



CONFINED IN CONFLICT

The increased mortality risk faced by children confined in residential institutions and orphanages during armed conflict, and how to prevent it



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Chief Executive

Hope and Homes for Children, 2026

IRYNA & OLHA’S STORY

Iryna* was taken from her mother not long after she was born. The system judged that, rather than put the hard yards in to support her mother to overcome her alcoholism, confining Iryna in one of Ukraine’s many residential institutions would somehow be better.

But better for who?

By the age of 18, the process of institutionalisation, and the complete severance of all contact with her family and their community, left Iryna vulnerable to exploitation. Marrying early, she was trapped in a deeply abusive relationship, marred by extreme sexual violence. She became pregnant and gave birth to Olha*. They suffered such appalling brutality that Olha was permanently disabled by it. Then the full-scale invasion hit, and they were caught up in a major conflict. While their evacuation somehow served as a lifeline by enabling them to escape Iryna’s husband’s violence, she nevertheless came under immense pressure from children’s services to give up Olha to a system of child institutionalisation. This filled her with dread because, in her own words:

Iryna was all too familiar with the system she had suffered within. Abuse. Continuously falling ill, and almost as continuously being left without treatment. Staff worked on shifts – a system that actively disrupted and prevented any close, caring relationship from forming between carer and cared-for. And she had seen other children die as a consequence.

Iryna and Olha found accommodation for displaced families, and it was then that one of Hope and Homes for Children’s mobile support teams connected with them. The support they provided was specifically designed to keep Olha and her Mum together. They assessed Olha’s needs and developed a targeted therapeutic plan, helped with the disability registration process so Iryna could access the grant she qualified for as a carer, and provided trauma counselling, training on how to care for a child with Olha’s disabilities, food and clothing. And Iryna was connected into a support network with other parents who had experienced similar challenges. She was no longer alone.

“
For a baby with disabilities, at a time of war, placing her in an institution would have been a death sentence.
”

Hope and Homes for Children’s mobile support team, Ukraine.
Hope and Homes for Children



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* To ensure the safety and privacy of the people we support, the names of the children, relatives and carers featured in this publication have been changed.

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RESIDENTIAL INSTITUTIONS AND ORPHANAGES: an important definition

RESIDENTIAL INSTITUTION

The scale of a residential institution is not only what determines the harm it inflicts on a child. *UNICEF's ICare classification (2026)* states, "small size alone does not guarantee better care or outcomes for children," since the quality of care also depends on what it terms "institutional culture": staff to child ratios, staff turnover and shift patterns, the length and purpose of a child's placement, and whether care is individualised, and that:

“

A residential institution is any setting providing alternative care... in collective living quarters... by paid, unpaid or voluntary staff ensuring continuous, 24-hour in-house care

”

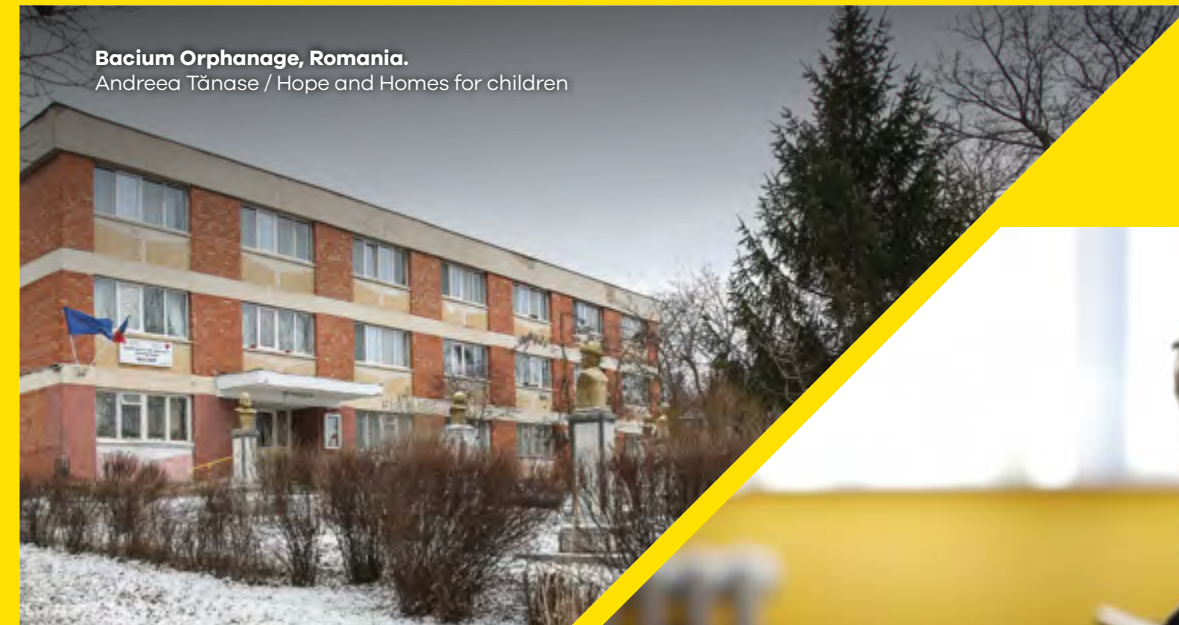
(*UNICEF, 2026*)

This covers both large scale facilities and small group homes. Neither the *UN Guidelines for the Alternative Care of Children (2009)* nor ICare treats headcount as the boundary between residential and family care. **Family care** is instead defined narrowly, as care **“provided to a child by private individuals in a private household”** (*ICare, 2026*), a test a staffed, shared residence does not meet regardless of its size.

This report does not include Ukraine's family type children's homes, (дитячий будинок сімейного типу - children's home of family type) within the above definition of residential institution. Under Ukrainian legislation, a family type children's home is a placement with a married couple or a single unmarried adult, legally designated as full time foster parents or guardians, who take 5 to 10 children into their own household, with the total number of children including any of the carers' own capped at 10 (*Cabinet of Ministers of Ukraine, Resolution No. 564, 26 April 2002, Regulation on the Family Type Children's Home, as amended*).

The regulation itself frames this as a family form of upbringing, distinct from institutional care. This report follows that classification because it reflects the legal status of the carers, as genuine foster parents rather than staff. ICare's own generic category of family type group homes sits inside residential care, and in countries where a family type home is staffed on a rotating basis rather than run by legally designated foster parents, for example some models used in Romania, that generic classification would still apply.

The definition used in this report is applied specifically to Ukraine. Anyone applying it outside Ukraine should check the legal and staffing structure of the specific arrangement rather than assume the definition transfers automatically.



Bacium Orphanage, Romania.
Andreea Tănase / Hope and Homes for children



Institution, Bosnia.
Hope and Homes for Children

ORPHANAGE

An orphanage is a form of residential institution, defined by ICare as:

“

A residential facility in which groups of children, whether orphan or otherwise, are cared for by paid personnel in a non-family-based environment

”

(*Chik et al., 2020, as cited in ICare, 2026*)

This report does not treat orphanages as a separate or lesser category of harm than other residential institutions, and emphasises throughout how most children living in orphanages are not orphans.

KEY INSIGHTS AT A GLANCE

▶ **5.4 million children** are confined in residential institutions and orphanages around the world. The vast majority of these children are not orphans.

▶ **Residential institutions and orphanages are not only harmful. They are lethal.** Even during peacetime. This report finds that children confined in residential institutions and orphanages during peacetime are almost three times as likely to die than children cared for in families. Children with disabilities, who are commonly over-represented in these settings, face a much higher risk of death.

▶ **Up to 1.2 million children** are currently confined in residential institutions and orphanages in countries affected by armed conflict. The number of conflicts around the world more than doubled from 31 in 2010 to 65 in 2025 – the highest number since the systematic recording of conflicts began in 1946. That number is expected to continue to grow, meaning more children confined in residential institutions and orphanages are likely to get caught up in crisis.

▶ **Most of these children have at least one living parent.** They are, in the main, separated from their families because of underlying factors such as poverty, disability or discrimination, not because they do not have a family.

▶ **Children confined in residential institutions and orphanages in conflict-affected countries face a mortality risk at least 2.02 times higher than children cared for in families living through the same conflict.** A deliberately hostile, adversarial version of this model, built entirely from values set below the floor for each of the components used in the main model, still produces a higher figure for this same comparison, 2.12 times. This report treats that result as evidence that 2.02 is more likely to understate the true elevation in mortality risk that institutionalised children face. In order to avoid offering an impression of overstated precision, the description of the values for the elevated mortality risk faced by children confined in residential institutions and orphanages in conflict-affected locations compared to children cared for in families in the same settings is “more than 2”.

▶ **Girls and young women with disabilities face up to 10 times more gender-based violence than those without disabilities,** and this report’s elevated mortality findings for such children confined in conflict should be read as an understatement of the risk they face, not an estimate of it.

▶ **Most conflict-related deaths,** in every conflict this report examines, are not from bombs and bullets, they **are from collapsed health, nutrition and water systems** which concentrate on static, larger populations, like children confined in residential institutions and orphanages, within that disrupted infrastructure.

▶ For children confined in residential institutions and orphanages, **five factors** – largely unique to the nature of that confinement – are either triggered or converted from chronic to acute by conflict onset in ways that **significantly elevate their risk of death:**

1. **Kinship severance,**
2. **The loss or fabrication of documentation,**
3. **Invisibility to the humanitarian system,**
4. **State guardianship exercised through rotating staff,**
5. **Fixed location that cannot move.**

▶ **The resources available** to address the increased likelihood of death of children confined in residential institutions and orphanages in conflict-affected locations **is small against their population size,** and that gap is increasing as humanitarian budgets contract and the number of conflicts continues to grow. Funders looking for measurable, evidence-based impact have few interventions with as clear a link between investment and lives saved. Moving children out of residential institutions and orphanages **back to family** before conflict hits is one of them. This report presents the evidence to substantiate that doing so costs less than the confinement it replaces.

▶ Now that we know residential institutions and orphanages pose an elevation in lethal threats to children during conflict, **this report calls for anticipatory accountability.** This means activating the legal obligations that already exist under the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child and the Geneva Conventions prospectively, rather than retrospectively after children have already died.

And to that point, **the purpose of this report is not despair. It is to establish, with evidence, that the foreseeable increase in the likelihood of death of these children can and must be prevented.**

WHY MODEL ELEVATED MORTALITY?

No global dataset isolates and tracks the mortality of children in residential institutions and orphanages during armed conflict from that of children cared for in families. In fact, they are sometimes not counted at all. This omission occurs because institutionalised children generally fall outside the child protection data tracking systems designed for humanitarian response (*Better Care Network, Save the Children, The Alliance for Child Protection in Humanitarian Action, UNICEF and the Inter-Agency Task Force, 2020*). Furthermore, their records are frequently lost, destroyed or abandoned during evacuations (*Human Rights Watch, 2023; Disability Rights International, 2022*), if they were kept at all.

This gap has a direct effect on how these children are treated. Governments, donors and humanitarian agencies decide what to fund and who to evacuate based on the risks they can rapidly survey. The children this report is concerned with are frequently invisible in the data those decisions rely on. The result is that children who cannot be counted are not included in humanitarian needs assessments or are at best deprioritised because they are perceived to be in a safe care environment, whether or not they are the children most at risk which, in some cases, can lead to their exclusion from timely life-saving support.

This report uses an approach already established in epidemiology for populations where direct measurement does not exist or has broken down and applies it to children confined in residential institutions and orphanages in conflict-affected locations. Indirect estimation, multiple systems estimation and excess mortality modelling exist specifically because delaying action due to incomplete data can be a lethal choice in a crisis (*Checchi and Roberts, 2005*). So instead of waiting for the systemic data reform required to include this too-often-overlooked population of children, this report constructs an evidence-based estimate of the human

consequences of continuing to confine them in residential institutions and orphanages in conflict-affected settings. It evidences the case to compel immediate action to prevent their deaths, while continuing to push for commitments to their inclusion in direct data collection.

This report builds its estimate from three components and combines them in two different ways to illuminate two different comparators. Component A is the mortality risk residential institutions and orphanages already carry in peacetime, before conflict begins, which establishes a pre-existing vulnerability among the children confined within them. Component B is the additional mortality risk that conflict brings to every child in an impacted location, whether they live in an institution or in a family. Component C is the further mortality risk that conflict specifically activates or converts from chronic to acute inside residential institutions and orphanages, through mechanisms such as an impaired ability to self-evacuate, the absence of a dedicated adult able to search for a missing child, or fabricated documentation.

Multiplying all three – Component A times Component B times Component C – compares a child confined in a residential institution or orphanage during conflict against a child cared for in a family in peacetime. Multiplying only Component A and Component C compares that same child against a child cared for in a family living through the same conflict, since Component B raises both children's risk equally and cancels out of the comparison. This narrower comparison – Component A times Component C – produces this report's headline finding of an elevated risk of mortality of more than two times for children confined in residential institutions and orphanages in conflict-affected locations compared to children cared for in families in the same settings.

Section 1

MYGOMA – the lethal collapse of orphanage care in conflict

On 15 April 2023, fighting broke out in Khartoum, Sudan. At the Mygoma orphanage, the largest in the country, staff could not reach the building or, because of the threat to their families, decided to evacuate.

The ratio of carers to children collapsed to an intermittent, approximate ratio of one adult for every 20 infants. Dr Abeer Abdullah, Mygoma's medical chief, confirmed that, "They needed to be fed every three hours. There was no one there." (*Reuters, 29 May 2023*). At least 50 children died in the five weeks that followed, according to Reuters' initial reporting (*Reuters, 29 May 2023*), a toll that continued to rise steeply to 60 in the following days (*AP, cited in the Guardian, 1 June 2023*), and to at least 71 by the time they were finally evacuated a week later (*AP and UNICEF, 8 June 2023*).

This report shows that Mygoma is not an isolated failure. It is illustrative of what happens, now predictably, when a residential institution or orphanage is caught up within the effects of war.

