	
Resident-to-Total Staff ratio	1.07	
Resident-to-Practitioner ratio	63	

Safe homes

Category:	Safe homes	
Type	Public	
Geographic location	▪ Dhaka (01) ▪ Chittagong (01) ▪ Khulna (01) ▪ Rajshahi (01) ▪ Barisal (01) ▪ Sylhet (01)	
Funding sources	Fully state funded	
Number of surveyed facilities and % of existing facilities	▪ 06 facilities surveyed ▪ 3.82% of sample ▪ 100% of existing facilities	
Total Number of Residents 0-18	225	
Sex	Girls: 218 (96.89%)	Boys: 7 (3.11%)
Total number of residents between 18-21 years	52	
Sex	Female: 52	Male: 0
Total number of elderly residents	134	
Sex	Female: 134	Male: 0
Age group	6-18 years	
Child categories admitted [n(%) of facilities]	Orphans: 0 Disadvantaged children: 5 (83.33%) Abandoned Children: 1 (16.67%) Street children: 1 (16.67%) Vagrants: 1 (16.67%) Children with disability: 1 (16.67%)	
Total occupancy rate	75%	
Regime	On-boarding scheme: 0 Family visits: 0 Never leave: 334 (100%)	
Health problems (rank based on most common responses)	Skin problems, mental health problems, seasonal flu	
Disability status (inclusiveness)	153 (41.24%) children have disability	
Average # of (total) staff per facility	77	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	02	
Resident-to-Total Staff ratio	2.92	
Resident-to-Practitioner ratio	112.5	

Sheikh Russel Children's Homes

Category:	Sheikh Russel Children's Homes	
Type (public, private)	Public	
Geographic location	▪ Dhaka (01) ▪ Chittagong (02) ▪ Khulna (01) ▪ Rajshahi (01) ▪ Barisal (01) ▪ Sylhet (01) ▪ Rangpur (01)	
Funding sources	Fully state funded	
Number of surveyed facilities and % of existing facilities	▪ 08 facilities surveyed ▪ 5.10% of sample ▪ 61.54% of existing facilities	
Total Number of Residents 0-18	995	
Sex	Girls: 690 (69.35%)	Boys: 305 (30.65%)
Total number of residents between 18-21 years	5	
Sex	Female: 5	Male: 0
Age group	6-18 years	
Child categories admitted [n(%) of facilities]	Orphans: 5 (62.50%) Disadvantaged children: 8 (100%) Abandoned Children: 8 (100%) Street children: 7 (87.50%) Vagrants: 3 (37.50%) Children with disability: 3 (37.50%)	
Total occupancy rate	102.05%	
Regime	On-boarding scheme: 368 (30.19%) Family visits: 553 (45.37%) Never leave: 298 (24.45%)	
Health problems (rank based on most common responses)	Skin problems and seasonal flu	
Disability status (inclusiveness)	30 (3%) children have disability	
Average # of (total) staff per facility	116	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	04	
Resident-to-Total Staff ratio	8.58	
Resident-to-Practitioner ratio	248.75	

SUK/CDC

Category:	Madrassas	
Type (public, private)	Public	
Geographic location	▪ Dhaka (02) ▪ Khulna (01)	
Funding sources	Fully state funded	
Number of surveyed facilities and % of existing facilities	▪ 03 facilities surveyed ▪ 1.91% of sample ▪ 100% of existing facilities	
Total Number of Residents 0-18	1110	
Sex	Girls: 67 (6.04%)	Boys: 1043 (93.96%)
Total number of Residents between 18-21 years	24	
Sex	Female: 0	Male: 24
Total number of elderly residents	6	
Sex	Female: 0	Male: 6
Age group	9-18 years	
Child categories admitted [n(%) of facilities]	Orphans: 0 Disadvantaged children: 3 (100%) Abandoned Children: 0 Street children: 0 Vagrants: 0 Children with disability: 1 (33.33%)	
Total occupancy rate	185%	
Regime	On-boarding scheme: 0 Family visits: 0 Never leave: 1140 (100%)	
Health problems (rank based on most common responses)	Skin problems, seasonal flu, gastroenteritis, diarrhoea, mental health problems	
Disability status (inclusiveness)	7 (4.32%) children have disability	
Average # of (total) staff per facility	23	
Average # of practitioners (staff excluding managers, admin and support staff) per facility	02	
Resident-to-Total Staff ratio	48.26	
Resident-to-Practitioner ratio	555	

