HOPE AND HOMES FOR CHILDREN

WHY ORPHANAGES HARM CHILDREN

The Evidence

Mark Waddington
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The evidence is overwhelming. Orphanages kill children, harm them and exploit them - regardless of who runs them, how much money they have, or how good the intentions behind them are.

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Institution, Moldova
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1. ORPHANAGES KILL CHILDREN: THE MORTALITY RECORD

At least 5.4 million children are living in orphanages around the world right now. Over 80% of them are not orphans — they have at least one living parent. The children most likely to be in those institutions are not there by accident. They are there because poverty is misread as neglect, because disability attracts stigma rather than support, because girls are placed under cultural pressures that systems rarely name, and because the humanitarian responses that arrive when crisis strikes continue to fund buildings rather than families. These patterns are the predictable outcomes of systems shaped by inequity, colonial legacy and structural exclusion. They persist because they are unaccountable to the children inside them.

The evidence on orphanage mortality stretches back more than 120 years and crosses continents, political systems, and cultures. It points to the same conclusion, again and again: orphanages kill children at catastrophic rates. And they do so because of the way orphanages are structurally designed. They remove children from the individual, motivated, attentive adult care that keeps human beings alive.

Near-total infant mortality in the United States, 1915

In 1915, Dr Henry Dwight Chapin, a distinguished New York paediatrician, published an analysis of infant mortality in residential institutions across ten major US cities. His findings were not that mortality was elevated. They were that it was near total. In all institutions surveyed except one, every child under two years of age died *(Chapin, 1915, cited in EIPMH, 2019)*. At the American Society of Pediatrics meeting convened to discuss these findings, his colleagues confirmed they were consistent with their own experience. Dr R Hamil described an institution in Philadelphia where mortality among infants under one year was 100%. Dr JHM Knox reported that of 200 infants admitted to institutions in Baltimore, approximately 90% died within the year — with the 10% who survived doing so because they had been removed from the institution and placed with foster parents or relatives *(EIPMH, 2019)*.

These deaths were not caused by the medical limitations of 1915. When a system of maternal care was introduced at Bellevue Hospital in New York — not better food, not better medicine, but individual human attention — mortality among infants under one year fell from 30–35% to less than 10% in a single year *(EIPMH, 2019)*. The intervention that saved children's lives was a relationship.

More than 15,000 children killed in Romania, 1965–1990

In just 26 of more than 500 residential institutions in Romania during the Ceaușescu era, more than 15,000 children died. At the Siret Neuropsychiatric Hospital alone, 340 children died in 1989 — a single year. In 1991, the first full year of foreign charitable access and some degree of individual care, two children died at the same facility *(IICMER)*. The difference was not resources. It was the presence or absence of attentive, individual human care.

When orphanage and residential institution mortality rates are this high and sustained for this long, local graveyards are unable to cope. Many of these facilities maintain their own cemeteries.

Photo 1: ***Institution, Rwanda.*** *Hope and Homes for Children*

More than 9,000 children dead in Ireland, 1922–1998

Between 1922 and 1998, more than 9,000 children died across Ireland's network of 18 mother and baby homes — one in every seven children who entered. The Commission of Investigation into Mother and Baby Homes, which reported in 2021, documented a catalogue of neglect, inadequate food and clothing, poor medical care and the routine indifference to children's suffering that institutional structures produce. In Tuam, County Galway, the remains of 796 children were found in a disused sewage chamber on the grounds of the former mother and baby home. Excavations to recover, identify and provide dignified reburial began in July 2025 *(Irish Times, June 2025)*.

Colonial institutional mortality: Canada and Australia

Canada's residential school system forcibly removed more than 150,000 Indigenous children from their families between the 1870s and 1996. Canada's Truth and Reconciliation Commission (TRC) recorded over 3,200 confirmed named deaths of children who attended residential schools, with the commission's chair, Justice Murray Sinclair, estimating the true total at over 6,000 *(TRC, 2015; CBC News, 2015)*. In 1902, the recorded national death rate at residential schools was 2.74 per cent — more than six times the death rate for all Canadian children aged 5–14 at the time *(TRC, 2015)*. In some residential schools, mortality rates reached 60 per cent *(CBC News, 2014)*. The TRC concluded in 2015 that the residential school system amounted to cultural genocide.

In Australia, governments, churches and welfare bodies forcibly removed Aboriginal and Torres Strait Islander children from their families under so-called 'protection' policies from the early days of colonisation through to the 1970s. These children became known as the Stolen Generations. The 1997 Bringing Them Home inquiry, conducted by the Human Rights and Equal Opportunity Commission, described these policies as genocide. Children placed in institutions experienced systematic abuse, neglect and cultural destruction. The intergenerational trauma these policies produced continues to manifest in excess mortality: a study of Aboriginal children admitted to Sydney Children's Hospitals found their in-hospital mortality rate was double that of non-Aboriginal children *(Craven et al., 2019)*.

> If we remove children from family care, and concentrate them in institutions, they will die.

Contemporary mortality: not a relic of the past

This is not a closed chapter. A 2020 peer-reviewed systematic review of 25 studies across nine countries in Asia, four in Africa, three in Eastern Europe, and of some settings in South America and the Caribbean, confirmed that the health deficits documented in Romanian and Irish institutions are not historical anomalies — they are an ongoing, consistent feature of orphanages globally *(DeLacey, Reed, Kyte and Wolff, PeerJ, 2020)*.