The key finding at the centre of this report is that children confined in residential institutions and orphanages in countries affected by armed conflict face a mortality risk at least two times higher than children cared for in families living through the same conflict. This risk rises to as much as 4.4 times under the least conservative assumptions that this report's evidence supports – where all factors that elevate the risk of mortality for these children are activated concurrently, as they did in Mygoma. This provides us with an evidence-based understanding that **the way a child is cared for significantly changes their chance of survival during a conflict.**

“
The way a child is cared for significantly changes their chance of survival during a conflict.
”



Sudan.
Waseem Lazkani

Section 2

THE ESCALATING CRISIS

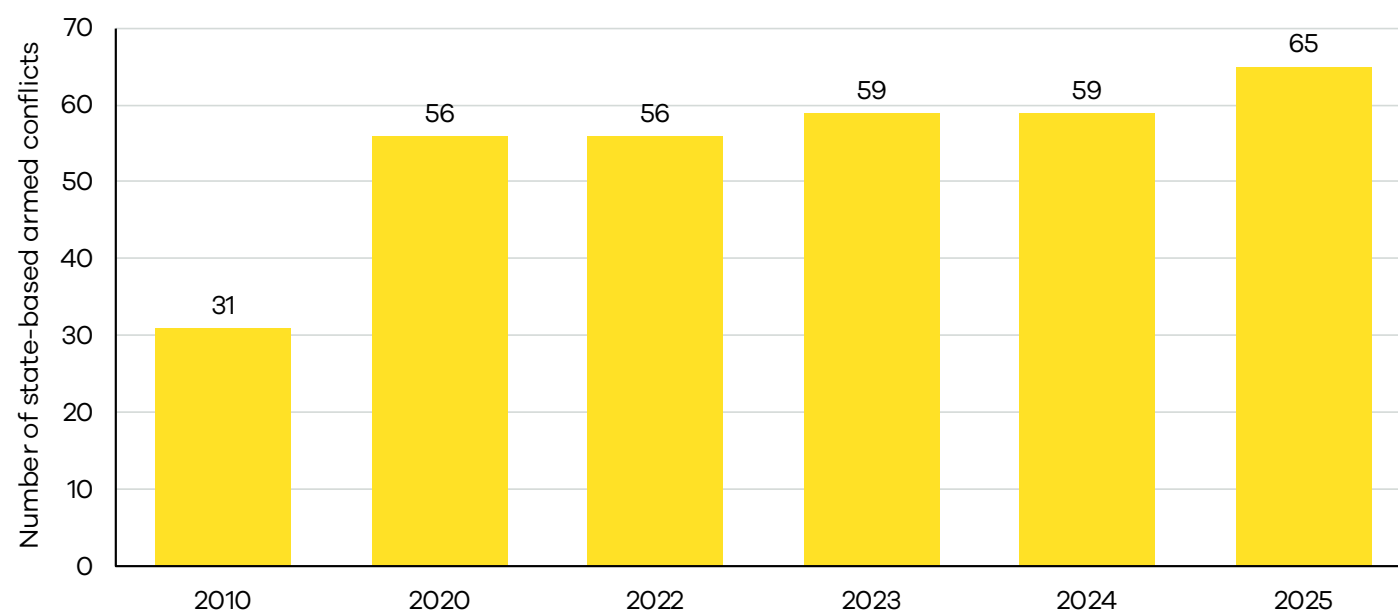
Up to 1.2 million children are currently confined in residential institutions and orphanages in locations affected by armed conflict. This figure applies *Desmond et al.'s* (2020) country-level estimates of populations of these children to the list of conflict-affected countries, counting a country's figure in full only where its conflict is genuinely national in scope. Where a conflict is instead confined to one bounded location within a country, such as Pakistan's recently merged districts or India's Jammu and Kashmir, the national figure is scaled down to that location's share of the national population of children confined in residential institutions and orphanages, using its most recent census data where it is available.

The list of countries corresponds closely to the World Bank's FY26 List of Fragile and Conflict-affected Situations, Conflict category (World Bank, 2025). This report uses "fragile"

in that defined sense throughout – a state's classification against the World Bank's own criteria – rather than as a general description of instability. A full country-by-country breakdown and description of the method used to produce the 1.2 million population estimate is set out in the Appendix. Unregistered facilities are excluded from the underlying data.

This population of children is most likely growing, not shrinking. The number of state-based armed conflicts reached 65 in 2025, drawing in more countries and with them likely more children confined in residential institutions and orphanages. This is the highest number of armed conflicts recorded since systematic data collection began in 1946, defining a worsening trend in which the number of conflicts has more than doubled since 2010 (*Davies, Pettersson and Öberg, 2026, Journal of Peace Research*).

State-based armed conflicts, 2010 to 2025



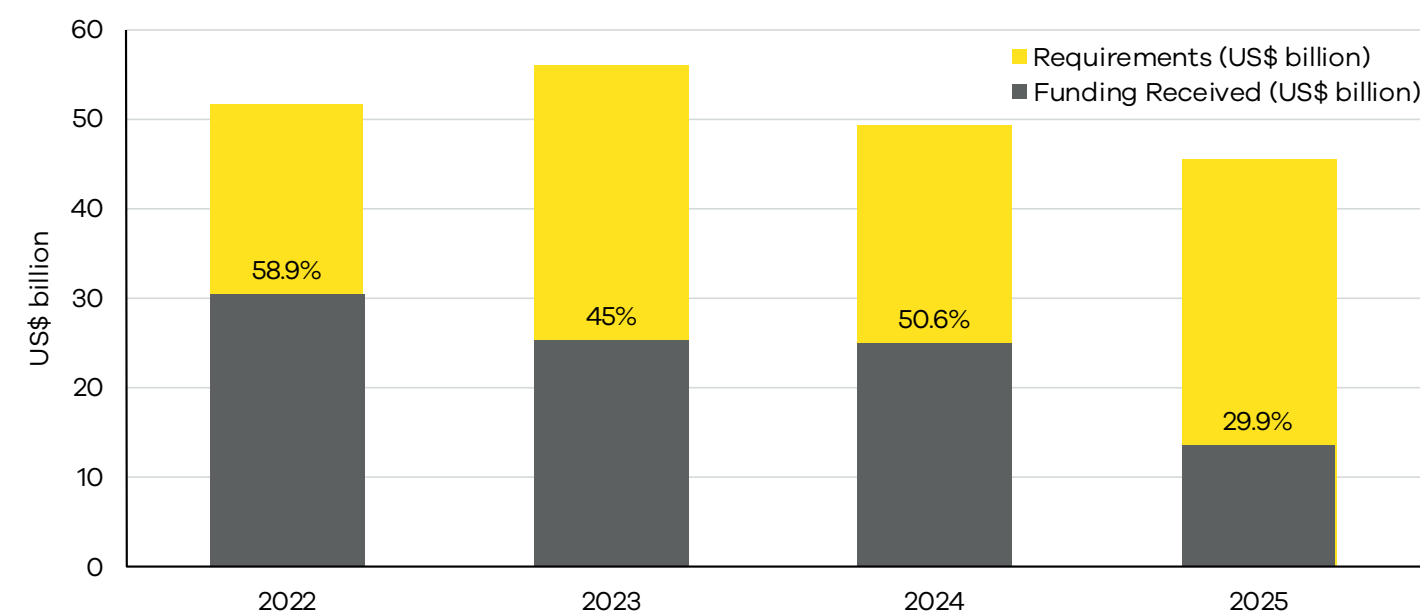
Source: Uppsala Conflict Data Program, Davies, Pettersson and Öberg, *Journal of Peace Research*, 2026

Figure 1. The number of state-based armed conflicts has moved relentlessly in one direction for over a decade.

At the same time, the resources available to respond to these crises are shrinking. Total international humanitarian assistance, meaning funding from every official channel combined – bilateral, multilateral, and appeals – fell by roughly 20% in 2025 alone, a fall of more than eight billion US dollars, driven in large part by deep cuts from the United States and Germany. By this measure, the humanitarian system is now approximately 30% smaller than it was at its 2022 peak and receives roughly the same total funding it did in 2017 (*ALNAP, Global Humanitarian Assistance Report, 2026*). Figure 2

below shows a narrower, related measure – funding received against the needs specifically stated in UN coordinated appeals, which sit inside this wider total. 2022's unusually high coverage of 58.9% reflects the scale of the donor response to the full-scale invasion of Ukraine that year, not a typical funding environment, and the decline since should be read against it as an outlier rather than as a baseline. Coverage was 50.6% in 2024 before falling sharply to 29.9% in 2025, the lowest share of the four years (*UN OCHA Financial Tracking Service, Coordinated Plans overview, retrieved 11 August 2026*).

Global humanitarian funding, requirement versus received



2022's unusually high coverage reflects the scale of the donor response to the full-scale invasion of Ukraine that year, not a typical funding environment.

Source: UN OCHA Financial Tracking Service, Coordinated Plans overview, retrieved 11 August 2026 (fts.unocha.org/plans/overview/2025). Tracks UN coordinated appeals only, a narrower measure than total international humanitarian assistance (see main text).

Figure 2. Since 2022, humanitarian appeals face reducing funding pledges at a time of increasing need.

The changing nature of conflict is likely to make this worse. ALNAP's Global Humanitarian Assistance Report 2026 finds that conflicts themselves are becoming more protracted. Indeed, the number of crises classified as protracted rose from 19 out of 43 in 2016, to 35 out of 46 in 2025, with the median protracted crisis now having an interagency response plan running for 15 years, up from 10 years in 2016. This matters for the children this report is concerned with, because a

conflict now typically lasting a decade or more will likely delay when a child confined in a residential institution or orphanage at crisis onset might be moved into family care. This delay has life-threatening consequences because what is already well evidenced is how the length of time children spend in confinement in institutional and orphanage settings impacts their health, to the extent it becomes life-threatening (see section 5).

Even in peacetime, children are already institutionalised for extended periods. A Swiss cohort, tracked over six decades, found children were institutionalised for an average of 4.3 years before permanent family, foster or adoptive placement (Sand et al., 2024, *Child Abuse and Neglect*). Romania's state care system averaged 7.5 years (European Roma Rights Centre, 2021). A national survey of institutions in Rwanda found an average stay of over 13 years, with almost a third of children already confined for more than a decade (Ministry of Gender and Family Promotion and Hope and Homes for Children, 2012). Whichever figure applies in a given setting, institutional confinement routinely runs into years. The evidence in this report presents a well-established dose-response relationship – the longer a child is confined, the deeper the harm. Increasing numbers of protracted conflicts will drive up that harm.



“
The clock is
already ticking.
”

The reason why the changing nature of conflict is likely to lead to further significant delays in getting children back to family is not only because of the rapidly growing pressure that results from increasing humanitarian need on reducing humanitarian funds, but also because of the response of the humanitarian system itself. And there are three elements to this response that bear heavily on the children this report is most concerned with.

Firstly, because of the collapse in official aid budgets, humanitarian systems are increasingly relying on tiering to determine where to allocate the funds that remain – ranking crises and needs by their apparent urgency and **fundability**. A residential institution or orphanage in this context are too often perceived as havens of protection. This report's own central finding – that children confined in these settings face at least two times the mortality risk of children cared for in families in the same conflict – shows that perception to be false. And if that false perception shapes how scarce, and shrinking, resources are tiered and allocated, these children risk moving from being overlooked to becoming structurally excluded. This runs parallel to the apparent fall in Figure 2's humanitarian funding requirement figure which does not, in fact, mean humanitarian need has fallen. Since 2023, the UN has narrowed how it counts people in need, and

from June 2025 went further with an explicit “hyper-prioritisation” exercise, in which appeals request funding only for the needs judged most acute and most fundable rather than the full assessed demand for support (OCHA, *Global Humanitarian Overview 2025 Special Edition, June 2025*; ALNAP, *Global Humanitarian Assistance Report 2026*). Figure 2 is, therefore, an under-representation of how big the gap really is.

Secondly, a compounding issue that amplifies this skewed structural distribution of humanitarian funding is how that funding tends to fade for protracted crises over their lifespan as acute phase attention moves elsewhere, even when needs remain high. Iraq's humanitarian funding fell from 1.9 billion US dollars in 2016 to 0.5 billion US dollars in 2022. Pearson and Holloway found that the assumptions behind this shift, including a planned pivot toward development aid instead of humanitarian assistance, have not held. Development aid did not materialise at the scale expected, and displaced people remain in the same or worse situations than before the transition began (Pearson and Holloway, 2025). This tapering of funding attention means that a child confined in a residential institution or orphanage when a conflict hits becomes progressively less likely, not more, to be reached the longer that conflict continues.

Thirdly, the impact of shrinking humanitarian budgets and hyper-prioritisation does not fall evenly across all sectors. Child protection – the area of humanitarian response that includes family tracing, alternative care and case management for separated children – has consistently received less funding relative to need than others. In 2023, child protection funding from across UN coordinated appeals came in at approximately 62% of the average rate other sectors received (*Alliance for Child Protection in Humanitarian Action, 2024*). The 2025 cuts made this gap worse. Based on data from just five agencies across more than 23 countries collected in March and April 2025, it was found that 1.1 million children were directly affected by cuts exceeding 110 million US dollars. Two of the disruptions it

documents speak directly to forms of family care. In Bangladesh, a foster care programme was reported at risk of collapse, while in Rwanda, 850 children, including some placed in alternative family care, were identified as being at significant risk of harm as a direct result of the cuts (*Alliance for Child Protection in Humanitarian Action, 2025*). When this funding is cut, residential institutions and orphanages adapt to anchor their own place within a crisis – with, as evidenced in section 5, acute elevated threats to children – while the pathways out of them, and the systems that would otherwise prevent children entering them in the first place, are often overlooked because of this structural distribution of humanitarian funding.

The rising number of conflicts is likely to capture increasing numbers of countries in which children are confined in residential institutions and orphanages. Humanitarian need is outstripping humanitarian funding. The hyper-prioritisation of the system is leading to a perceived reduction in that need, while allocating funding on the basis of what can be fundraised for and what is judged to be most acute. Children confined in residential institutions and orphanages in conflict-affected locations are already overlooked and de-prioritised because they are traditionally understood to be safe spaces and are not usually included in humanitarian needs assessments and monitoring. The consequences of this, in the context of this report's own mortality evidence, will be severe. Indeed, without a deliberate change in policy and financing of the kind this report recommends, the most likely direction of travel is toward more children confined in residential institutions and orphanages in conflict-affected countries dying as a consequence.



“
The consequences
of inaction are
increasingly lethal.
”

Section 3

WHO THESE CHILDREN ARE

The word “orphanage” needs clarifying. The majority of children confined in residential institutions and orphanages have at least one living parent. They are not orphans. They are there because their family is struggling with poverty, because a child has a disability without the support their parents need, or because alternative family care arrangements were never offered as an option by the authorities responsible for them. These are not children with no one to care for them. They are children whose families have not been given the support, or the choice, to keep them.

For more than 20 years, studies have demonstrated how this pattern holds across very different countries. A European Union survey of institutions for children under three found no biological orphans among those in the member states surveyed, and only 6% among those in the other states surveyed (*Browne et al., 2005*). A related, peer-reviewed study of the wider European region found a similar picture, with only 4% of young children in institutional care having no living parent (*Browne et al., 2006*). In Sri Lanka, only 8% of children in voluntary institutions had lost both parents, meaning 92% had at least one living parent (*Bilson and Cox, 2005*). In Cambodia, a national survey of adolescents in residential care found almost 80% had at least one living parent (*Stark et al., 2017*). A more recent multinational study surveyed 1,054 adults across 19 nations who had experienced alternative care, including residential care, for at least six months in childhood, and found that more than 80% had at least one living parent (*Wilke et al., 2025*). The exact proportion varies by country and by how the data were collected. But in every country where this has been measured, children who have lost both parents make up a small minority of the children institutions confine. And one factor consistently recurs across these countries as a reason children end up separated from their families: disability.