Annex 2: Data Collection Tools

Tool 1: Facility assessment

Metadata

SL. [Official use only]		Respondent ID	
Date	-	Time	-
Name of Enumerator			
Name of Supervisor			
Name of the Facility			
Name of manager			
Name of respondent			
Designation			
District			
Sub-District			
Union/municipality			
Village			
Detail Address			
Facility or respondents phone number	1st ---------- 2nd----------		

General information

Sl.	Question	Options/instructions	Code
1.1	Type of facility	1= Orphanage 2= Safe Home 3= Baby Home 4= Rehabilitation Centre for Social Disabled Girls 5= Residential centre for children with disabilities 6= Sheikh Rassel Children's Home 7= Children's Residential Centre under MOWCA 8= Vagrants' Home 9= Madrassa/religious education school 10= Other specify)	
1.2	Organization running the institution	1= State 2= Private/faith-based organization 3= Private NGO 4= Private International NGO 5= Other private	
Remarks			

Sl.	Question	Options/instructions	Code
1.3	Registered with Government according to the Law on Registration of Social Institutions)	1= Yes 2= No	
1.3.1	Year of registration		
1.4 Started to operate as children's residential institution ----------			
1.5	Information/communication activities carried out to inform the community on the facility, the services offered and the conditions for admission	1= Yes 2=No	
1.5.1	If yes, specify	----------	

Sl.	Question	Options/instructions	Code
2.1	Admission criteria: conditions for the child to be admitted in the facility - tick one or more options Multiple Answers can be taken)	1=Orphan 2= Disadvantage child, according to children's act with referral from authority 3= Abandoned or lost child, child found in the street with no parent or guardian 4=Street child, child living in the street 5=Vagrants 6=Child with disability 7=Other – specify	
2.2	Sex of residents	1=Only girls 2=Only boys 3= Girls and boys	
2.3	Age group of residents	---------- years If any comments, write here----------	
2.4	Admission procedure	1=Simple enrolment with no conditions 2=Application to be admitted subject to screening/acceptance by the selection Committee 3=Referral/request by relevant authority Probation Officer, DSS, police station, or a social worker) 4= Other – specify {Under the Children's Act, a social worker working in [DSS] or the union or municipal social worker working under the [DSS] or ***Khalamma*** aunty) or ***Boro Bhaia*** senior brother) or any other worker of similar rank, irrespective of designation, who is engaged in providing care for children	

2.5 Children living in the facility to date day of the visit and interview):

Sl.	Question	Number	Instructions
2.5.1	Girls 0-18 years old		Only information of admitted children should be reported
2.5.2	Boys 0-18 years old		
2.5.3	Of which Groups of siblings		
2.5.4	Total number of children		

2.6 Other residents to date

Sl.	Question	Number	Instructions
2.6.1	Female Youth 18-21 years old		
2.6.2	Male youth 18-21 years old		
2.6.3	Female adult above 21 years old grew up in the institution and remained living in it)		
2.6.4	Male adult above 21 years old grew up in the institution and remained living in it)		
2.6.4	Elderly female		
2.6.5	Elderly Male		

2.7 Children's regime

Sl.	Question/ প্রশ্ন	Number
2.7.1	Onboarding scheme returns home during school holidays)	
2.7.2	Family visits go home at least once a year)	
2.7.3	Never leave the institution to visit parents, relatives or guardians	

2.8 Children's admissions and exits

Sl.	Question/প্রশ	Number/সংখ্যা
2.8.1	Children admitted in the last 30 days	
2.8.2	Children exited in the last 30 days	
2.8.3	Children admitted in 2022	
2.8.4	Children exited in 2022	

2.9 Destination of children who left the facility in 2022

Sl.	Question	Number	Remark
2.9.1	Family reintegration birth parents, extended family, other kinship)		