In Sudan, before the current conflict, the Mygoma orphanage in Khartoum had infant mortality rates of 75%, with two or more babies to a cot and rampant cross-infection *(Reuters, 2014)*. A landmark longitudinal study — the most rigorous of its kind — tracked mortality across the entire life course of children placed in Swiss infant care institutions, where physical and medical care was adequate but individual responsive attention was structurally absent. Those children were 1.5 times more likely to die than peers raised in families in the same location — a mortality differential comparable to the effect of smoking *(Lannen et al., Child Abuse and Neglect, 2026)*. Deaths before age 40 were twice as common in the institutionalised group. The harm was found to be caused by the lack of individual care within an institutional setting.

Children continue to die now, today, in orphanages and residential institutions, unnecessarily.

The deadly impact on children with disabilities

Children with disabilities are disproportionately represented in orphanages and residential institutions around the world because of stigma and because their families are denied the community support, resources and services that would allow them to remain at home. The Lancet Commission on institutionalisation confirmed this directly, noting that children with disabilities are overrepresented in institutions globally *(van IJzendoorn et al., Lancet Psychiatry, 2020)*. UNICEF estimates that children with disabilities are up to 17 times more likely to enter residential institutions than their peers without disabilities, rising to up to 30 times in Europe and Central Asia *(UNICEF, 2022)*. Once placed, these children face compounded harm: the Lancet Commission's policy recommendations identify children with disabilities in institutions as facing the greatest risks to their development, health, welfare and protection from abuse of any group *(Goldman et al., Lancet Child and Adolescent Health, 2020)*. The consequences at their most extreme are documented in Romania, where Cighid — a facility established specifically for children with disabilities — recorded the deaths of 160 of 183 children admitted, an 87% mortality rate, in just 30 months of operation *(IICCMER, 2022)*. The UN Committee on the Rights of Persons with Disabilities made a formal legal determination in 2022 that children with disabilities confined in Ukrainian institutions face a disproportionate mortality risk *(OHCHR/CRPD, October 2022)*. What the evidence establishes beyond reasonable doubt is that of all the children placed in orphanages, children with disabilities are the most likely to die.

The UN's verdict: orphanages as prisons

The United Nations Global Study on Children Deprived of Liberty *(Nowak, 2019)* — the first comprehensive scientific attempt to document the situation of children deprived of liberty globally — concluded that conditions in residential institutions for children are often characterised by violence, sexual abuse and neglect, amounting to inhuman and degrading treatment. Professor Nowak's study identified the most egregious features of institutional settings as: separation and isolation from families and communities; forced cohabitation; depersonalisation; lack of individual care; instability of caregiver relationships; lack of self-determination; and fixed routines not tailored to individual needs. The most direct forms of deprivation of liberty documented included solitary confinement, physical restraints and forced medication.

The study found that many children move through a vicious cycle of different deprivations throughout childhood — from orphanage, to 'educational supervision' institutions, to drug rehabilitation, to imprisonment and reoffending. The orphanage is not a refuge from this cycle. For many children, it is its starting point.

Children with disabilities are at the sharp end of this. They are disproportionately placed in institutions precisely because community-based support is absent, and once placed, they face the highest risks of abuse, neglect and invisible suffering. Girls with disabilities in institutions face elevated rates of both physical and sexual violence *(Ćirić Milovanović, 2013; HHC Families Not Institutions Roadmap, 2022)*.

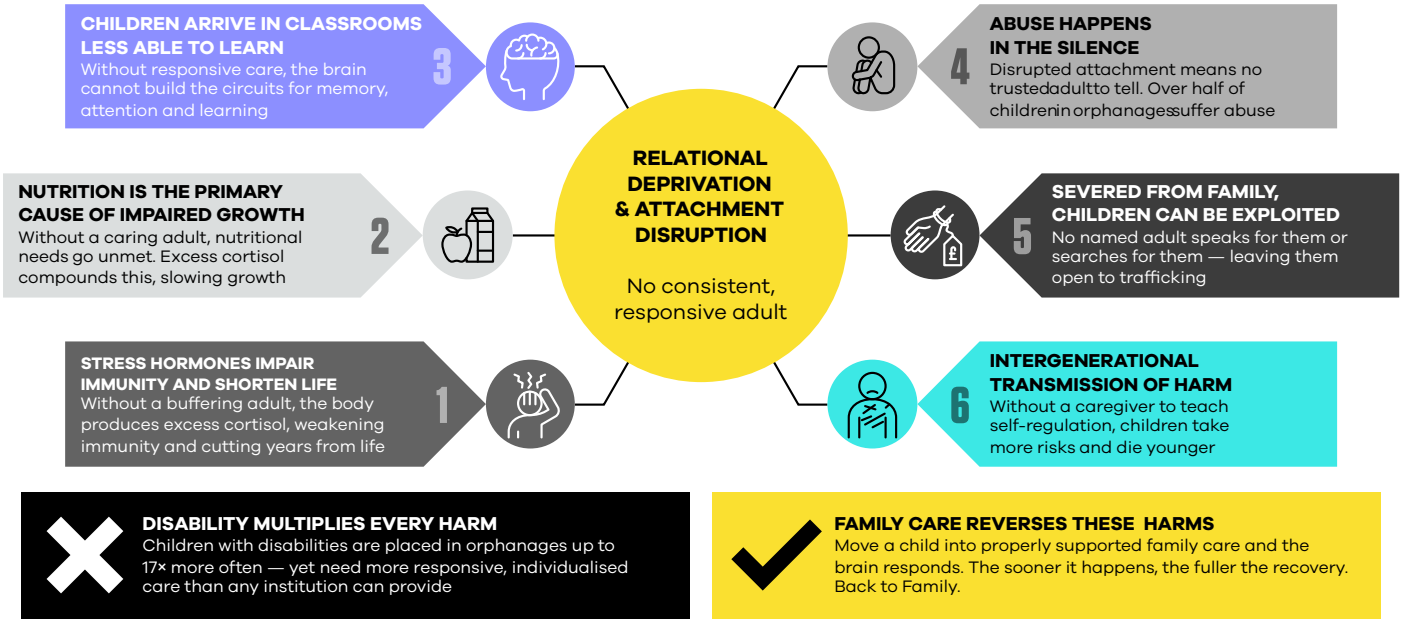
Photo 2: ***Institution, India.*** *Hope and Homes for Children*