In Ukraine, nearly half of the more than 105,000 children confined in residential institutions before the 2022 invasion were living with a form of disability, according to Ukraine’s National Social Service (*Human Rights Watch, 2023*). Disability increases the

likelihood of a child entering institutional care in the first place, sometimes by a factor of up to 17, and up to 30 in parts of Europe and Central Asia (*UNICEF Europe and Central Asia, 2023; UNICEF Europe and Central Asia, 2024*). Underlying poverty is another major factor. These are associations drawn from observational data, meaning they describe children who share a characteristic and an outcome, not a proven chain of individual cause and effect. But the pattern they describe – that disability and poverty are so closely associated with separation from family far more often than the death of a parent – is well documented for Ukraine and the wider Europe and Central Asia region.

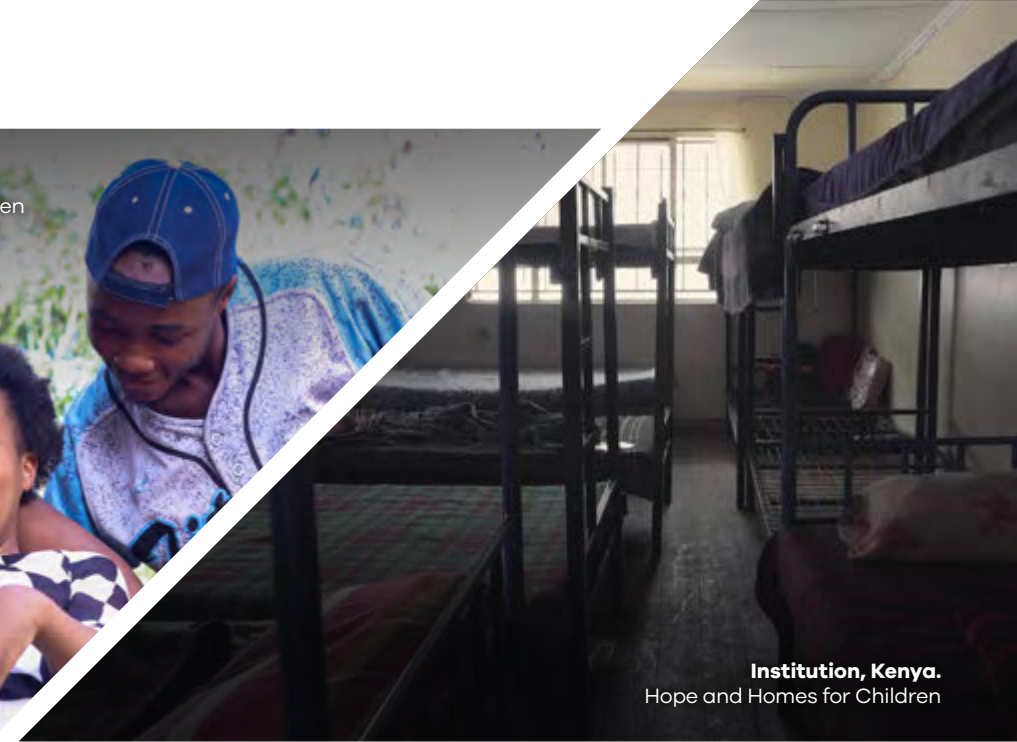
Estimates of the total number of Ukrainian children who live with disabilities vary by source and date. UNICEF Ukraine reported approximately 160,000 children living with disabilities as of December 2024 (*UNICEF Ukraine, 2024*). A separate analysis by the Kyiv School of Economics, drawing on the Ministry of Social Policy’s 2023 budget, put the figure at 231,000 children with disabilities (*Kyiv School of Economics, 2024*). These estimates speak directly to the demand for community rehabilitation and support services, and represent a clear threat to progressing the replacement of residential institutions with a system of family care (*Global Disability Fund, Ukraine country brief, March 2025*).

Systemic discrimination is a characteristic of care systems that are dependent on residential institutions and orphanages. Children from female-headed households, single mothers and grandmothers raising children alone

Cigi* is Back to Family in Rwanda.
Richard Munyaneza / Hope and Homes for Children



Institution, Kenya.
Hope and Homes for Children



– like Iryna – are taken into confinement in residential institutions and orphanages at much higher rates. Project work in Brasov, Romania, between 2005 and 2009, found 87% of mothers attending an at-risk clinic were unmarried (*Gaia, 2011*). Ireland’s mother and baby home network was run entirely on such discrimination (*Commission of Investigation into Mother and Baby Homes, Final Report, 2021*). This reflects a structural inequity that impacts non-traditional family configurations rather than parental failing. And such discrimination is well documented across various characteristics.

Roma children have been traditionally over-represented in Romanian, Bulgarian and Ukrainian residential institutions. In Romania, Roma children made up 31.8% of children in residential institutions overall, rising to 80% in some facilities. In Bulgaria, the figure was around 50% (*European Roma Rights Centre, 2011*). In Ukraine, where the law bans collecting ethnicity data outside the census, estimates from NGO workers and Romani families ranged from around 10% to 80% to 100% of

children in some institutions (*European Roma Rights Centre, 2023*). Canada’s historical system of “Indian Residential Schools” separated more than 150,000 Indigenous children from their families explicitly on discriminatory grounds – a system its own Truth and Reconciliation Commission characterised as cultural genocide (*Truth and Reconciliation Commission of Canada, 2015*) – and Indigenous children remain dramatically over-represented in Canadian care systems today relative to their share of the child population: 7.6% of all children in Canada compared to 53.7% of foster children in private households (*Statistics Canada, 2024*). The same is true for Australia, where Indigenous children are found in out-of-home care at rates roughly 1.5 to 11 times higher than non-Indigenous children (*Eiermann, Nielsen, Wildeman and Fallesen, 2025, Child Maltreatment*). Similar patterns have been recorded elsewhere – children of Greenlandic background, living in Denmark, have been separated from their families at several times the rate of children with Danish parents (*Danish Institute for Human Rights, 2022*).

Children affected by leprosy face a related pattern, driven by stigma rather than the disease itself. Leprosy has been curable with multidrug therapy since 1982, and the World Health Organisation confirms that a person is unable to transmit the disease after the first dose of treatment (*World Health Organisation, 2026*). Despite this, The Leprosy Mission has documented that approximately 750 leprosy colonies remain in India that are characterised by institutional confinement, especially of children, and are a legacy of the Lepers Act 1898 which the Indian government did not repeal until 2016 (*Leprosy Mission, 2016*). India's Law Commission concluded in 2015 that more than 100 national and state laws still discriminate against people affected by leprosy, and a subsequent Supreme Court case argued that some of these laws allow a person to be detained indefinitely on the basis of a leprosy diagnosis alone, including children (*Law Commission of India, 2015 and LiveLaw, 2017*). Alice Cruz, the United Nations Special Rapporteur on the elimination of discrimination against persons affected by leprosy and their family members, told the Human Rights Council in 2023 that children affected by leprosy are frequently expelled from school, separated from other pupils, rejected by peers, and bullied or abused by family members, neighbours and teachers, and that informal segregation into leprosy colonies continues in some places. The Committee on the Rights of the Child and UNICEF endorsed the statement (*Office of the United Nations High Commissioner for Human Rights, 2023*). At Bal Bhawan, a residential institution in Ludhiana for children whose parents are affected by leprosy, one child explained why she had been placed there rather than raised at home. "There's a social stigma attached to the disease. Our parents didn't want to risk our lives by keeping us in the leprosy home." (*The Tribune, 2025*). The Leprosy Mission Trust India describes the same dynamic in its own education programme. It states that children from families affected by leprosy are often kept out of mainstream schools because of misplaced

fear of the disease (*Leprosy Mission Trust India, 2026*). As with the other characteristics documented in this section, a health condition that is now fully treatable, and the ongoing stigma that surrounds it, becomes grounds for a child's separation from family. The families captured within this pattern have not failed their children. The systems, awareness and structure around them have not developed to support them.

In Rwanda, Belgian colonial authorities placed children into state-run institutions on two grounds set out in a colonial decree: where the state judged parents to have failed in their duty of care, and where children were already orphaned or abandoned (*Kuehr, 2015*). This was distinct from a separate, more explicitly discriminatory practice. Belgian colonial authorities also forcibly removed children of combined Belgian and African parentage from their African mothers, across Rwanda, Burundi and the Belgian Congo (DRC), a practice the Brussels Court of Appeal ruled a crime against humanity in December 2024. Between 14,000 and 20,000 children were separated in this way across the whole Belgian colonial project (*de Hemptinne, 2025; Heynssens, 2016*). In Kenya, current institutionalisation originates in the Christian Missionary Society which separated children from their families from the late 1800s (*Chege and Ucembe, 2020*).

Where this colonial and missionary legacy has been documented, local authorities have continued to centre parenting as the problem, rather than attending to forms of family care as the solution to the challenges communities face in addressing their capabilities to ensure all children are cared for in families. Institutionalisation in conflict settings sits squarely within this legacy, a legacy that does not begin with war. It begins with the systemic discrimination prosecuted on children and families who carry certain characteristics, resulting in their separation. Conflict then exposes that pre-existing injustice to the specific mortality risks this report predicts.

LIUDMYLA'S STORY

Liudmyla* is 29. She has three children. Abandoned by her husband, she is bringing them up alone in a small town in Ukraine. She grew up in foster care herself.

Local child protection services determined that the children should be taken from Liudmyla and placed in an institution, not because of a specific crisis or problem with her parenting, but because poverty, isolation and three children, one of them nine months old, had become too much to manage alone. A single mother, already carrying the stigma of having been fostered herself, is exactly the profile a discriminatory system predates upon. And a social worker with a full caseload has every incentive to trigger predatory action, because referring a child into a residential institution or orphanage is far less intensive than the complex work of preventing family separation. It clears a file. It moves the risk onto someone else's desk.

But it ignores the best interests of children and their parents.

Hope and Homes for Children's social workers were able to intervene and arrange part-time support for Liudmyla – with cooking and cleaning, as well as provision of clothing, food and help registering for benefits. Liudmyla puts the change in her own words. "I lived like a grey mouse before, but with support, I am like a tulip in bloom." She grows vegetables now and talks about the harvest she's expecting with real pride.

As important as the direct assistance, though, was the work Hope and Homes for Children undertook with the local authority, so that many more families would benefit from this kind of service rather than be wrenched apart and their children confined in institutions. A new system predicated on a new mindset is emerging.

“
I lived like a grey mouse before, but with support, I am like a tulip in bloom.
”



Liudmyla with two of her children, Ukraine.
Hope and Homes for Children

Section 4

WHY CHILDREN END UP IN INSTITUTIONS

Poverty, disability and discrimination explain which children are generally separated from their families, but they do not fully explain why so many institutions exist – globally, it is estimated that 5.4 million children are confined in residential institutions and orphanages (*Desmond et al., 2020*).

 **5.4M** CHILDREN IN INSTITUTIONS GLOBALLY

80% HAVE ONE OR BOTH PARENTS ALIVE 

A foundational 2009 review for Save the Children revealed that the number of orphanages has been increasing sharply in specific countries, more than doubling in Ghana between 1996 and 2009, rising elevenfold in Liberia over two decades, with Indonesia's government quadrupling orphanage funding after the 2004 tsunami based on a mistaken belief about the number of children actually orphaned. The review traced this rise to financial incentives offered to orphanage owners by governments and well-meaning donors, rather than to a genuine rise in the number of children without a family (*Csáky, Save the Children, 2009*). Subsequent research has identified foreign funding specifically as a pull factor that draws children into orphanages, alongside active recruitment and the sheer numbers of orphanages in a given area (*Rotabi, Roby and Bunkers, 2017*).

More recent studies have gone further, describing a self-sustaining orphan industrial complex in which international demand for the experience of helping – voluntourism – actively jeopardises the child protection systems it intends to support (*Cheney and Rotabi, 2014*). *van Doore and Nhep (2023)* describe orphanage tourism and volunteering as mechanisms that actively sustain institutionalisation by supplying the international funding and validation that keep orphanages operating as a going concern. Governments are becoming increasingly concerned with this issue. In 2019, the Dutch Parliament held a parliamentary roundtable on orphanage tourism and commissioned research into how the Netherlands was involved in the practice (*Kinsbergen et al., 2021*).

4.1 STATE SYSTEMS RUN ON A COST-PER-CHILD BASIS

Government-run systems are driven by structural incentives. Many state care systems fund residential institutions on a per capita basis, meaning the budget an institution receives rises with the number of children referred into it. This creates a direct incentive to fill beds rather than to support families and, ironically, leads to a circumstance in which children are routinely referred into residential institutions and orphanages under the pretext of challenges faced by their family that could, with the very resources locked up in those institutional and orphanage systems, have been addressed. Such systems establish perverse incentives across their substantial workforces: overloaded social workers – concerned about the risks associated with the complex and intensive requirements of engaging families – will often refer a child

into an institution to transfer the risk and reduce their caseload. Lack of government accountability compounds this. The results are often huge state systems that Hoover up large numbers of children. In Ukraine, around 1.3% of the child population, roughly 100,000 children, had been captured in such a system prior to the full-scale invasion (*UNICEF, reported by Euronews, 14 March 2022*). Even countries that have signed international commitments to eliminate residential institutions do not always translate that commitment into domestic budget allocations or service design. Overseas donor funding has enabled orphanages to proliferate faster than governments have been able to monitor or regulate them, entrenching orphanage economies in some contexts (*Cheney and Ucembe, 2019; Punaks and Feit, 2014*).

4.2 PRIVATE DONOR-FUNDED SYSTEMS PAID FOR BY THE VISIT

Many residential institutions and orphanages are operated as businesses, with child-finders employed to recruit children from vulnerable families, often under false promises of education. Once inside the institution, children become fundraising assets, presented to visiting donors, filmed or, in the worst documented cases, pressed into performing, begging or labour for the benefit of the institution's owners (*Hope and Homes for Children, Families Not Institutions Roadmap, Module 1*).

Analysis of funding streams has found that the overwhelming majority of this money originates outside the country in which the institution operates. Nepal and Haiti show this dynamic operating at a national scale. In Nepal, out of 11.6 million children, almost 16,000 live in 585 registered orphanages, most of them concentrated in cities and popular tourist destinations, with 90% of those orphanages receiving their funding solely from outside the country, mainly from Germany, the United States and the United Kingdom (*Elevate Children Funders Group, 2017*). In Haiti, of roughly five million children, an estimated 30,000 live in approximately 750 mostly privately-run orphanages. At least 260 international funders support projects across

more than 280 of them, with total funding to Haitian orphanages conservatively estimated above 100 million US dollars a year, 92% of it from the United States (*Lumos Foundation, 2017*). Haiti's own government estimates that 80% of children in its orphanages have at least one living parent, and almost all have other family members. Haiti's 100-million-US-dollars-a-year orphanage economy represents a scale of resourcing that could support all 30,000 children confined in its orphanages to be transitioned **back to family** or placed in alternative family care arrangements (*Lumos Foundation, 2017*). Data from Nepal establishes the cost-effectiveness of doing that – its orphanage economy costs up to 11 times more than the social services bill required to provide direct support to vulnerable families, and three times more than professional foster care (*Elevate Children Funders Group, 2017*).