Sl.	Question	Number	Remark
2.9.2	For independent living, having reached 18 years of age		
2.9.3	For marriage		
2.9.4	Placed in guardianship		
2.9.5	Runaway/পলাতক		
2.9.6	Death/মৃত্যু		
2.9.7	Other (specify)		

2.10 Health problems

Sl.	Question	Options/instructions	Rank
2.10.1	What are the most common health problems (rank)	1=Ear, eye, mouth infections 2=Skin problems 3=Nutritional status 4=Respiratory, pneumonia 5=Gastroenteritis, diarrhoea 6=Mental health problem 7=Others – specify	

2.11 Children's disability status

Sl.	Question	Options	Code
2.11.1	Do you have children with sensor disability blind, deaf, dumb)?	1= Yes 2=No	
2.11.2	Do you have children with motor disability?	1= Yes 2=No	
2.11.3	Do you have children with mental disability?	1= Yes 2=No	
2.11.4	Do you have children with multiple disability?	1= Yes 2= No	

Infrastructure (অবকাঠামো)

Sl.	Question		Number/Code
3.1	Full capacity		
3.2	Infrastructure's capacity for children has increased over the years	1=Yes 2=No	

Age of infrastructure

Sl.	Question	Options/instructions	Code
3.3	Age of infrastructure	1= 0-10 years 2= 10-25 years 3= 25-50 years 4= More than 50 years	
Remarks __			
3.4	Infrastructure was built for the purpose	1=Yes 2=No	
3.5	Infrastructure was adapted from another destination or use	1=Yes 2=No	
3.5.1	If yes, specify the previous destination or use	___	

3.6 Description of facility (প্রতিষ্ঠানের বর্ণনা)

Sl.	Question	Options/instructions	Code
3.7	Location	1=Urban 2=Rural	
3.8	Served by public transport	1=Yes 2=No	
3.9	Does the institution have a water connection?	1=Yes 2=No	
3.10	Does the institution have electricity connection?	1=Yes 2=No	
3.11	Does the institution have internet connection?	1=Yes 2=No	
3.12	Does the institution own a car/minibus?	1=Yes 2=No	
	If yes, then what? _	Specify	

Staff profile

Sl.	Designation	Sex 1= Female 2 = Male	Age	Number of years of service in the facility	Academic Background 1=Primary 2=Secondary 3=Degree in social science 4=Degree other 5=Above	Special Training in childcare 1=Yes 2= no	Type of contract 1 = Paid 2= Voluntary	Regime 1= Residential 2= Full-time 3= Part-time 4= Visiting
1								
2								
3								

4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								

4.6 Staff present in the facility during the night shift

Sl.	Function	Number
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Sl.	Question	Options	Code
4.7	Does your institution require police clearance prior to staff recruitment?	1= Yes 2= No	

Services

Sl.	Question	Options	Code
5.1	Accommodation	1= Shelter, short time, less than 3 months) 2= Long-term accommodation Full-time accommodation	

Services provided to children

Sl.	Question	Within the premises	Outside the premises
5.2.1 Meals			
	One meal		
	Two meals		
	Three meals		
5.2.2 Medical monitoring (স্বাস্থ্য পর্যবেক্ষক)			
	Weekly (সাপ্তাহিক)		
	Monthly (মাসিক)		
	Other – specify (অন্যান্য - নির্দিষ্ট করুন)		
5.2.3	Formal education (আনুষ্ঠানিক শিক্ষা)		
5.2.4	Informal education/literacy AbvbyôvwbK wk¶v/¯^v¶iZv		
5.2.5	Vocational training - specify) অনানুষ্ঠানিক শিক্ষা/স্বাক্ষরতা		
5.2.6	School support (স্কুল সহায়তা/টিউশন সহায়তা)		
5.2.7 Individual follow-up by an appointed social worker			
5.2.8	Weekly		
5.2.9	Monthly		
5.2.10	Other – specify		
5.2.11Counselling/psychosocial support/mental health			
	Weekly		
	Monthly		
	Other – specify		
5.2.12	Disability Rehabilitation		
5.2.13	Legal assistance		
5.2.14	Religious education		
5.2.15	Sports		
5.2.16	Art and music education		
5.2.17	Recreation, picnics, and trips		
5.2.18	Services for children living outside the facility		
5.2.19	Regular meetings with parents		
5.2.20	Regular meetings with the community		