2. HOW ORPHANAGES DISRUPT OR SEVER ATTACHMENT

Human beings did not evolve in confinement in buildings. We evolved in no small part in response to childhood experiences of close, caring relationships — specifically, in the consistent, responsive, individually attentive relationships with a small number of caregivers. Orphanages and residential institutions deprive children of those kinds of relationships and disrupt the attachment that is so crucial for a child's development. The science establishes the predictable, measurable consequences of separating children from the people who love and care for them.

WHY ORPHANAGES HARM CHILDREN

Key harms flow from the same casual pathways



1. **Without a buffering adult, the body produces excess cortisol weakening immunity and elevating the risk of mortality.**
When a child is distressed, a caring adult helps them calm down. That process — repeated thousands of times across the first years of life — teaches the body's stress system how to regulate itself. In an orphanage, there is no consistent adult to provide that. Babies confined in orphanages learn not to cry because they go unattended for prolonged periods. The body's stress response stays switched on for too long, producing excess cortisol. Over time, this weakens the immune system, making children less able to fight off illness. As documented in the landmark Swiss study described in Section 1, this mechanism alone — in the absence of any physical neglect — produces a mortality differential comparable to smoking, and an estimated 12 years of lost life.
(Lannen et al., Child Abuse & Neglect, 2026)

2. **Without a caring adult noticing whether a child is eating well, nutritional needs go unmet — and impaired growth follows.**
Relational deprivation and growth impairment are directly connected. A responsive caregiver notices that a child is not finishing their food, is losing weight, or is falling ill more often. In an orphanage, with too many children and too few staff, those individual signs go unseen. The result is measurable: across 308 studies covering more than 100,000 children in over 60 countries, the average child in institutional care falls in the bottom 12% of expected height and weight for their age — as if their body were three to four years behind where it should be. For children under 6 months, the deficit is worse still, placing them in the bottom 5%. Excess cortisol from unregulated stress compounds this, actively suppressing physical development. A child at this level of growth deficit is between 40% and 70% more likely to die from common infections like pneumonia and diarrhoea than a well-nourished peer.
(van IJzendoorn et al., Lancet Psychiatry, 2020)

3. **The brain is built through relational interactions — without it, children arrive in classrooms less able to learn.**
In the first years of life, every time an infant reaches out and a responsive adult reacts — picking them up, making eye contact, using words — a connection forms in the brain. These exchanges, repeated daily, build the neural circuits that underpin attention, memory and the ability to think. In an orphanage, those exchanges simply do not happen at the scale children need. Without that relational foundation, the body produces excess cortisol that interferes with the development of the part of the brain responsible for concentration, working memory and learning. The consequence is a cognitive gap equivalent to five to six years of missed schooling — and unlike most gaps, it does not close with time. Research tracking children into adolescence found it widened rather than narrowed, precisely as education was making greater demands on the very capacities that had been suppressed. *(van IJzendoorn et al., Lancet Psychiatry, 2020; Evans & Yuan, World Bank, 2019; Wade et al., PNAS, 2019)*

4. **Disrupted attachment leaves children without a trusted adult to turn to.**
One of the most important things a secure attachment gives a child is an adult they trust: someone they can go to when something frightening or upsetting happens, and who they trust will believe them and act. When attachment is disrupted — as it is in every orphanage, where only 24% of children develop secure attachment compared to 62% in family care — children lose that resource. There is no trusted adult to tell. And in a closed system with no family watching from outside, no community oversight, and no safe way to report, abuse is able to happen and persist unseen. More than half of all children in orphanages experience physical or sexual abuse — at a rate six times higher than in foster care. That figure is not a reflection of the people who work in orphanages. It is a reflection of the structural conditions in which there is no adult with an unconditional bond to a child. *(Sherr et al., Psychology, Health & Medicine, 2017; van IJzendoorn et al., Lancet Psychiatry, 2020)*