All this is characteristic of an underlying pattern of orphanages being used to recruit children – often dishonestly and coercively – to generate profits by attracting donations from abroad. The Government of Australia has formally recognised it as orphanage trafficking under its Modern Slavery Act 2018 (*Commonwealth*

of Australia, 2018), a recognition subsequently reinforced internationally through a resolution – explicitly on orphanage trafficking – adopted at the Inter-Parliamentary Union’s 147th Assembly in 2023.

The legal concept underpinning this recognition of orphanage trafficking had in fact already been established under international law, which argues that the recruitment, transfer and continued exploitation of children for institutional profit meets the international legal definition of trafficking regardless of whether a border is ever crossed (*van Doore, 2016, and 2020*). And recent prosecutions put this into practice. In September 2024, police in Malaysia rescued more than 400 children from 20 “welfare homes” run by Global Ikhwan Services and Business Holdings. Most of them had been placed as infants by employees of the organisation and were later subjected to sexual abuse, forced labour and exploitative fundraising, with charges brought under Malaysia’s Anti-Trafficking in Persons and Anti-Smuggling of Migrants Act (2007) alongside child sexual abuse statutes (*Butler, 2024, BBC News; Malay Mail, 30 October 2024*). A comparable pattern recurs in Nigeria, where children have been recruited from rural families with promises of education and placed in institutions later found to be trafficking operations (*Freedom United, 2026; Vanguard, 2026*). A distinct variant on this also occurs in Nigeria, where women confined in facilities disguised as orphanages or maternity homes have been forced to carry and deliver babies who are then sold – documented by Nigerian and US authorities as “baby factories” (*US Department of State, 2018*).

4.3 THE PERSISTENT PERCEPTION GAP

The evidence that institutions harm children stretches back more than a century, as the historical record set out later in this report shows. Despite this, most people, including well-intentioned donors, faith organisations and volunteers, continue to believe that an orphanage is a place of refuge or safety for a child.

Cambodia illustrates the widespread recognised gap between legislation and its application. The country’s 2008 human trafficking law contains offences that could be prosecuted as orphanage trafficking. Nevertheless, the number of orphanages in the country grew by 75% between 2005 and 2010, a rise researchers attribute to foreign funding and orphanage tourism rather than to any corresponding rise in the number of children actually orphaned (*Nhep and van Doore, 2021*). Despite this, no case of orphanage trafficking has ever been successfully prosecuted under Cambodia’s trafficking offences. The US State Department’s 2018 Trafficking in Persons Report specifically noted the failure of law enforcement to act against orphanage directors complicit in child trafficking crimes, a failure serious enough that Cambodia was downgraded to the Tier Two Watch List – a category within the State Department’s annual Trafficking in Persons report which ranks every country’s government on how well it meets the minimum standards set out in the US Trafficking Victims Protection Act for tackling human trafficking (*US Department of State, 2020*). This is not evidence that Cambodia’s law is deficient, rather that the presence of a workable legal framework does not by itself protect children when the officials and courts responsible for it do not apply it.

While the children these cases are concerned with are already included in the wider population confined in residential institutions and orphanages, they do offer evidence of another reason why that population is as large as it is.

This perception gap is what sustains investment. But the demand for that investment does not come from children. Who profits, who is held accountable, and whose perception goes unchallenged are not incidental to the mortality risk this report models.

Section 5 THE MODEL

This report presents a conservative estimate for the elevated mortality facing children confined in residential institutions and orphanages during armed conflict by building a model from three separate components. Direct measurement is not currently possible, since no global dataset tracks children’s mortality in residential institutions and orphanages as a distinct group during conflict to compare their mortality against children cared for in families in the same setting. The model follows an approach already established in epidemiology for populations where direct measurement does not exist or has broken down, and indirectly estimates the elevated mortality from separate but converging bodies of evidence (*Checchi and Roberts, 2005*).

The model comprises three components because it is addressing three genuinely different sets of risks. Component A describes what residential institutions and orphanages do to a child’s health before any conflict begins, and how this elevates their risk of mortality. It is established through growth delay, delayed illness detection and structural neglect (*van IJzendoorn et al., 2020, Lancet Psychiatry, Källander et al., 2008, Lannen et al., 2026*), corroborated by further evidence on anaemia and iron deficiency (*Scott et al., 2014, Fuglestad et al., 2013*), and describes vulnerabilities that travel with a child into later crises. Component B describes what conflict does to every child in the same location, whether they are in an institution or a family. It is established through three independent studies of general child and infant mortality during war (*Wagner et al., 2018, Lancet; Jawad et al., 2020; Abouharb, 2023*). Component C describes what happens specifically inside a residential institution or orphanage once conflict arrives, distinct from what a child cared for in a family experiences in the same conflict setting. It includes structural failures such as limited capability to self-evacuate, the absence of a dedicated adult able to search for them, lost or fabricated documentation, and kinship severance, with few equivalents for a child in family care (*Kien et al., 2019*).

The three components are multiplied together, not added, because each operates through a distinct causal pathway rather than a shared mechanism. Standard epidemiological practice combines independent risk factors of this kind by multiplication rather than addition, since each pathway compounds the risk created by the others rather than simply sitting alongside each other (*Rothman and Greenland, 1998, corroborated by Diaz-Gallo et al., 2021*). That choice is directly tested by building a second, structurally different model by using addition, which is populated with values deliberately set below the already conservative figures the multiplicative model uses and what the evidence actually supports. That additive model still produces a substantially elevated risk that is actually higher than the value produced by the multiplicative model, which is the strongest evidence this report can offer that its central finding does not depend on the particular way its three components are combined.

This report makes two different comparisons, each against a child cared for in a family. The first compares a child confined in a residential institution or orphanage in a conflict-affected location with a child cared for in a family in peacetime. This requires the presence of all three Components. Component A and Component C apply because they describe the harm the institutionalised child alone carries, before conflict and once it arrives. Component B is present because it applies to all children in the same conflict setting regardless of how they are cared for, and describes different risks to those in Component C. In this comparison, only one of the two children has lived through conflict, so Component B is one of the real differences between them that contributes directly to the elevated mortality risk. The second comparison establishes the elevated risk of mortality faced by a child confined in a residential institution or orphanage in a conflict-affected location and compares it to the risk faced by a child cared for in a family living through the same conflict. In this case the children being compared share the same conflict setting, so Component B makes no difference to the gap between them and is cancelled out.

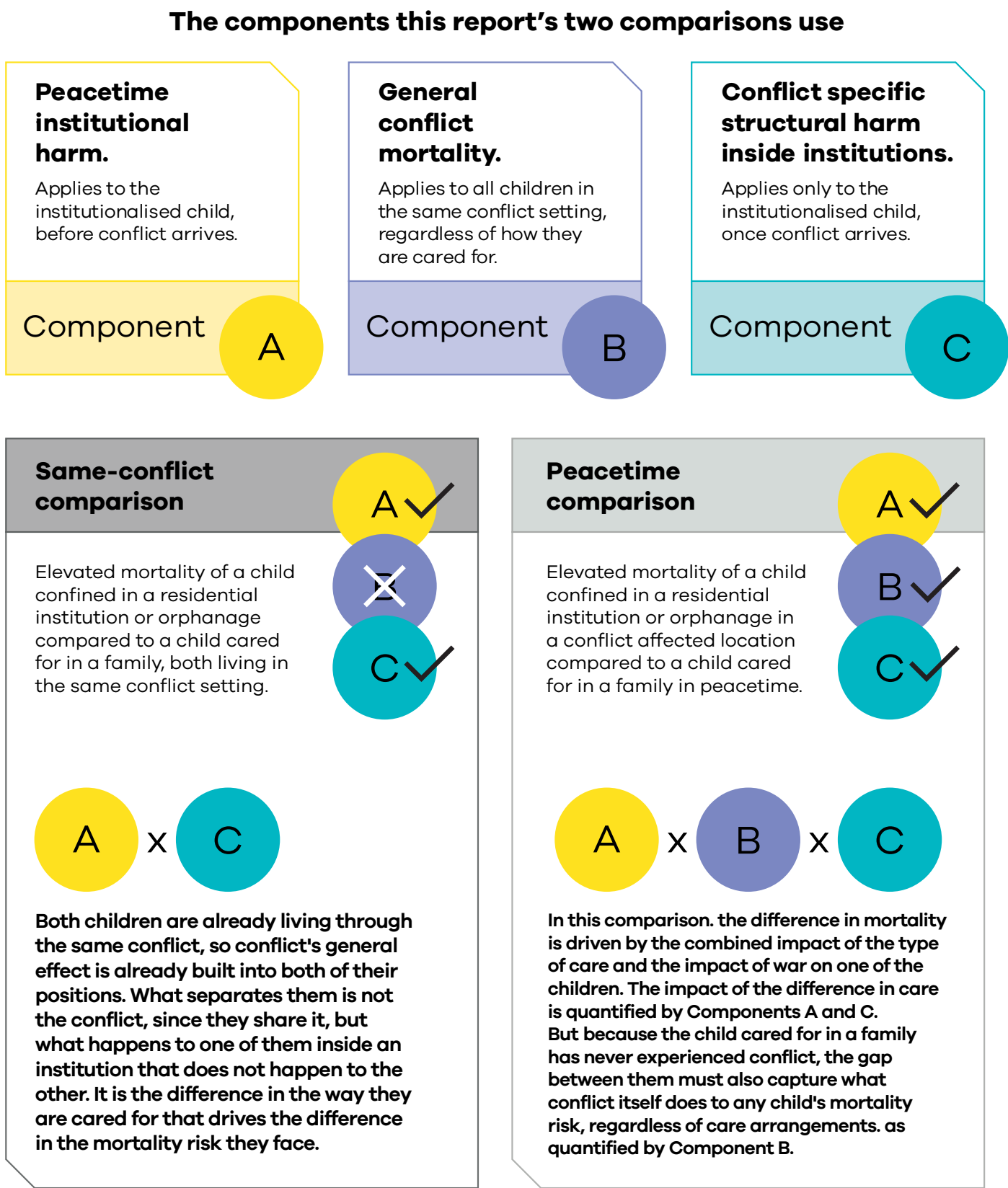


Figure 3. What the model compares.

5.1 COMPONENT A: how residential institutions and orphanages harm children – the lethal peacetime penalty

The first element of the injustice this report documents has nothing to do with conflict: it is the elevated mortality faced by children as a consequence of the harms associated with residential institutions and orphanages in peacetime. This elevated mortality – Component A of the model – establishes profound vulnerabilities that are amplified in crisis situations. There are three pathways that lead toward this increase in peacetime lethality.

5.1.1 Growth delay

The most comprehensive evidence on growth delay among children confined in residential institutions and orphanages comes from a 2020 systematic review and meta-analysis covering 308 separate studies and more than 100,000 children across more than 60 countries (van IJzendoorn et al., 2020, Lancet Psychiatry).

A **META-ANALYSIS** works by combining the results of many independent studies into a single, more reliable estimate, rather than depending on the findings of any one study on its own.

This review found that children in residential institutions show, on average, growth delays of 1.18 standard deviations below children cared for in families, rising to 1.71 standard deviations for children under 42 months old.

A **STANDARD DEVIATION** is a way of describing how far a measurement sits from the average, in units built from how spread-out the whole population is. So, if you lined up 100 children from shortest to tallest on a measure of physical growth, the child exactly in the middle would sit at zero standard deviations. A child 1.18 standard deviations below that midpoint would sit at about position 12 from the bottom, among the smallest 12 children in every 100, a significant difference.

Delayed growth of this kind is a well-established predictor of child mortality in lower- and middle-income countries. Olofin et al. (2013) report three hazard ratios for growth deficits of this kind, each compared with a well-nourished peer.

This report uses the statistical term **HAZARD RATIO** to describe how much more likely one group of children is to experience an outcome, usually death, than another group, based on studies that followed both groups over time. A hazard ratio of 1.0 means two groups experience the outcome at the same rate. A hazard ratio above 1.0 means one group experiences the outcome more often, at any given point, than the other. A hazard ratio of 1.5, for example, means that one group was 50% more likely to experience the outcome at any point during the study than the comparison group. A hazard ratio describes an association, a pattern found by comparing two groups over time. It does not, by itself, prove causation.

For children one to two standard deviations below the median weight for their age, described as mild underweight, the hazard ratio is 1.52 (with a 95% confidence interval of 1.28 to 1.81). For children two to three standard deviations below, described as moderate underweight, it is 2.63 (with a 95% confidence interval of 2.20 to 3.14). For children more than three standard deviations below, described as severely underweight, it is 9.40 (with a 95% confidence interval of 8.02 to 11.03).

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A **CONFIDENCE INTERVAL** defines the range within which a calculated estimate, such as a hazard ratio, is likely to fall, indicating the precision and reliability of that estimate. A 95% confidence interval means that if a study were repeated many times, 95 of every 100 ranges calculated this way would contain the true value, with narrower ranges signalling greater certainty. Using the lowest figure within this range – the floor – ensures a conservative estimation of elevated risk.

These growth deficits are not static, they accumulate the longer a child remains institutionalised. A pilot study comparing children adopted internationally from residential institutions against other neglected and non-neglected children found significantly reduced height and head circumference in the institutionalised group, a difference the authors attributed to the duration and severity of early deprivation (Miller et al., 2015). Duration effects of this kind are also consistent with the Bucharest Early Intervention Project's finding that outcomes worsen the longer a child remains in a residential institution before placement into alternative family care (Nelson et al., 2007).

A further independent study corroborates this finding with direct mortality data, rather than growth data alone. A 2022 systematic review and meta-analysis in the Lancet Public Health journal drew on 13 prospective cohort studies covering more than 3.2 million people. It found that children with experience of state care faced more than double the rate of death, and more than three times the rate of suicide during the studies' follow-up periods, compared with peers raised in families (Batty, Kivimaki and Frank, 2022).

A **PROSPECTIVE COHORT STUDY** follows a defined group of people forward through time and records what happens to them, which means this finding is built from decades of tracked outcomes rather than from people recalling their own childhoods.

Crucially, this mortality gap remained even after the researchers accounted for the disadvantages children had before entering care. The care system itself was adding to the risk, not simply reflecting a harder start in life that already existed. All 13 studies were conducted in high-income countries during peacetime, which suggests its findings are likely to understate the harm facing children in institutions in conflict-affected settings that typically resource-stressed.