Funding

Sl.	Question	Options/instructions	Code
6.1	Funding source	1= Public institution fully State funded 2= Private institution	

6.1.1	If source of funding = 2			
Sl.	**Source of budget**	**Options**	**Code**	**Ranking**
6.1.2	State Capitation grants	1=Yes 2=No		

6.1.1	If source of funding = 2			
Sl.	**Source of budget**	**Options**	**Code**	**Ranking**
6.1.3	National donations/ contributions	1=Yes 2=No		
6.1.4	International cooperation	1=Yes 2=No		
6.1.5	International donations	1=Yes 2=No		
6.1.6	Other – specify	1=Yes 2=No		

6.2 Budget

Year	Total Budget	Income	Expenditure	Main source of budget
2018				
2019				
2020				
2021				
2022				

Child participation

Give examples of child participation in your institution both in activities and in decision making

Complain mechanism for children

Sl.	Question	Options	Code
8.1	Explicit/written rules/policy on complaint mechanism for children	1= Yes 2=No	
8.1.1	If yes, document available at facility?	1= Yes 2=No	
8.2	Do you inform children when they enter the institution to whom they should refer when they have a compliant?	1= Yes 2=No	
8.2.1	If yes, what do you tell them ----------		
8.3	Give an example of a complaint by a child and how it was managed		

Child behaviour management

Sl.	Question	Option	Code
9.1	Explicit/written rules/policy on child behaviour management	1= Yes 2=No	
9.1.1	If yes, document available at facility?	1= Yes 2=No	
9.2	Are the children informed about the behaviour rules that apply to them when they enter the institution?	1= Yes 2=No	
9.3	Is staff trained on how to deal with challenging behaviour?	1= Yes 2=No	
9.4	Give an example of an incident child broke the rules) and how it was managed		

Child safeguarding policy

Sl.	Question	Options/instructions	Code
10.1	Explicit/written rules on child safeguarding policy or staff code of conduct	1= Yes 2= No	
10.1.1	If yes, document available at the facility?	1= Yes 2= No	
10.2	Are staff trained on the child safeguarding rules/ policy or Code of Conduct?	1= Yes 2= No	
10.3	Give an example of an abuse committed by staff and how it was managed		

Improving the quality-of-care

11.1 Please give examples of the latest initiatives/actions last two years or so) that you have taken to improve the quality of care provided to the children

Sl.	Question	Options/instructions	Code
11.2	What are your priorities for improving the quality of care in your institution RANK)	1=Infrastructure 2=Equipment 3=Staff number 4=Staff qualification 5=Food, clothing 6=Hygiene 7=Education 8=Vocational training 9=Other	

Supervision

Sl.	Question	Options/instructions	Code
12.1	Institution supervised by	1= Yes 2= No	
12.2	Frequency of supervision tick only one option)	1= Monthly 2= Bi-monthly 3= Quarterly 4= Annually	
12.3	How many visits did you receive by the probation officer in 2022?	1=Once a week 2=Once a month 3=Irregularly 4= On demand, according to needs	

Recommendation

What recommendations would you make to reduce the number of children living in orphanages and other similar institutions in Bangladesh?

Only for Baby home manager

14.1	On Guardianship - How do you identify potential guardians for the children?
14.2	How do you assess whether they have the necessary parenting skills to take care of child?
14.3	Do you play any role after the child is placed with the new guardian?