5. **Separated from the family who loves them, with no named adult to speak for them, children become vulnerable to trafficking, forced labour and sexual exploitation.**
Intact family bonds are the primary protection against exploitation. A parent notices their child is missing. A family member refuses when someone tries to take them. A relative searches, reports, pursues. When a child is placed in an orphanage, those bonds are severed. There is no named individual with a personal commitment to that child — no one to speak for them, search for them, or refuse on their behalf. That structural absence is what makes exploitation possible. Research across conflict settings in the Democratic Republic of Congo, Central African Republic and Sierra Leone found that the presence of intact family relationships was the single strongest protection against forced recruitment and exploitation, and its absence the single strongest vulnerability. In Ukraine, an estimated 20,500 children were taken to Russia following the 2022 invasion, many of them from residential institutions.
(Yale Humanitarian Research Lab, 2023; IRC, PLOS ONE, 2023)

6. **Without a caregiver to help them learn to manage their own feelings and behaviour, children go on to take more risks throughout later life, and die younger.**
Self-regulation — the ability to manage emotions, assess risk, and make safe decisions — is not something children are born with. It develops gradually, through thousands of interactions with a caring adult who helps a child calm down, think through consequences, and understand the world around them. Children raised in orphanages miss this process entirely. The Swiss study cited above found a striking pattern in the causes of death among those who had been institutionalised: only 25% died from natural causes, compared to 64% of those raised in families. The excess deaths were from accidents, violence, and causes that could not be determined — a pattern consistent with impaired self-regulation and risk-taking behaviour across a lifetime. This intergenerational transmission of harm does not stop with the individual: children who were never taught to regulate themselves struggle to provide the consistent, responsive care that their own children need. Close to half of parents who placed children in Ukrainian orphanages had themselves grown up in institutions. The cycle continues until it is interrupted — by a family.
(Lannen et al., Child Abuse & Neglect, 2026; Children's Ombudsman of Ukraine, 2021)

Children with disabilities are particularly vulnerable to attachment disruption in institutional settings, both because their needs require more consistent responsive adult attention — which institutions structurally cannot provide — and because the institutional environment offers no mechanism for the kind of individually adapted interaction that their development requires.

Neuroimaging confirms much of this. *Tottenham et al. (2010)* used magnetic resonance imaging to assess brain structure in children with histories in orphanages and found significant neural differences, including poorer emotion regulation and elevated anxiety. More than 50% of children with orphanage histories met criteria for a psychiatric disorder, with a third meeting criteria specifically for anxiety disorder *(Developmental Science, 2010)*. This is a brain that has been shaped for threat-scanning rather than for learning, exploring and connecting.

It is important not to stigmatise or generalise about these children on the basis of these findings, because these harms can be largely overcome or managed by transitioning children into properly supported family care. The Bucharest Early Intervention Project — the most rigorous longitudinal study of institutional care ever conducted — found that children moved from orphanages into family care showed significant neurological and cognitive recovery, with earlier placement producing better outcomes *(Wade, Fox, Zeanah and Nelson, American Journal of Psychiatry, 2023)*. This is consistent with 30 years of practice and experience at Hope and Homes for Children. The harms produced by orphanages are not necessarily permanent. The brain responds to relationships — and it can recover.

3. WHAT ORPHANAGES DO TO CHILDREN'S HEALTH

The harm of orphanages is not only psychological. It is physical — embedded in children's bones, their blood and their immune systems. Orphanages produce malnourished, stunted, iron-deficient children whose bodies are less able to fight infection, less able to survive illness, and less likely to develop into healthy adults.

Stunting and physical growth failure

Children in orphanages do not simply grow more slowly. They lose ground. A landmark analysis of Romanian, Chinese and Russian children confined in residential institutions and orphanages found that for every 2.63 months spent in them, a Romanian child lost one month of linear growth. For Chinese children the figure was one month lost for every 3.03 months of confinement. For Russian children, one month lost for every 3.36 months. Across all three populations, the relationship was the same: the longer the child stayed, the further behind they fell *(Johnson, D.E., 2000)*. Essentially, for every three months a child spends in an orphanage, they lose approximately one month of physical growth.

This growth deficit in orphanage settings is consistent and unrelenting globally. In Ethiopia, a 2019 cross-sectional study found stunting in 45.8% of children under five in Addis Ababa orphanages — more than double the national average for that age group *(Tesfaye et al., BMC Nutrition, 2021)*. A meta-analysis of 55 studies involving 12,797 children — drawn from research spanning more than 60 countries — found that children in orphanages were, on average, in the bottom 12% of expected height for their age *(van IJzendoorn et al., Lancet Psychiatry, 2020)*.

Stunting is not limited in its consequences to height. Children who spend even relatively short periods — less than six months — in orphanage settings will have head circumferences significantly smaller than they should have been by the age of six — falling to a position that fewer than one child in 750 would normally occupy at their age. This is the measurable consequence of what confinement in orphanages does to children's brains *(Sonuga-Barke et al., Developmental Medicine and Child Neurology, 2008)*.

Stunting reflects sustained nutritional deprivation that reshapes the body's developmental trajectory. Children who are stunted have compromised organ development, weakened immune systems and are significantly more likely to die from common childhood illnesses. A 2013 global analysis found that children with simultaneous stunting, underweight and wasting had a mortality hazard ratio of 12.3 — more than twelve times the mortality risk of well-nourished children *(McDonald et al., 2013)*.