Taken together, this evidence supports treating growth delay as a genuine, independent contributor to elevated mortality risk for children confined in residential institutions. Olofin et al.'s dose-response relationship anchors the size of that contribution: this model uses a growth deficit contribution to Component A's hazard ratio range of 1.4 as its floor and 1.7 as its ceiling, both figures falling within Olofin et al.'s most conservative of its three categories – mild underweight – and well within its 95% confidence interval. This keeps its contribution anchored to the most conservative end of their evidence. Importantly, these figures are general population proxies regarding the elevated mortality associated with growth delays rather than findings specific to institutionalised children, which is why this report treats them as deliberately conservative starting points rather than precise estimates for this population.

MYKOLA'S STORY

Mykola* was taken into a residential institution as a baby shortly after the full-scale invasion of Ukraine.

Staff followed a fixed toileting routine, seating all the toddlers on a potty at set times of the day, not permitting any child to leave until they had all passed a bowel movement which would often take an hour or longer, a practice that led to Mykola having colonic and rectal complications. On the day his foster mother arrived to collect him, staff forced him to strip naked in front of the eight adults in the room so that his clothing could be returned to the institution before she was permitted to dress him in the clothes she had brought.

Mykola weighed eight kilograms when he joined his foster family. He was three and a half years old. A weight this far below the standard growth curve for his age sits beyond where the World Health Organisation's charts can offer a reliable percentile. What can be said is that at three and a half years old he weighed what a healthy six-month-old baby should. Since joining his family, who give him consistent, individual, loving care, he has regained weight rapidly and is now within the expected range for his age.

“At three and a half years old he weighed what a healthy six-month-old baby should.”

”



Measuring an infant.
Wellington Tavares

A

Growth delay's contribution to the elevated risk of mortality is a net figure, including whatever share of it runs through immune suppression and infection susceptibility, the mortality predictor most closely linked to growth deficit in the underlying literature. Anaemia and iron deficiency work through this same pathway, not a separate one.

GROWTH DELAY and ANAEMIA

are two different signs of the same underlying deprivation – chronically inadequate nutrition, in quantity and quality, combined with a high burden of infection. A child's body responds to poor diet and repeated illness in more than one way at once. Growth delay, measured as stunting or being underweight, and anaemia, measured through low haemoglobin, both act on mortality risk mainly through weakening the immune system's ability to fight infection. This report treats them as two corroborating measures of one underlying harm, not as two separate risks to be multiplied in order to avoid any overlap or double-counting. And it allows us to use anaemia and iron deficiency as a different measurement of elevated harm from the same underlying risk to test whether – as an independent body of evidence – it corroborates the 1.4 floor set out above.

A study of children in Eastern Europe and Central Asia (Fuglestad et al., 2013) found iron deficiency, a shortage of iron severe enough to affect the body's supply of oxygen carrying protein in the blood, in 26% of them about a month after transitioning out of confinement in residential institutions and into alternative family care, falling to 18% six months later. These children had already left the institution by the time they were measured, with family care and improved nutrition already underway, so this figure is likely to understate how many children were iron deficient while still institutionalised.

Iron deficiency matters for mortality because it weakens the immune system's ability to fight off infection. Scott et al.'s 2014 meta-analysis of nearly 12,000 children brings that mortality risk into sharp relief. They found that for every 1 gram per decilitre increase in a child's haemoglobin, the standard measure of how much oxygen carrying protein is in a child's blood, the odds of death fell by 24%, an odds ratio of 0.76, with a 95% confidence interval of 0.62 to 0.93.

An "ODDS RATIO" compares how often something happens in one group against how often it happens in another. An odds ratio of 1.0 would mean no difference between the two groups at all. An odds ratio of 0.76 means the odds of the event, in this case death, are 24% lower in the group being compared. It describes whether an outcome happened in one group compared against another, without regard to when. This is different from a "hazard ratio" which compares how quickly an outcome happens across the whole period a study follows its participants, not simply whether it had happened by the end of it. Where a study tracks an outcome like death over many years, as several of the studies in this report do, a hazard ratio is the more accurate measure since it captures how early or late the outcome occurred, not just whether it occurred at all.

The model presented in this report needs the opposite of what Scott et al. measured. Their finding describes what happens when a child's haemoglobin goes up. Institutionalised children's haemoglobin is more likely to be lower, so we need to know what a fall in haemoglobin, not a rise, does to the risk of mortality.

When a study reports what more of something does to risk, the same relationship read backwards tells us what less of that thing does to risk. Dividing 1 by the original percentage change does not reverse symmetrically though, because a percentage is always calculated against whichever number you start from. Scott et al.'s odds ratio of 0.76 describes what more haemoglobin does to risk, a 24% reduction, calculated against the original risk. Dividing 1 by 0.76 gives 1.32, which describes the same underlying difference the other way round, that is, what less haemoglobin does to risk. This means Scott et al.'s finding implies a mortality risk of 1.32 times for every 1 gram per decilitre fall in haemoglobin, with a corresponding confidence interval of approximately 1.08 to 1.61.

The central mortality risk estimate derived from Scott et al.'s study is 1.32, which lands close to growth delay's 1.4 floor. Because anaemia and growth delay are different indicators of the same underlying deprivation, this closeness offers independent corroboration for the 1.4 floor. And this corroboration extends to every institutionalised child, not only the 26% Fuglestad et al. found to be iron deficient, because Scott et al.'s relationship is continuous. It holds at every level of haemoglobin, not only

below the threshold used to diagnose iron deficiency. A child whose haemoglobin sits somewhat below that of a child cared for in a family carries some of this same elevated risk, in proportion to that smaller gap, even without crossing the diagnostic threshold. The poor diets and infections already evidenced above are likely to affect children below that threshold too, not only those who cross it.

However, we cannot use the figure derived from Scott et al. as the model's floor. Even reversed to show mortality risk, it still measures haemoglobin concentration – a blood test result – not a child's weight or height. Olofin et al. is used for the 1.4 floor because their study measured exactly what van IJzendoorn et al. measured: weight and height against a growth standard, in standard deviations. Olofin et al. established mortality risk for children at different positions on that same measure, so its hazard ratio applies directly to growth delay. Scott et al.'s figure does not, although it remains valuable as independent corroboration that there is an additional manifestation of harm from the same underlying cause.

That 1.4 floor is reinforced further by Batty, Kivimaki and Frank's finding, set out above, of more than double the adult death rate following childhood state care – a peacetime, high-income country finding. If anything, that gap suggests this report's peacetime range continues to understate the true cost of institutional confinement rather than overstate it.

“
Children in residential institutions show, on average, growth delays of 1.18 standard deviations below children cared for in families.
”

5.1.2 Delayed illness detection

A

This pathway operates independently of growth delay. It concerns how quickly illness is detected among children confined in residential institutions and orphanages.

One study found that in globally depriving institutions, at a caregiver to child ratio of 10 to 30 children per caregiver, caregiver contact occupied as little as 6% of a child's waking hours (*van IJzendoorn et al., 2020, citing Juffer et al., 2017*). The same review distinguishes these globally depriving settings from psychosocially depriving institutions, at three to six children per caregiver, and states that most institutions studied fell into this worse, globally depriving category (*van IJzendoorn et al., 2020*).

*The term “**GLOBALLY DEPRIVING**” describes institutions where a shortage of caregivers is severe enough to affect nearly every part of a child's care, not only their emotional and social needs. In the settings measured here, that meant as few as one caregiver for every 10 to 30 children, with caregiver contact making up as little as 6% of a child's waking hours. This is different from psychosocially depriving institutions, which have more caregivers – three to six children each – but where children still lack the consistent, individual relationship family life provides. Most of the institutions studied fell into the more severe, globally depriving category.*

Recent assessment work by Hope and Homes for Children in Gilgil Sub-county in Nakuru County, Kenya, speaks directly to this issue. Children are frequently placed in residential institutions there because of the perception that they offer free healthcare and education. This means

the family's stated reason for separation is the very thing the institution then fails to deliver because in both unregistered and registered residential institutions throughout the Sub-county, there is often no health worker, no health record and no treatment budget at all (*Gilgil Care System Assessment, 2025, Hope and Homes for Children internal field assessment*). This matters because the difference between prompt and delayed care seeking is, for some childhood illnesses, often the difference between recovery and death.

A separate study establishes the size of the mortality reduction from timely illness detection. *Sazawal and Black's (2003)* meta-analysis of community-based trials across several low- and middle-income countries measured this in two ways. First, it measured the reduction in deaths from pneumonia itself: 36% among infants, 36% among children aged 0 to 4, and 42% among neonates. Second, it measured the reduction in deaths from all causes, a smaller figure, 20 to 27% depending on age group, because pneumonia accounts for only part of overall child deaths.

This report uses the pneumonia specific figures, not the all-cause figures, because they isolate the effect timely case management has once a child already has a treatable illness. The all-cause figures are diluted by children who die from causes pneumonia case management cannot address, so they would understate the effect of timely detection this pathway is concerned with.

This is used here as evidence of the size of the mortality reduction from timely illness detection, regardless of setting. This report draws a conservative estimate, 35 to 40%, from the pneumonia specific range. That estimate sits close to the two lower age group results – 36% for infants and for

children aged 0 to 4 – and stays clear of the highest, neonatal figure of 42%.

Read the other way round, if timely case management reduces mortality by 35 to 40%, delayed or absent treatment implies a mortality risk of 1 divided by 0.65 to 1 divided by 0.60. That means a child who does not receive timely treatment faces approximately 1.5 to 1.7 times the mortality risk of a child who does, for the illness in question. This 1.5 to 1.7 range compares two groups of children who are both part of the general community population – those who received timely pneumonia treatment against those whose treatment was delayed or absent. It is a general population finding about the value of catching illness early. It is not specific to institutions.

Applying this range to institutionalised children specifically requires one further step. It assumes that being confined in a residential institution places a child, at minimum, into Sazawal and Black's delayed treatment group rather than their timely treatment group. The evidence set out above supports that assumption, and points further. Community settings, of the kind Sazawal and Black studied, still have referral mechanisms and networks that eventually notice a sick child. Gilgil describes institutions with no mechanisms for detection or treatment. If that is right, an institutionalised child's position is at least as severe as, and plausibly more severe than, the delayed treatment end of Sazawal and Black's comparison. This means 1.5 functions here as a floor for what this pathway's contribution should be.

The Gilgil assessment is a single internal field assessment from one sub-county. On its own, it does not prove residential institutions and orphanages generally have worse illness detection than community care settings, but it gives no support for the opposite assumption – that institutions

do better. And it aligns with the evidence on the Romanian, Irish and US systems presented in section 5.1.5. Nonetheless, this pathway's contribution is discounted below the 1.5 floor, at 1.3. The argument for treating 1.5 as a floor rests on generalising the Gilgil assessment, a single internal assessment from one sub-county in Kenya, to describe residential institutions and orphanages across every conflict affected country this report covers. That generalisation is supported by van IJzendoorn et al.'s wider evidence on the prevalence of globally depriving institutions, and by what Hope and Homes for Children's own country teams and partner organisations report observing elsewhere. Nevertheless, it remains a generalisation, so setting this pathway's contribution at 1.3 is a reasonable way of hedging against it.

Taken together, this evidence supports treating delayed illness detection as a second, independent contributor to elevated mortality risk for children confined in residential institutions and orphanages. As with growth delay, the figure used here, 1.3, should be read as a conservative floor rather than a precise estimate for this population, more likely to understate than to overstate the true mortality cost of delayed detection inside residential institutions and orphanages.

Again, the same Batty, Kivimaki and Frank finding referred to in the growth delay pathway – more than double the adult death rate following childhood state care – does not distinguish between mechanisms. But it points in the same direction. This report's overall peacetime mortality risk range, produced by combining every pathway in this model, still falls short of that finding. Again, that suggests the range understates the true cost of institutional confinement rather than overstates it.

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ARTEM'S STORY

Artem* (10) was removed from the care of his older half-sister after she was physically abusive toward him and placed in one of Ukraine's residential institutions. By the time Hope and Homes for Children began working with him, he had never attended school and had fallen significantly behind. He especially needed medical and psychological support the centre was not giving him.

Staff at the centre changed constantly, Artem says, and he never had one person he could turn to for support or guidance. When he fell ill, staff would refuse to treat him. They told him it was his parents' job, not theirs. No doctor was ever called. No appointment with a nurse was made. His clothes did not fit properly, and when he asked staff to fix a broken zip on his jacket, he got the same answer, that his parents should fix it, not them.

Artem was not allowed to leave the centre's grounds, even when his own parents came to visit him. On the days set aside for phone calls home, he was sometimes refused his turn, for reasons no one explained. And if one child in his group broke a rule, staff punished the whole group for it. Under this kind of regime, it was very difficult for Artem to have a safe space to speak with his parents or develop a close enough relationship with another responsible adult to alert them when he was ill.

Today Artem lives with a guardian family. He has his own room for the first time, and a pet. His birthday, never celebrated previously, was properly celebrated this year. And he has started swimming lessons.

Orphanage.
Hope and Homes for Children

“By the time Hope and Homes for Children began working with him, he had never attended school and had fallen significantly behind.”



5.1.3 Structural neglect

This pathway operates independently from growth delay and delayed illness detection. It concerns whether a child has continuous, individualised, quality time with a familiar adult, not whether enough staff are present to feed them or notice they are unwell. A child can be adequately fed, and seen quickly when sick, and still lack a stable, consistent attachment with the adults caring for them.

A **BOND** is an adult's felt connection to a child – the parent's or carer's side of a relationship. An “attachment” is the child's side of that same relationship – their connection to a caregiver or parent. This report is about what happens to children, so it reserves bond for the few places where it is specifically describing an adult, for example a parent's own legal standing and connection to a child.

DISORGANISED ATTACHMENT is the most severe and highest risk form of attachment insecurity. A child with disorganised attachment has no consistent way of seeking comfort from a caregiver, and instead shows contradictory, fearful or frozen behaviour toward them. Across 10 studies covering 399 children, the combined category of disorganised and unclassifiable attachment – security patterns that could not be confidently placed in any of the standard categories – was found in 54% of institutionalised children against a normative rate of 21% in children cared for in families, close to two and a half times as high (Lionetti, Pastore and Barone, 2015). This is not itself a mortality finding. It is direct evidence that institutional care does not simply fail to support attachment, it measurably pushes attachment itself toward its most disorganised and highest risk form.