Written documents available at the facility (take photo)

Sl.	Question	Options/instructions	Code
15.1	Organization description, programme, organogram	1= Yes 2= No	
15.2	Registration document		
15.3	Registers (specify)		
15.4	Annual reports		
15.5	Supervision reports		
15.6	Guidelines for management/procedure manual		
15.7	Child Safeguarding Policy as such		
15.8	Staff code of conduct as such		
15.9	Behaviour Management policy as such		
15.10	Internal regulations other than the above		
15.12	Other policies (specify)		
15.13	Checklist of documents to be found in the children's files		
15.14	Updated and complete staff files		
15.15	Others (specify)		

Documents posted and visible in the facility premises hall, common spaces, living rooms, corridors) provide photos

Sl.	Question		Code
14.1	Behaviour rules for children	1= Yes 2= No	
14.2	Behaviour rules for staff	1= Yes 2= No	
14.3	Behaviour rules for everybody, children and staff alike	1= Yes 2= No	
14.4	Staff Code of Conduct	1= Yes 2= No	
14.5	Daily routine	1= Yes 2= No	
14.6	Weekly menu or menu of the day	1= Yes 2= No	
14.7	Educational messages	1= Yes 2= No	
14.8	Visual pleasure (drawings, decoration)	1= Yes 2= No	
14.9	Other – specify	1= Yes 2= No	

Tool 2: Profile of children in residential care

Metadata

SL. [Official use only]		Respondent ID	
Date	-	Time	-
Name of Enumerator			
Name of Supervisor			
Name of the Facility			
Total number of children			
No. of managers			
Name of respondent			
Designation			
District			
Sub-District			
Union/municipality			
Village			
Detailed Address			
Facility or respondent's phone number	1st ---------- 2nd ----------		

Question	Children 1		Children 2		Children 3		Children 4		Children 5	
	Code	Verified	Code	Verified	Code	Verified	Code	Verified	Code	Verified
Sex 1= Male 2= Female 3= Others										
Age										
Age when they were admitted										
Duration of placement										
Are they from ethnic group? 1=Yes 2=No										
Came from:										
Parental status										
Whether there is record of parents/ relatives 1=Yes 2=No										
Contact with family 1=Yes 2=No										
If Contact with family is 1=yes, then Medium of contact?										
Primary caregiver before admission										
Physical condition										
Have any disability?										
Educational status Educational status vs age)										
Referral										
Reason for being admitted										
Admission evaluation process 1=Yes 2=No										
Care order 1=Yes 2=No										
Care plan 1=Yes 2=No										
Exit plan 1=Yes 2=No										
Personal file 1=Yes 2=No										
Birth certificate 1=Yes 2=No										

Annex 3: Staff Categories

Managers	Admin	Childcare staff	Educational staff	Social workers	Therapists and counsellors	Health Care	Support staff	Other
• Deputy Coordinator • Director • Executive Director • Deputy Director • Superintendent • Deputy Superintendent • Officer • Officer in charge • Head of Institution • Manager • Principal • Mohtamim • President • General Secretary • Trust head • Deputy • Project Director	• Assistant coordinator • Assistant Director General Secretary • Assistant superintendent • Assistant secretary • Assistant director • Assistant superintendent • Administrative and Accounts officer • Accountant • Accounts assistant • Clerk • Computer Operator • Cashier • Office Assistant	• Supervisor • Assistant Supervisor • Caregiver • Aya • Head Warden • Warden • Khalamma • Boro bhai (brother) • Tutor • House Tutor • Mother • Matron cum Nurse	• Education Secretary • Head teacher • Teacher • Resource teacher • Assistant teacher • Residential teacher • Craft teacher • Religious Teacher • Dance Teacher • Music teacher • Karate teacher • Mentor • Educator • Instructor • Technical Instructor • Agriculture super • Physical instructor • Trade instructor • Life skills trainer • Trainer • Computer trainer • Thermoforming operator • Braille operator • Mentor • Librarian • Coordinator • Scout	• Child Protection Social Worker • Case Manager • Crisis manager • Outreach Worker • Community mobilizer	• Physiotherapist • Speech therapist • Psychosocial Counselor • Counselor	• Compounder • Nurse • Doctor • Para-medic	• Attendant • Cook, assistant Cook • Guard • Night Guard • Attachment • Ebtedai Head • Assistant ebtedai • Food distributor • Storekeeper • Hafeez • Driver • Sweeper • Police • Najame Talimat • Store Keeper • Darule kama • Assistant Darule kama • Electrician • Postman • Messenger • Khadem • Mechanic • Gardener • Ansar	• Bench assistant • Advocate

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