Photo 3: ***Institution, Kenya.*** *Hope and Homes for Children*

Photo 4: ***Institution, Rwanda.*** *Hope and Homes for Children*

Iron deficiency, anaemia and immune failure

Iron deficiency is documented in 15–25% of children leaving orphanages, and anaemia in up to 54% at the point of transition *(Fuglestad et al., 2016; Miller et al., 2021; Yildiz et al., 2022)*. Iron is essential for immune function: iron-deficient children have weakened immune responses and are less able to fight infection at the cellular level. Iron deficiency anaemia is independently associated with 1.2 to 1.5 times elevated mortality through impaired immune function *(Stoltzfus, Mullany and Black, 2004)*. Iron deficiency also predicts worse outcomes on IQ and attention measures *(Doom, Georgieff and Gunnar, Developmental Science, 2015)*.

Infection, detection failure and preventable death

In settings where children receive limited individual adult attention, fever onset and early illness deterioration frequently go undetected for hours or days. In lower and middle income countries — where pneumonia and diarrhoeal disease are leading causes of child mortality — the difference between prompt and delayed care-seeking is the difference between recovery and death. The case fatality rate in untreated pneumonia can exceed 20%, and death can occur within three days of illness onset *(Sazawal and Black, Lancet Infectious Diseases, 2003; Källander et al., WHO Bulletin, 2008)*. Timely case management reduces pneumonia mortality by 35–40% *(Källander et al., 2008)*. In orphanages, that management frequently does not happen.

A 2020 review of 25 studies from four continents confirmed these patterns hold across residential institutions and orphanages globally: stunting ranges from 9% to 72%; underweight from 7% to 79%; anaemia from 3% to 90%; parasitic infection from 6% to 76% *(DeLacey et al., PeerJ, 2020)*. These are significant predictors of elevated mortality.

4. WHAT ORPHANAGES DO TO CHILDREN'S EDUCATION OUTCOMES

Orphanages do not just harm children's physical health. They suppress their cognitive development, erode their capacity to learn and systematically reduce their life chances — regardless of the quality of any education provided.

A review of 308 studies involving more than 100,000 children across more than 60 countries found that children growing up in orphanages consistently score significantly lower on cognitive tests than children growing up in families — and the gap is largest in the youngest children, during the years when the brain is developing fastest *(van IJzendoorn et al., Lancet Psychiatry, 2020)*. Using a World Bank framework that converts cognitive test scores into years of schooling, that gap translates to five to six years of learning that a child in an orphanage never acquires *(Evans and Yuan, World Bank, 2019)*.

That gap does not close as children get older. It gets worse. Research tracking children from the Bucharest Early Intervention Project found that by adolescence, the difference in memory and learning capacity compared to children who had grown up in families had widened, not narrowed *(Wade et al., PNAS, 2019)*. A study following people who had been placed in orphanages as infants, then tracking them for sixty years, found the same memory deficits still clearly present in late adulthood *(Sand et al., Child Abuse and Neglect, 2024)*.

The mechanism that produces this harm is well-established. When the brain detects threat — whether a physical danger or the chronic threat established in an unresponsive care environment — it activates the stress response and suppresses the prefrontal cortex: the seat of executive function, working memory, inhibitory control and cognitive flexibility — precisely the capacities that formal learning requires. Under chronic toxic stress without a responsive adult to buffer it, this suppression becomes structural *(Shonkoff, Garner et al., Pediatrics, 2012)*.

Windsor et al. (2011) assessed language outcomes at age eight in the Bucharest Early Intervention Project: children remaining in residential institutions showed stunted sentence lengths, weak sentence repetition and poor written word identification — measures that directly correspond to early literacy *(Journal of Child Language, 2011)*. Children placed in foster care by age 13 performed similarly to their peers growing up in families. The only variable producing this difference was whether the child was benefiting from the care and protection of a family.

Being iron deficient makes the cognitive harm worse. A study of children who had left orphanages found that those who had been iron deficient had lower IQs and higher rates of ADHD symptoms years after leaving — on top of the harm caused by the lack of individual care alone *(Doom, Georgieff and Gunnar, Developmental Science, 2015)*. For children with disabilities, this compounds further still: the disability and the deprivation make each other worse.

Photo 5: ***Institution, Bosnia.*** *Hope and Homes for Children*

5. VIOLENCE AND SEXUAL EXPLOITATION INSIDE ORPHANAGES

Orphanages are not safe. Violence against children inside residential institutions is endemic and structurally enabled as a predictable consequence of concentrating vulnerable children in closed settings with high child-to-adult ratios, weak external oversight, and limited access to safe reporting mechanisms.

The global evidence base

The UN Secretary-General's World Report on Violence Against Children *(Pinheiro, 2006)* documented a catalogue of rights violations endemic to institutional settings: verbal abuse, beatings and physical torture, sexual abuse including rape, and psychological harm including isolation, harassment, humiliating discipline, solitary confinement, physical restraints and forced medication.

In Kazakhstan, a 2002 study found that over 63% of children in residential institutions reported being subjected to violence, with 28% saying it occurred regularly. In Romania, almost half of institutionalised children confirmed that beating was routine punishment, and more than a third knew of children who had been forced to have sex *(Stativa, UNICEF, 2000)*. In India, 56.37% of children in institutions across the country reported physical abuse by staff members *(Kacker, Varadan and Kumar, 2007)*. In Ireland, the Commission to Enquire into Child Abuse identified 800 perpetrators responsible for the physical and sexual abuse of 1,090 children across Irish institutions between 1914 and 2000. In North America, violence against children in residential institutions is six times more prevalent than violence in foster care *(Spencer and Knudsen, 1992; cited in Barth, 2002)*.