STRUCTURAL NEGLECT describes the institutional conditions that prevent a stable attachment from forming in the first place – a regimented routine, a high ratio of children to caregivers, rotating shift patterns, and frequent changes of caregiver. This is different to “attachment disorder” which is a diagnosis applied to an individual child, based on that child's observed symptoms. Structural neglect instead describes the institutional conditions themselves, the exposure that gives rise to those symptoms, rather than a diagnosed outcome in any particular child. This report uses structural neglect for that reason, and because the underlying mortality evidence (Lannen et al., 2026) documents those institutional conditions and their association with mortality, not a clinical diagnosis in the children studied. A stable attachment depends on a consistent, familiar adult, not on how many staff are rostered at any one time. Residential institutions are structured around rotating shift workers by their very design, which means even a fully staffed facility does not give a child the kind of continuous, individual relationship a parent or single foster carer provides, in which a stable attachment can form.

Israeli kibbutzim, which for decades raised children with trained caregivers in communal children's houses rather than with their own parents at night, offer a natural illustration. Research on this system found markedly lower rates of secure attachment among children in communal sleeping arrangements than among children sleeping at home with their parents (Sagi et al., 1994). The system was gradually abandoned as this evidence accumulated (Aviezer, Sagi and van IJzendoorn, 2002). This corroborates, from outside the traditional institutional care literature, that even secure, well-resourced group care does not substitute for a stable attachment.

SASHA & OLENA'S STORY

Sasha* and Olena* are fostering 10 children long term – four of them from institutions, including a girl with severe disabilities. The couple have been fostering since 2011. Six other children have passed through their care over the years, among them a boy who arrived in the dark in handcuffs, left on their doorstep in the rain. He's grown now but keeps in regular touch.

Their roof was damaged as a result of aerial bombardment. Hope and Homes for Children supported the repair along with training for the couple. Fostering at this scale and under this pressure is a demanding, constant responsibility. Olena now helps train other foster parents herself.

Sasha serves in the Territorial Defence Force. By day he works and tends the family's livestock.

By night he takes part in efforts to bring down Russian drones. When the sirens sound, Olena has a routine. She makes soup and carries it down with the children into the cellar that serves as their bomb shelter. It is usually the same soup, and her same, calming tones. They play games together. Somehow, the cellar has become a predictably reassuring environment for the children.



“The children were here, and I was right beside them, defending them, protecting them.”

Sasha

Foster parents Sasha and Olena, Ukraine.
Heorhii Derhachov / Hope and Homes for Children

The attachment security gap holds, even where physical resourcing favours the institution. A study of HIV positive children in Ukraine found that institutions offered a better physical environment than families on a standardised assessment of the caregiving environment, but produced larger gaps in physical growth and cognitive development, not smaller ones (*Dobrova-Krol, van IJzendoorn, Bakermans-Kranenburg and Juffer, 2010a*). A related paper from the same research group examined attachment specifically, and found institutionalised HIV positive children were markedly less likely to form a clearly discernible attachment relationship than those cared for in families (*Dobrova-Krol, Bakermans-Kranenburg, van IJzendoorn and Juffer, 2010b*). This is not itself a mortality finding, but again, it is suggestive of adequate physical care not substituting for a stable attachment.

This can have lethal consequences. The scale of these consequences is illustrated by a 60-year follow-up study of children placed in Zurich infant institutions, where physical and medical care was judged adequate throughout. Because nutrition, staffing levels and medical resourcing were held constant at an adequate standard, the study isolates relational deprivation as the variable driving any excess mortality. It found an all-cause mortality hazard ratio of 1.48, adjusted for gender and birth weight, with a 95% confidence interval of 1.01 to 2.17 (*Lannen et al., 2026*).

This figure is likely to understate the true effect. The study's own authors identify two reasons why. First, a large share of the institutionalised cohort emigrated and were harder to trace, so if any of them died, their deaths were uncounted. Restricting the comparison to Swiss citizens, who could be tracked completely, raised the hazard ratio to 1.63. Second, the institutionalised cohort was born on average four years later than the comparison group. Left uncorrected, this age gap means the institutionalised cohort had fewer years of follow-up, making them appear less likely to have died during the study period than they actually were. Correcting for that gap raised the hazard

ratio to 1.58. Both corrected figures are higher than 1.48, and both are more clearly statistically significant than the reported figure. So 1.48 is treated as the conservative contribution of structural neglect to Component A, held constant for both floor and ceiling, consistent with how delayed illness detection is treated above, since the evidence supports a single reasoned figure rather than a graded severity range.

Lannen et al.'s finding is not an isolated result. Section 5.1.1 above already notes the 2022 systematic review and meta-analysis that found more than double the rate of adult mortality, and more than three times the rate of suicide during the study's follow-up period among people with a history of state care compared with peers raised in families (*Batty, Kivimäki and Frank, 2022*). A separate Swedish cohort study adds a further, more specific corroboration. It followed over 15,000 people from childhood into adulthood and found elevated all-cause mortality among those who had experienced any form of out-of-home care as children, and produced an adjusted hazard ratio of 2.85 against people with no such experience, and 2.18 specifically for those placed in residential institutional care (*Gao, Brännström and Almqvist, 2017*).

Neither this study nor the meta-analysis above isolates the precise comparison this report's model needs – a child in a residential institution against a child cared for in a family. Together, though, they show that the direction of Lannen et al.'s finding – meaningfully elevated mortality following childhood institutional or state care – is not unique to one cohort, one country or one research team.

Again, structural neglect does not overlap with delayed illness detection, it describes different causal chains. The clearest evidence that these two pathways operate independently of each other comes from the Lannen et al. study itself. Its institutions are described in the study's own words as providing adequate physical and medical care, implying illness was being reasonably identified and treated. Yet the same

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institutions gave children less than one hour of caregiver interaction a day, and mortality was still markedly elevated. So this is a setting in which the delayed illness detection mechanism appears to have been largely absent while the structural neglect mechanism was severe – and mortality rose regardless. Nevertheless, while it is unlikely that the two pathways of delayed illness detection and structural neglect are being counted twice, this report does not treat that evidence as conclusive proof of full independence.

5.1.4 Calculating the peacetime elevated mortality range

Together, these three pathways support a conservative peacetime mortality elevation for children in residential institutions of between 2.69 and 3.3 times that of children cared for in families, in low- and middle-income country settings, with no conflict present at all. The 2.69 figure at the floor of this range has been calculated by multiplying three contributions. The first is the growth deficit contribution of 1.4 times, using the conservative end of the Olofin et al. dose-response relationship, corroborated by the anaemia and iron deficiency evidence set out in section 5.1.1. The second is the delayed illness detection contribution of 1.3 times, a deliberate hedge below the 1.5 to 1.7 range implied by the *Sazawal and Black (2003)* study, as set out in section 5.1.2. The third is the structural neglect contribution of 1.48 times, Lannen et al.’s adjusted all-cause mortality hazard ratio, set out in section 5.1.3. These three contributions are multiplied rather than added, 1.4 times 1.3 times 1.48 to produce 2.69, because each operates through a distinct biological or care system pathway, making a multiplicative estimate consistent with standard epidemiological practice when risk factors are largely independent of one another.

The ceiling of 3.3 is reached by taking growth deficit at the ceiling of 1.7 times. As section 5.1.1 sets out, this 1.7 ceiling still falls within the mild underweight category’s own 95% confidence interval of 1.28 to 1.81

It is possible that some of the study’s underlying delayed illness detection’s own hazard ratio already partly reflect the physiological or behavioural consequences of relational deprivation, rather than delay in noticing symptoms alone, in which case some overlap between the two pathways would exist. To guard against the possibility of any overlap impacting the headline elevated mortality figure, the model applies a dampener to the final calculation (see section 6).

(*Olofin et al., 2013*). In order to maintain credibly conservative estimates this avoids drawing on the moderate or severe categories, which reach considerably higher, at 2.63 and 9.40 times respectively. Delayed illness detection is held at 1.3 times, the same figure used for the floor, rather than increased for the ceiling, because the evidence behind this pathway, set out in section 5.1.2, supports a single reasoned judgement rather than a graded severity range. Structural neglect is also held at 1.48 times at both floor and ceiling, for the same reason, set out in section 5.1.3. Multiplied directly, 1.7 times 1.3 times 1.48 produces 3.2708. This report presents this as 3.3, rounded for readability.

Bringing these three separate bodies of evidence together into a single mortality multiplier is one of this report’s original contributions and establishes the background lethality of residential institutions and orphanages before crisis onset. It provides an empirical anchor for the modelling of elevated mortality in conflict settings by establishing that during peacetime, a child in a residential institution or orphanage already faces close to three times the risk of death compared to a child cared for in a family. This is a pre-existing vulnerability that children in family care do not face, and one that is dramatically amplified in times of conflict.

Component A. How the peacetime mortality range of 2.69 to 3.3x is built

Three pathways, each evidenced separately, then multiplied together

Pathway	Evidence base	Floor	Ceiling
Growth delay	308 studies, 100,000+ children, 1.18 SD growth deficit (van Ijzendoorn et al., 2020). Olofin et al., 2013 converts SD deficit to mortality risk, floor drawn from the mild underweight category’s own confidence interval. Corroborated, not added to, by anaemia and iron deficiency evidence (<i>Fuglestad et al., 2013, Scott et al., 2014</i>) and by Batty, Kivimaki and Frank’s 2022 finding of more than double the adult death rate after childhood state care. Not multiplied in separately here, since it does not isolate a mechanism specific to growth delay, and is used in the same general way elsewhere in this report.	1.4x	1.7x
Delayed illness detection*	Caregiver contact approx. 6% of waking hours (<i>van Ijzendoorn et al., 2020, citing Juffer et al., 2017</i>). Sazawal and Black, 2003 pneumonia evidence implies 1.5x to 1.7x, from general community settings, not institutions. <i>Kallander et al., 2008</i> provides qualitative corroboration that prompt recognition of deterioration matters for these conditions. Hope and Homes for Children’s Gilgil, Kenya assessment finds a more severe condition than delay alone, no health worker, record or budget at all, which removes the case for discounting far below that range. Set at 1.3x, a conservative judgement. not a precise calculation.	1.3x	1.3x
Structural neglect*	60-year Zurich follow-up study, adequate physical and medical care throughout. Directly measured all-cause mortality hazard ratio (<i>Lannen et al., 2026</i>). Corroborated by a parallel finding on disorganised attachment in institutionalised children (<i>Lionetti, Pastore and Barone, 2015</i>), and by peacetime evidence from Israeli kibbutzim (<i>Sagi et al., 1994; Aviezer. Sagi and van Ijzendoorn, 2002</i>). Conflict specific escalation of this mechanism is addressed separately in Component C, section 5.3.1.	1.48x	1.48x

* Held constant at floor and ceiling. See note below.

Floor: 1.4 x 1.3 x 1.48 = 2.69x Ceiling: 1.7 x 1.3 x 1.48 = 3.3x

Peacetime mortality elevation for children in residential institutions: 2.69x to 3.3x

This exists before any conflict begins. War does not create this injustice, it finds it already there

Note: the 1.3x delayed illness detection figure is a conservative judgement weighing Sazawal and Black’s 1.5x to 1.7x community based evidence against the residual uncertainty of extending it into an institutional population, and is held constant at floor and ceiling for the same reason. Anaemia and iron deficiency evidence is not used again here as additional corroboration, since it is already treated as corroboration for growth delay above, and using it twice would risk double counting the same underlying nutritional mechanism.

Figure 4. How the peacetime mortality range of 2.69 to 3.3x is built.

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HHC PRACTICE INSIGHT – REVERSING THE HARM – RWANDA’S MPORE PEFA CLOSURE

The harm and subsequent vulnerabilities caused by residential institutions and orphanages that this section documents are not fixed. Hope and Homes for Children’s closure of the Mpire PEFA institution in Rwanda’s Kicukiro district illustrates how it can be reversed. Children were moved out of the institution, with some returned to their birth families, others joining extended kin, and some being adopted or fostered within Rwanda. Programme data collected on the 55 children aged under six found an average developmental gain of 38% across five indicators within

18 months, rising from 61% to 99% of what was expected for their age. The largest gain was in cognitive development, at 46% (*Hope and Homes for Children Rwanda, Mpire PEFA closure report, 2012, and internal programme data, 2022*). Similar results are consistently achieved across the 10 countries Hope and Homes for Children currently operates in. While this does not conclusively prove that every institutional harm can be reversed everywhere, it does suggest **that the associated mortality trajectory this section describes can be interrupted, and that family care is what interrupts it.**

Development of children (55) aged under six 18 months + after placement in alternative care (%)

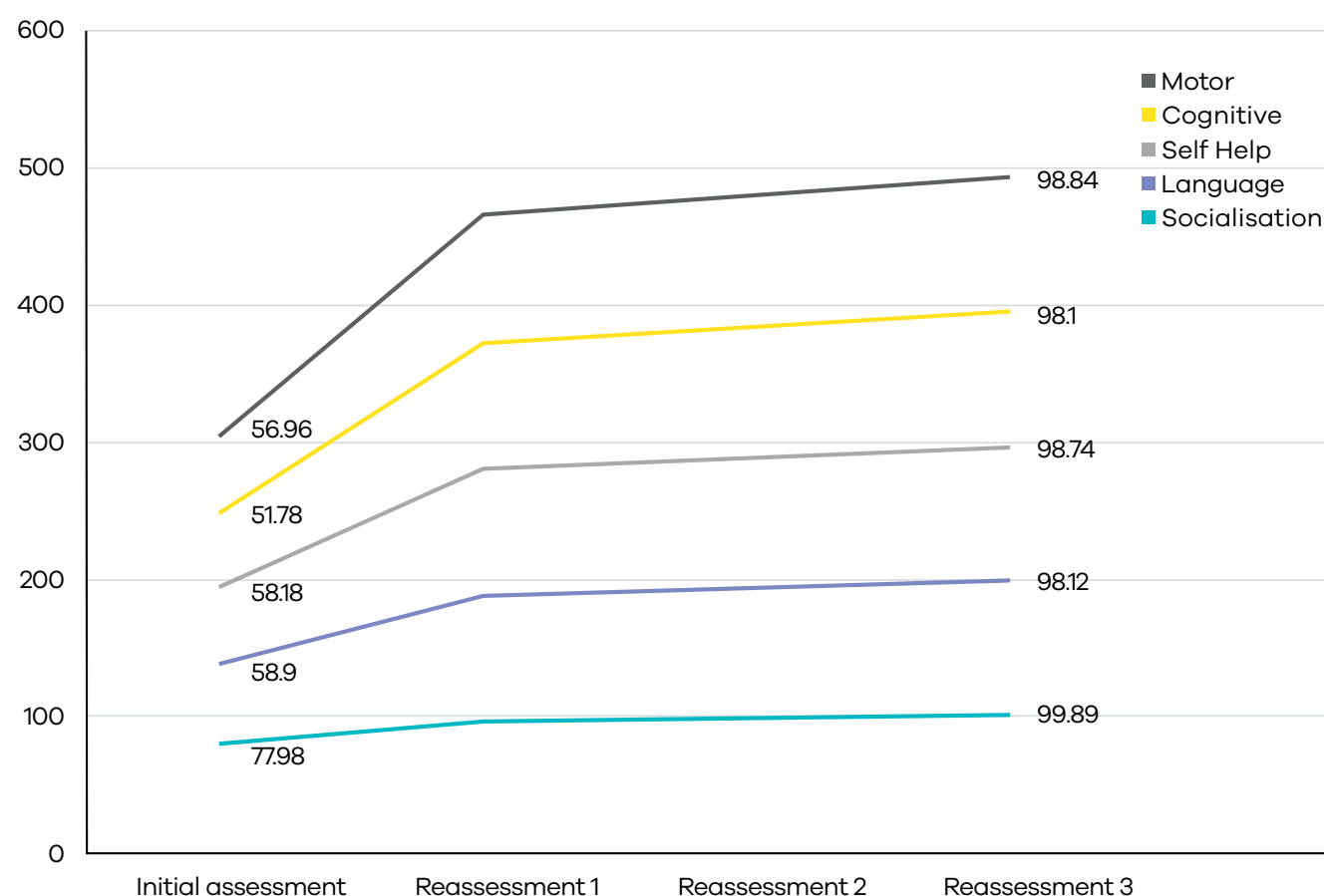


Figure 5.