Sherr et al. (2017) found that over half of all children in institutional care experienced physical or sexual abuse. This is the result of a system in which children are simultaneously isolated, disempowered and denied access to reporting mechanisms. Where there is no one to tell, abuse continues.

Children with disabilities are at the greatest risk. They may be less able to report what is happening to them, less likely to be believed, and more likely to be isolated in wards or units where external oversight is minimal *(HHC Families Not Institutions Roadmap, 2022; Ćirić Milovanović, 2013)*. Girls with disabilities face specifically elevated risks of sexual violence.

Predatory recruitment into orphanages

Particularly disturbing is the evidence of deliberate abuse by institutions themselves. The Lancet Commission documented that the absence of robust safeguarding policies in many orphanages, combined with high child-to-adult ratios and limited oversight, had placed children at risk of trafficking for sex or labour, exploitation through orphan tourism and harm through medical experimentation *(van IJzendoorn et al., Lancet Psychiatry, 2020)*.

A study in Malawi found that more than 50% of the orphanages examined were engaged in directly recruiting children from families — actively removing children from their parents, not protecting children who had lost them *(Lumos, 2016, cited in Lancet Commission 2, 2020)*. These are not child protection institutions. They are institutions that manufacture the very crisis they claim to address.

Sinet Chan, a survivor who had been placed in an orphanage in Cambodia, described her experience to an Australian parliamentary inquiry: children were required to perform for visiting tourists — singing, playing games, learning languages — while any gifts brought for the children were confiscated by the director and sold. The Australian parliamentary committee concluded that there was persuasive evidence that children were trafficked into orphanages for the purposes of exploitation, and that the situation should be considered a form of modern slavery. Australia subsequently passed the Modern Slavery Act 2018, in which the explanatory memorandum explicitly names the trafficking and exploitation of children in orphanages as an example of modern slavery *(Parliament of Australia, 2017; 2018)*.

6. TRAFFICKING, FORCED LABOUR AND THE ORPHANAGE ECONOMY

The voluntourism industry — in which paying visitors travel to orphanages to volunteer with children — is estimated to be worth approximately US$2.6 billion per year, involving 1.6 million people annually *(ReThink Orphanages, cited in Lancet Commission 2, 2020)*. [Note: this figure is not independently verified against a primary source.] Children are commoditised within them. The industry creates direct financial incentives to recruit children into orphanages, maintain them in conditions of visible poverty and suffering to attract donations, and prevent their return to families. This is not a side effect — it is the business model.

The Lumos Foundation's Cycles of Exploitation report (2021) documented the systematic links between residential institutions and human trafficking. *Van Doore (2016)* coined the term 'paper orphans' to describe children who are falsely documented as 'orphans' or 'abandoned' in order to facilitate their placement in institutions that attract international donations and voluntourists. In Cambodia, at least 248 orphanages were found to be financially supported by voluntourism, with children kept malnourished and in poor conditions to maximise donor sympathy *(UNICEF Cambodia, 2016, cited in Lancet Commission 2, 2020)*.

Beyond voluntourism, orphanages create conditions of heightened vulnerability to other forms of trafficking and forced labour. Children who grow up without family bonds, without named adults responsible for them, and without legal visibility are easier to exploit. *Laverde Palma et al. (2025)* established that institutional fragility in conflict-affected settings directly facilitates criminal networks and increases recruitment of children into armed groups and exploitation *(Social Sciences, MDPI, 2025)*.

In Ukraine, Yale's Humanitarian Research Lab found that many of the estimated 20,500 Ukrainian children forcibly transferred to Russia since February 2022 had been taken from orphanages and residential institutions in occupied regions *(Yale Humanitarian Research Lab, 2023)*. These children had no named adult to refuse, resist or search for them. The family bond that might have protected them had already been severed before the first Russian soldier arrived.

Photo 6: ***Institution, Romania.*** *Hope and Homes for Children*

7. HOW THESE HARMS COMPOUND EACH OTHER

Each of the harms described here — mortality, attachment disruption, physical health problems, cognitive suppression, violence, exploitation and trafficking — does not operate in isolation. They compound, amplify and accelerate each other through a set of interlocking mechanisms that make the sum of orphanage harm substantially worse than any individual component would suggest.

The child who enters an orphanage as an infant begins to experience relational deprivation immediately. The absence of individual responsive care activates the stress response, suppresses brain development and disrupts the formation of secure attachment. This simultaneously impairs the child's immune function — through the harm that prolonged stress hormones do to the immune system — making them more vulnerable to the infections to which overcrowded, under-resourced institutional environments expose them. Iron deficiency, which develops in a setting where nutrition is inadequate and individual dietary needs go unaddressed, further suppresses immune function and compounds the cognitive harm already being produced by relational deprivation. These three pathways — relational, nutritional and immunological — operate independently and multiply the consequences of each other *(McDonald et al., 2013)*.

The child who is already cognitively suppressed — whose executive function is impaired by chronic toxic stress and whose working memory is reduced by relational deprivation — is also the child least able to recognise, articulate or report abuse when it occurs. The attachment disruption that makes the child desperate for adult attention makes them more susceptible to exploitation by adults who offer it. The physical weakness produced by malnutrition and iron deficiency makes the child less able to resist.

Children with disabilities face this compounding with particular severity. Placed disproportionately in institutions, they arrive in settings that are structurally incapable of meeting their specific needs. Their developmental trajectory is then shaped not only by the generic harms of institutional care but also by the specific failure of the institution to provide the adapted, individual, disability-appropriate care their development requires.

The longer the child stays, the worse each harm becomes. The Lancet Commission meta-analysis confirms that a longer duration in institutions is associated with greater deficits across every developmental measure *(van IJzendoorn et al., 2020)*. In the Bucharest Early Intervention Project, the gap in working memory between children who remained in institutions and those placed in families widened across adolescence *(Wade et al., 2019)*.

> Only 21% of adults who grew up with parents report poor health three decades later. For those who lived in residential care during childhood, this rises to 85%. A systematic review drawing on more than 3.2 million people found that children with state care experience had more than double the mortality risk and more than three times the suicide risk in adulthood compared to those who grew up in families *(Batty, Kivimäki and Frank, Lancet Public Health, 2022)*. Almost half of parents in Ukraine who placed their babies in orphanages had themselves grown up in institutions *(Children's Ombudsman of Ukraine, 2021)*. The cycle continues until it is interrupted — by a family.

Photo 7: ***Institution, Rwanda.*** *Hope and Homes for Children*

8. EVEN WELL-RUN ORPHANAGES CAUSE HARM

At this point, a reasonable person might ask: if the problem is inadequate staffing, poor nutrition, weak oversight and underfunding, why not simply improve orphanages? This is the wrong question — and asking it reflects a fundamental misunderstanding of how orphanage harms are produced.

The harm that orphanages cause does not arise primarily from their shortcomings. It arises from their structure. A child does not need more resources in their orphanage. They need a family. No level of resourcing can provide that. No staffing ratio can replicate the unconditional commitment of a parent. No training curriculum can manufacture the individual, consistent relationship on which human development depends.

The evidence is explicit on this point. The Bucharest Early Intervention Project compared children in institutions of varying quality, including improved institutional settings. Even in those improved settings, children showed persistent deficits across cognitive, emotional and physical development compared with children placed in foster care *(Wade, Fox, Zeanah and Nelson, American Journal of Psychiatry, 2023)*. The Lancet Commission concluded on the basis of over 300 studies that even small, well-resourced institutions with adequate staffing ratios still produce worse outcomes than family-based care *(van IJzendoorn et al., 2020)*. The London residential nurseries of the 1960s and 1970s — small, well-staffed, UK-regulated — produced children with IQs significantly lower than children who had not been institutionalised *(Tizard and Rees, 1974)*.

THE QUESTION IS NEVER 'WHAT IS THE BEST VERSION OF THIS ORPHANAGE?' THE QUESTION IS 'WHY IS THIS CHILD NOT IN A FAMILY?'

Attempting to improve orphanages also carries a specific danger: it lends them legitimacy. Every pound spent improving an orphanage is a pound not spent on the family support services that would have prevented the child's separation in the first place.

Government-run and private orphanages: different ownership, the same harm

Orphanages come in two broad forms: those run by governments, and those run privately — by charities, faith-based organisations, NGOs, or individual operators. Both inflict the same fundamental harm on children. But they do so through different mechanisms, and understanding the difference matters for reform.

Government-run orphanages — the dominant model in Eastern Europe, the former Soviet states and some parts of Asia — are typically funded on a per capita basis: the more children referred into the system, the more budget the institution receives. This creates a structural incentive to fill beds rather than support families. In Ukraine before 2022, approximately 105,000 children were in residential institutions — the highest number in Europe outside Russia, with around 50% having disabilities *(HRW, 2023; DRI, 2022)*. In Russia, the residential institutional population is estimated at 400,000–500,000 *(Desmond et al., 2020)*.

Private orphanages — run by charities, faith-based organisations and NGOs — operate on a different logic, but one that is equally harmful. Their funding depends substantially on donors and volunteers. Their existence requires a visible supply of children in need. In Cambodia, Ghana and other countries with large private orphanage sectors, the overwhelming majority of children in orphanages have at least one living parent. In Ghana, a government study found that 90% of children in orphanages had living parents and that 140 of the 148 orphanages in the country were unregistered *(Disability Rights International)*. The private orphanage sector in these countries is not a response to child welfare need. It is a marketplace that commoditises children.

Both government and private orphanages share the same fundamental problem: they are built on the premise that separating children from families and concentrating them in institutions is a workable solution to child wellbeing. It is not. It never has been. And more than 100 years of evidence proves it beyond any reasonable doubt.

Photo 8: ***Institution, Bosnia.*** *Hope and Homes for Children*

Photo 9: ***Claire* back with her family, Rwanda.*** *Mushimiyimana Cadeau / Hope and Homes for Children*

9. THE ALTERNATIVE IS FAMILY — AND IT WORKS

Eliminating orphanages does not mean abandoning children. It means investing in the systems that keep families together and ensure every child has a committed adult in their life.

Countries that have done this — Bulgaria, Moldova, Romania and Rwanda — are on the verge of eliminating orphanages entirely and have consistently achieved better outcomes for children at a fraction of the cost. Orphanages can cost nearly ten times as much as keeping a child safely at home *(HHC Statistics Bank)*. The Heckman Equation demonstrates returns of approximately 13% per year for high-quality early childhood investment in responsive caregiving environments.