5.1.5 The historical record does more than corroborate the peacetime elevated mortality finding, it points to longstanding knowledge of lethal systems of care that have been allowed to persist

The historical perspective on these findings matters because it establishes that the harm and elevated mortality associated with residential institutions and orphanages is not a byproduct of current times, and validates the overall conclusion that institutional environments are, by their very nature, unsafe for children. The recently published studies presented in the above section are part of a documented record that stretches back more than 100 years, across very different countries, political systems and cultures, illuminating an enduring structural pattern of catastrophic mortality.

In 1915, the New York paediatrician, Henry Dwight Chapin, published findings on infant institutions across 10 major US cities. In all but one, every child under two years old died. Colleagues at the American Society of Pediatrics confirmed the same pattern elsewhere – one Philadelphia institution reporting 100% mortality among infants under one, and Baltimore institutions recording approximately 90% mortality among 200 admitted infants, with the small number of survivors mostly explained by their removal to foster families. When a system of consistent maternal care was introduced for institutionalised infants at Bellevue Hospital in New York, mortality among children under one fell from between 30 and 35% to below 10% within a single year (*Chapin, 1915, cited in European Institute of Perinatal Mental Health, 2019*).

In Romania under the Ceauşescu regime, between 100,000 and 170,000 children were confined across more than 700 residential institutions by 1989. Official investigations by Romania’s Institute for the Investigation of Communist Crimes found that more than 15,000 children died across just 26 of the most severe institutions between 1967 and 1990, a figure its own researchers believe likely understates the true total across the full network. At the Cighid children’s home, 138 of the 183 children admitted died within 30 months, a mortality rate of 75.4%. Indeed, the volume of deaths was so high that Cighid required its own dedicated cemetery (*IICCMER, 2022, Foundation for Hope Romania, 2014*).

In Ireland, a network of 18 mother and baby homes was operated between 1922 and 1998, housing approximately 57,000 children born to unmarried mothers. Ireland’s 2021 Commission of Investigation into Mother and Baby Homes found that approximately 9,000 of those children died – just over one in six children. The Commission concluded that the homes significantly reduced children’s prospects of survival rather than protecting them. At St Mary’s in Tuam, County Galway, 796 of approximately 3,200 children entering the orphanage are known to have died over 36 years, with their remains being interred in a disused septic tank. At Bessborough House in Cork, infant mortality peaked at 82% in a single year (*Commission of Investigation into Mother and Baby Homes, Final Report, 2021*). The reason these children were separated from their families was because of discrimination. And that discrimination had lethal consequences.

These records, from three different countries and three different eras, converge on the same underlying finding this report has already quantified – that removing a child from family care and placing them in a residential institution or orphanage carries a measurable elevated mortality cost. The historical perspective not only establishes that the elevated mortality associated with residential institutions and orphanages has been known for many years in many locations, but that it was allowed to persist.

In this regard, the institutionalisation of children constitutes a state-sanctioned commitment to permitting and investing in the conditions that all the evidence shows precipitate mass fatalities.

The vulnerabilities associated with the pathways to this mortality cost are carried by children up to and during conflict onset. A child carrying vulnerabilities linked to growth deficit, delayed illness detection and structural neglect does not enter a conflict on an equal footing with a child growing up in a family who is less likely to have these vulnerabilities – they experience crisis in an already weakened condition. So the general rise in mortality risk that armed conflict brings to all children, described in the next section of this report, impacts an institutionalised child’s already compromised body with greater force.

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5.2 COMPONENT B: the general risks of war faced by all children, but which compound the pre-existing vulnerabilities of children confined in residential institutions and orphanages

5.2.1 Most deaths are not from bombs or bullets

The vast majority of excess deaths in conflict do not come from direct violence. They come from the collapse of health systems, from malnutrition and from untreated infectious disease.

This pattern has now been documented independently in three separate conflicts by three separate research teams using three different methods. In eastern Democratic Republic of Congo, a series of household mortality surveys conducted by the International Rescue Committee between 1998 and 2007, using stratified cluster sampling across the conflict-affected provinces, estimated 5.4 million excess deaths over this period. Well under 2% of these were directly attributable to violence across the IRC's own survey rounds, falling from 1.5% in earlier rounds to 0.4% in the most recent one, with the vast majority of deaths from the indirect public health effects of conflict through conditions such as malaria, diarrhoea and malnutrition that become fatal only once health systems collapsed (*International Rescue Committee, 2007*). The IRC's total figure of 5.4 million has been disputed. A later study using census and demographic survey data rather than household cluster sampling produced a considerably lower estimate, in the range of 1.7 to 2.4 million excess deaths for a similar period. What matters here is the proportion of deaths from indirect rather than violent causes.

In northwest Syria, a 2022 study found that conflict caused the crude mortality rate to more than triple, rising 3.55 times, and that from 2017 onwards most conflict-related deaths were from non-violent causes (*Alrashid Alhiraki et al., 2022*). In Sudan, a 2025 study using multiple systems estimation, a method for counting deaths in a population where full death registration has broken down, found that of an estimated 61,202 all-cause deaths in

Khartoum State between April 2023 and June 2024, some 26,024 were attributable to intentional violence, meaning close to 57% of deaths in this dataset were from other causes (*Dahab et al., 2025*). The proportion of violent to non-violent deaths is not identical across these three conflicts. What is consistent is the direction, that in every conflict examined, a very large share of excess civilian mortality comes from causes other than direct attack.

These studies measure population-wide mortality rather than isolating child deaths specifically. For children confined in a residential institution or orphanage with pre-existing vulnerabilities, where an interruption to feeding schedules, medication supply or medical access can be fatal within days, this indirect route to death is the one that matters most.

So this report treats conflict mortality as operating through two distinct routes. Direct conflict mortality covers death from violence itself, shelling, gunfire and the weapons of war. Indirect conflict mortality covers death from the collapse of the systems that keep children alive – health care, nutrition, clean water and sanitation. This distinction matters because it changes what protecting these children actually requires. It is not primarily about distance from front lines. It is about whether the systems a child depends on to survive keep functioning. A parent and families can adapt more easily when supply chains and services fail – finding food, noticing illness, seeking help. A child in a residential institution depends on a system doing all of that instead – the very system conflict disrupts or causes to collapse.

5.2.2 Estimating Component B's contribution to the model

Component B of the model concerns what armed conflict does to the general risk of death faced by all children in the affected location, whether they are in family care or in a residential institution or orphanage.

Two independent studies, *Jawad et al. (2020)* and *Abouharb (2023)*, establish that sustained conflict raises child mortality across the whole population. Both anchor the floor and ceiling of this report's general conflict mortality range, set out below.

Jawad et al.'s contribution is a 193-country panel regression, a method that tracks the same countries over time rather than studying one at a time. The study's raw data shows countries experiencing war averaging 1,355 deaths per 100,000 population per year, against 962 in countries with no conflict at all, a general population figure built from unadjusted average mortality rates rather than one calculated specifically for children.

This report uses that raw comparison deliberately, rather than Jawad et al.'s statistically adjusted estimate of war's effect. An adjusted estimate tries to strip out factors that caused a country's mortality rate independently of the war, such as a country already being poorer or having weaker infrastructure before conflict began. But some of what the study adjusts for is not a pre-existing difference. It is something the war itself caused, which then went on to cause deaths – a damaged health system, for instance. Removing this from the calculation understates war's true toll rather than correcting for something unrelated to it. Jawad et al. recognise this distinction themselves. They deliberately left health expenditure, HIV and AIDS prevalence, and refugee movement out of their adjusted model, stating that these "can be considered mediators (i.e. factors on the causal pathway between conflict and health) rather than confounders." This report extends the same reasoning to the other variables their model does

still adjust for, including GDP per capita, since in many conflict settings a country's income per person falls because of the war itself, rather than reflecting some fixed difference that existed before the war began. Using the raw, unadjusted comparison avoids this problem, and captures conflict's full impact on a population, including its damage to health systems, food production, and access to medicine and supplies.

There is good reason to expect that this general population figure understates the risk facing children, and especially younger children. Run separately by age group, Jawad et al.'s own adjusted model found that children under five experienced an absolute increase in war associated mortality of 263.7 deaths per 100,000, more than three times the general population's absolute increase of 81.5 deaths per 100,000 in that same adjusted model. This does not give a precise multiplier for children on the raw scale used below, since Jawad et al. do not publish a children specific baseline mortality rate to divide it by. But it does corroborate the elevated risk calculated below as a genuine floor for children, since the same study's own age breakdown shows war's mortality effect concentrating disproportionately on the youngest children it measured, an important signal addressed directly in section 7.

Abouharb's study distinguishes between types of conflict rather than treating war as a single category. Civil wars produced an average 5.2% rise in infant mortality in their first year, reaching 11.5% cumulatively in countries that had spent most of their existence in civil war. Major interstate wars, involving heavy artillery and sustained bombardment, produced a larger first year rise of 10.5%, reaching a cumulative doubling of infant mortality, from 61 to 122.4 per 1,000 live births in countries that had spent almost their entire existence in major interstate conflict.

B

Unlike Component A, the model does not combine the results of these three studies by multiplying them together, since each is measuring the same thing – the general effect of conflict on child mortality, rather than separate mechanisms that compound one another. The right way to combine independent estimates of the same effect is to identify the range within which they converge, treating any single study's most extreme figure with appropriate caution rather than adopting it outright.

The floor of the range for Component B draws directly on Jawad et al.'s panel regression across 193 countries, using the raw comparison set out above. Dividing 1,355 by 962 gives 1.4, meaning the average death rate in a war affected country is 1.4 times the rate in a conflict-free country. This figure is used as the floor because Jawad et al.'s data simultaneously spans all conflict types, civil wars and interstate wars together, across the largest and most methodologically distinct dataset of the two studies, making it the appropriate general baseline for a population that experiences both conflict types. As set out above, this is a general population figure rather than one calculated for children specifically, and the same study's age stratified findings suggest it understates rather than overstates the true figure for children. Applying it to children, as this report does, is therefore a conservative judgement, not merely an assumption.

Abouharb's civil war specific finding – a cumulative rise of 11.5%, equivalent to approximately 1.1 times baseline mortality – is not used as the floor, because it measures only one type of conflict, and mixing a single conflict type's figure into a floor meant to apply generally would be a category error, not a genuine act of convergence.

The ceiling of 2.0 times has one published ratio pair directly behind it. Abouharb's finding for major interstate war – a cumulative doubling of infant mortality from 61 to 122.4 per 1,000 live births (a ratio of 2.0) – is the clearest evidenced anchor for the top of this range.

Other evidence corroborates the range of 1.4x to 2.0x. Children born in countries classified as fragile and conflict-affected face close to three times the risk of dying before age five compared with children born in non-conflict-affected countries – 70 against 26 deaths per 1,000 live births in 2023 (*UN Inter-agency Group for Child Mortality Estimation, 2024*). This is a cross-country comparison, not the kind of within-country, over-time comparison Jawad et al.'s panel regression provides, since fragile and conflict-affected states differ from other countries in poverty, health infrastructure and governance capacity, as well as in conflict exposure, and this report does not treat the full gap as attributable to conflict alone. This 3x figure sits above the model's Component B ceiling of 2.0, and is treated as corroborating context.

Component B: the general conflict mortality range

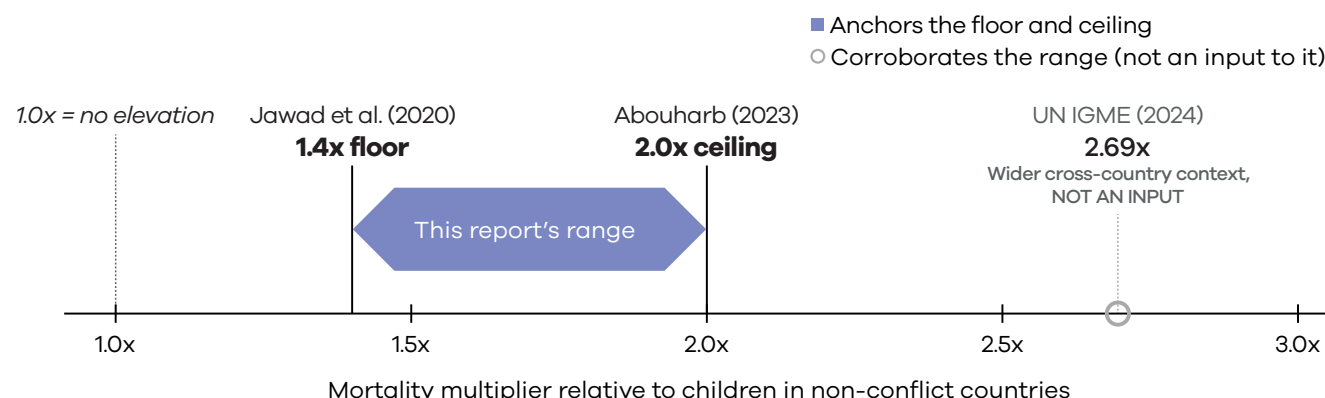


Figure 6. Two independent studies anchor a general conflict mortality range of 1.4 to 2.0 times, corroborated by a further study of cross-country data.

5.3 COMPONENT C: the mortality risks specific to residential institutions and orphanages that conflict converts from chronic to acute

An objection that might be raised about this model is, if institutionalised children start from a worse baseline of health, and conflict makes everyone worse off, is that not the whole story? It is not.