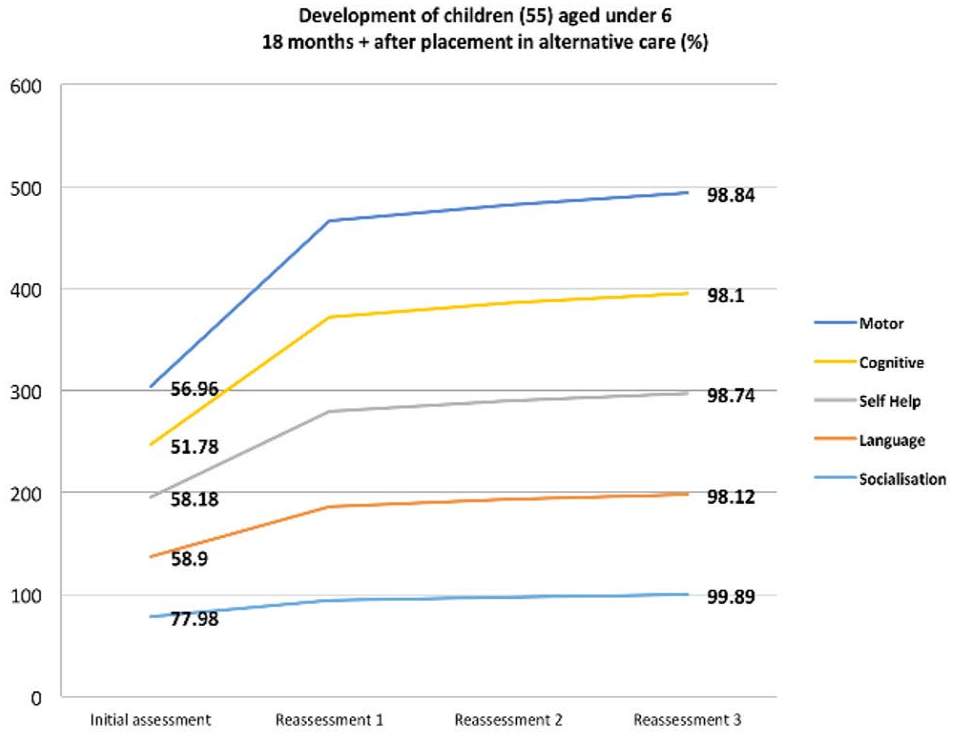
The alternative to orphanages is a diversity of family care options: services that address the root causes of family separation — poverty, disability, discrimination, lack of access to health and social services — before separation happens; gatekeeping systems that ensure no child enters any institution without rigorous assessment; kinship care, where extended family are supported to care for children; foster care, in which trained and supported families provide temporary care while reunification work continues; and, where necessary, deinstitutionalisation — the planned, safe, well-resourced closure of orphanages and their replacement with community-based family support services.

The Bucharest Early Intervention Project demonstrated that children moved from orphanages into family-based care showed IQ scores averaging nine points above their institutionally reared peers — sustained across more than twenty years of follow-up *(King et al., 2023)*. That is approximately three years of grade-equivalent cognitive recovery, produced by a single change: a family.

HHC's own results: Rwanda, South Africa, Moldova

The data from Hope and Homes for Children's Rwanda programme provides some of the most important evidence of what recovery from orphanage harm looks like in practice. Fifty-five children under the age of six were assessed at the point of transition from one of Rwanda's largest orphanages and then reassessed at six, twelve and eighteen months. At baseline — the moment they left the orphanage — these children showed developmental deficits across every domain measured: motor skills, cognition, language, self-help and socialisation.

These were not children with fixed or intrinsic limitations. They were children whose development had been suppressed by the care environment. Across each domain, scores moved steeply upward. By the third assessment at eighteen months, all five domains had reached scores in the high nineties — approaching or reaching levels typical for their age.



What the Rwanda data establishes, beyond any reasonable doubt, is that the harm orphanages cause to children is not the outcome of poverty, disability or the circumstances that led to separation. It is the direct, measurable, reversible consequence of the orphanage itself. We have similar data showing the same positive outcomes for children transitioned out of orphanages and into supported families in South Africa and Moldova.

REMOVE THE ORPHANAGE. BACK TO FAMILY. THE REST FOLLOWS.

Hope and Homes for Children exists as the catalyst for the global elimination of orphanages. We help governments, local authorities and those involved with running orphanages and institutions to close them safely, and to replace them with the systems that ensure every child can get Back to Family.

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HOPE AND HOMES FOR CHILDREN

About Hope and Homes for Children

5.4 million children around the world are unnecessarily confined to residential institutions, separated from family and at risk of serious emotional and physical harm, abuse and neglect.

Orphanages and institutions cannot provide children with the quality of care they need - children's care needs reform, family care needs strengthening.

We work to increase local skills and commitment, supporting partners to provide sustainable family-based solutions for all children, and to reform care systems away from institutional care and **Back to Family**.

BACK TO FAMILY

** Names changed to protect identities*

Head office
Hope and Homes for Children
Wilton Village, King Street
Wilton, Salisbury
SP2 0RS, UK

hopeandhomes.org

Email
info@hopeandhomes.org

Phone
+44 (0)1722 790111