Residential institutions and orphanages introduce a third set of risks – structural features of the institutional form itself, that have limited equivalents for a child in family care. All five of these mechanisms are structural vulnerabilities of institutional life that already exist in peacetime. Each becomes a mortality risk in conflict through a specific trigger, a discrete event or condition that conflict introduces, and that converts an already present vulnerability into a likelier fatal outcome. The trigger differs by mechanism. For kinship severance, it is an armed actor's demand for recruits, informants or control. For fixed location, it is violence reaching a site that cannot relocate, and the friction of an evacuation an institution cannot manage the way a family can. For state guardianship, it is the sudden displacement, occupation or upheaval that separates a child from an institution at the exact moment the capacity to search for them is diminished. For documentation failure and fabrication, it is the chaos and reduced oversight of crisis, in which records are more easily lost or falsified and less easily checked. For humanitarian invisibility, it is the specific architecture of a humanitarian response, built around child protection channels these institutions sit outside of. Component C's floor and ceiling are built from these five mechanisms collectively. One, kinship severance, anchors the floor through a structured judgement, calibrated most directly on the clearest single study available. The other four are not separately quantified, but each is documented as converging with kinship severance in the same settings, to shape the calibration of Component C's ceiling. Each mechanism is illustrated by documented events from real conflicts.

Placing measured peacetime vulnerabilities inside a conflict specific component is not a departure from established practice. Indeed, it is standard, current practice in an entire field of epidemiology concerned with exactly the question of how an acute event converts an already present, independently measured vulnerability into a fatal outcome, without needing to divide that vulnerability's origin between the two. This reasoning was established by Mittleman and colleagues' study of heavy physical exertion as a trigger of acute myocardial infarction. It found that a person's underlying cardiac risk, built up over years and measured entirely independently of any single moment of exertion, could be converted into a heart attack by a discrete, acute trigger (*Mittleman et al., 1993*). Mittleman and Mostofsky's 2011 review extended the same triggering framework across physical, psychological and chemical events. A 2014 systematic review in the *European Heart Journal* applied it to anger specifically (*Mostofsky, Penner and Mittleman, 2014*), and a 2025 review applied the same logic to respiratory viral infection (*Nguyen et al., 2025*). This report applies that same reasoning to each of the five mechanisms set out below – each a peacetime measured or documented vulnerability that conflict converts into a more likely fatal outcome through its own specific trigger.

That conversion does not always happen in a single moment. Research on children separated into institutions after Indonesia's 2004 tsunami distinguishes primary separation, caused directly by the disaster, from secondary separation, where a child is placed later, as a family's capacity to cope erodes over the following weeks and months. A parallel survey of Islamic boarding schools in tsunami affected Aceh

C

found only a quarter of affected children were already there when the disaster struck. The rest arrived over the following year, 20% immediately afterwards, 25% within six months, and 24% within a year (Martin, 2013). The same distinction applies to the five mechanisms below. Some convert vulnerability into risk in a single acute moment, such as a building destroyed in one strike. Others operate on a longer, delayed timeline, a family's capacity to keep a child collapsing gradually as conflict continues, well after the point of onset.

This section also explains the method behind that reasoning, since it differs from Component A's. Component A's three pathways each have a study that measures something close to a direct mortality hazard ratio. None of the five mechanisms here does. Forcing each one into its own exact multiplier would manufacture a precision the evidence cannot support.

5.3.1 Kinship severance

Kinship severance is the severing of a child's relationships with brothers, sisters and wider family, for example when residential institutions and orphanages hoover up children from their families, or separate siblings by age. This is a peacetime vulnerability. Institutionalisation itself creates it, independently of any conflict, since a child placed in a residential institution or orphanage already lacks the continuous presence of a protective family member. Conflict escalates and deepens the impact of kinship severance through a specific trigger – exposure to recruitment by an armed actor's demand for combatants, labour, informants or control. A child without a present, protective adult is easier to engage and influence, easier to move and easier to exploit than a child a family can marshal itself to protect. As the evidence below shows, what converts kinship severance from a standing vulnerability into an acute mortality risk, is the moment an armed actor targets an exposed child through recruitment, induction, kidnapping, trafficking or forced transfer.

Instead, this report uses the GRADE methodology, developed for rating the certainty of evidence in health guidance (Guyatt et al., 2008, BMJ), and a structured expert judgement framework, used in risk fields like nuclear safety when a quantity cannot be measured directly (Cooke and Nane, 2021). Both methods share the same discipline. They state how certain each piece of evidence is, show the reasoning openly enough that a reader could weigh it differently, and test the resulting judgement against the most unfavourable assumptions available. Caution is required, though. GRADE's certainty ratings have shown only limited ability to predict whether effect estimates hold up over time, and structured expert judgement can only be validated against quantities that are eventually checked. Neither method, therefore, is a guarantee of accuracy.

KINSHIP SEVERANCE. *A child with a present, protective family connection has people to resist an armed actor's approach, an alternative source of belonging that reduces the pull of joining an armed group, and a place to return to that gives purpose to reunification and escape. Severing that connection removes both protection and purpose. It takes different forms across different conflicts – recruitment into an armed group, induction into a national army, kidnapping from an institution, forcible transfer and deportation – but each is a different manifestation of the same underlying loss: a child without a present, protective adult or family connection is easier for an armed actor to reach and exploit.*

Research across the Democratic Republic of Congo and the Central African Republic found that the erosion of protective family relationships was a primary driver of adolescents' recruitment into, and return

to, armed groups (Blackwell et al., 2023). A longitudinal study following the same cohort of Sierra Leonean former child soldiers over several years found that post-conflict social factors, including family and community acceptance, predicted their later mental health more strongly than factors from before or during the war, with reduced stigma and greater acceptance associated with better outcomes (Betancourt et al., 2010). Neither study is about institutionalised children specifically. But together they establish the underlying mechanism – that family connection, or its absence, shapes both a child's vulnerability to recruitment and their capacity to recover from it, independent of where that child was living when the war reached them.

But there is specific evidence concerning these same mechanisms operating on children already severed from family and already confined together in residential institutions and orphanages when armed actors arrive. Human Rights Watch documented an instance of the Myanmar army holding some 60 children aged 13 to 14 at an army camp in Rakhine State who had been "adopted by the army", most of them severed from close family, and told they would be inducted once old enough. A specific case describes a boy who lost both parents, was taken in by the army, and told he had to become a soldier "to repay his debt" for being "adopted" (Human Rights Watch, 2007, *Sold to Be Soldiers*).

Syria shows the same pattern in a more organised and more directly institutional form. The Islamic State kidnapped thousands of children directly from orphanages, as well as from schools, as part of a wider child recruitment programme (International Centre for the Study of Radicalisation, 2018). It was found that these children were specifically targeted, a pattern they attribute to the group's freedom to operate largely unchallenged in the territory it controlled and to a wider strategy of targeting children who had less adult supervision (Hamming and Amarasingam, 2023). On the researchers' own account, these children were reachable in part because they were already concentrated in a known location.

Ukraine provides the starkest illustration, and the most recent. Yale University's Humanitarian Research Lab has identified more than 8,400 Ukrainian children relocated to at least 57 facilities in Russia, part of a broader pattern in which Ukraine's own Bring Kids Back UA initiative estimates more than 19,000 children deported in total, with only 1,236 returned. Yale's research states that Russia targeted vulnerable groups for this programme, many from residential institutions, and documents a designated cadet school creating a direct pipeline into Russia's armed forces. The UN Special Rapporteur on Trafficking in Persons, in an October 2025 report to the UN General Assembly, identified family separation and the absence of guardians for separated and unaccompanied children as risk factors for child trafficking in conflict settings generally, and cited patterns of alleged expedited adoption and forcible transfer of children in Ukraine specifically (UN Special Rapporteur on Trafficking in Persons, 2025, A/80/166, reported in Office of the United Nations High Commissioner for Human Rights, 31 October 2025). Albeit applying different methods, this is the same elevated risk, documented independently across the Democratic Republic of Congo, the Central African Republic, Sierra Leone, Myanmar, Syria and Ukraine, over three decades, by researchers and journalists.

A systematic review of refugee and asylum-seeking children and adolescents in Europe found markedly elevated rates of clinically significant mental disorder compared with general population children (Kien et al., 2019, *European Child and Adolescent Psychiatry*). The review's included studies did not allow a reliable comparison between accompanied and unaccompanied children specifically, but what the finding shows is that children whose family attachment has been disrupted by displacement, the condition institutionalised children already carry before conflict hits, face markedly elevated rates of death, through impaired self-regulation, delayed help-seeking and heightened exploitation risk. This report treats the elevated prevalence Kien et al. documents as the basis for a calibrated, conservatively structured judgement, on

Component C's floor (section 5.3.2 sets out that judgement in full, and the wider evidence that supports it).

Kien et al.'s elevated prevalence is itself measured independently of any specific conflict, a chronic peacetime vulnerability in its own right, consistent with the pattern set out at the start of this section.

Where a child's placement is a consequence of orphanage trafficking (section 4.2), the act of severance is a

deliberate mechanism of recruitment itself, achieved through the fabrication of orphan status and the concealment of a child's family of origin (*van Doore, 2016*). This report does not attempt to quantify a separate contribution for this subset of the population, but notes that the severance judgement set out in section 5.3.2 is, for these children, present in a more complete and more intentionally engineered form, which supports reading that figure as conservative for that group.

5.3.2 The floor of Component C: 1.5x

The floor of Component C is set at 1.5 times. This is kinship severance's contribution.

It is not a figure read directly from a single study. It is a structured judgement, calibrated most directly from Kien et al.'s elevated prevalence study, and corroborated by six further, independent bodies of evidence that converge on the same mechanism: Blackwell et al.'s finding on the Democratic Republic of Congo and the Central African Republic, Betancourt et al.'s finding on Sierra Leone, Human Rights Watch's documentation of Myanmar, the International Centre for the Study of Radicalisation's and Hamming and Amarasingam's documentation of Syria, Yale University's Humanitarian Research Lab's findings on Ukraine, and the UN Special Rapporteur on Trafficking's 2025 finding that family separation and the absence of guardianship are risk factors for child trafficking and forced transfer in conflict, Ukraine specifically among them. No single one of these sources measures a mortality hazard ratio the way Lannen et al. does for structural neglect. Their evidential

weight comes from their number and their independence – six different conflicts, different decades, different research methods, converging on one finding: that severed family attachment, whatever form the resulting harm takes (recruitment, induction, kidnapping or forced transfer), is what an armed actor exploits once a child becomes detached from their family.

Kinship severance's 1.5 is not left to stand alone as a bare judgement either. The four further mechanisms this section documents, fixed location, state guardianship, documentation failure and humanitarian invisibility, are not separately quantified, but each describes a further mechanism through which conflict removes protection from an institutionalised child that a family, in the overwhelming majority of cases, retains. Their convergence with kinship severance in the same settings this report examines is treated here as corroborating evidence that 1.5 is a conservative floor for this component.

NADIA, TARAS & SASHA'S STORY

Three siblings, Nadia*, a teenage girl, Taras*, a younger boy, and Sasha*, their sister, were removed from their mother and placed in an institution before the full-scale invasion in Ukraine. The institution sorted them into separate age groups and did not let them see each other. Nadia was bullied so badly and for so long, it left her with a skin condition, damaged sight, and problems with her adenoids.

When the institution evacuated west after the invasion, the three were placed together with a foster carer, Kateryna*, a placement Hope and Homes for Children helped to arrange. It took Taras several months to overcome night time anxiety. Kateryna found a routine that settled him, by taking him into the garden at night with a torch to help her plant flowers.

And for more than a year, whenever a new child was placed with them in the foster family, Nadia, Taras and Sasha asked Kateryna the same question: do you still love me?

An institution that categorises children by age, rather than recognising brothers and sisters as a family and trying to understand them on that basis, actively severs kinship attachments, the very relationships that children depend upon to feel safe and to work through prolonged periods of anxiety.

“Kinship attachments are the very relationships that children depend upon to feel safe and to work through prolonged periods of anxiety.”



Family.
Ron Lach

5.3.3 Fixed location: increased exposure to direct violence and delayed capability to evacuate

A residential institution or orphanage cannot disperse, relocate or adapt the way a family can. This is a peacetime vulnerability. A fixed site with a concentrated, dependent population is exposed to any disaster that can reach it, fire, flood, earthquake, not only war. Conflict converts this into an acute mortality risk through two distinct triggers. The first is violence reaching a site that cannot move out of its path – shelling, siege or crossfire striking a building that was never built to disperse. The second is the moment evacuation itself becomes necessary, when an institution's dependence on staff, transport and external authorisation to move its children, rather than a family's ability to simply leave, becomes a source of potentially fatal delay. Both triggers act on the same underlying feature. A family facing danger can choose to leave on its own. A residential institution depends on someone else's capacity and permission to do the same, and that dependency is what this section documents.

This is not a new observation. Hope and Homes for Children exists because of it. In 1994, our founders Mark and Caroline Cook read about children in Sarajevo's main orphanage during the siege of the city, and travelled there within weeks. They found the Bjelave orphanage had sustained hits from mortars and heavy weapons in its exposed position on top of one of the city's hills, with teenagers left to scavenge food in the streets, and babies crammed into the only warm room in the building, the basement (*Hope and Homes for Children, Our Story*). A fixed, identifiable structure, in a city under siege, could not move out of the path of the war around it.

Hope and Homes for Children's own field teams have documented this risk directly and more recently on the Rwanda – Democratic Republic of Congo border. In January of 2025, stray small arms and rocket fire, associated with fighting across the nearby border, struck an orphanage in Gisenyi housing children with disabilities.

At least 21 residential institutions for children in Ukraine were damaged or destroyed in the first nine months of the 2022 invasion, according to Ukraine's National Social Service, and Human Rights Watch has documented dozens more across the country since (*Human Rights Watch, 2023*). Facilities supporting people with disabilities specifically were among those affected – a monitoring report found 16 psychiatric residential care facilities, 3 boarding houses and nursing homes for people with disabilities and older adults, and 6 residential care departments destroyed or damaged across Ukraine by 1 November 2022 (*Kharkiv Institute of Social Research, League of the Strong, National Assembly of People with Disabilities and European Disability Forum, 2023*). On 1 September 2024, Russian forces struck a rehabilitation centre and an orphanage in Sumy directly, injuring six children (*United24 Media, 2024*). A stronger building is not a safer one if it cannot move when the threat does.

Even when evacuation is possible and successful, significant friction remains. In March 2022, 43 children, 11 accompanying carers and nine of the carers' own children, were evacuated by Hope and Homes for Children from the Centre "It Is Good at Home" in Dnipropetrovsk to Iași, Romania. The evacuation succeeded because the conditions for it already existed before the invasion – complete individual records for every child, an established relationship with Romanian child protection authorities, and carers recruited and already trained to offer family care. Nevertheless, it was still delayed because of the initial bureaucracy within the regional administration – which itself had actually made the request for support for the evacuation – with more than two weeks of negotiation before the cross-border transfer went ahead (*Postoliuk, personal communications, 2026*). Even this successful evacuation still moved at the pace of an administration's authorisation, not the pace of oncoming danger.

The clearest illustration of what happens when self-evacuation is structurally impossible, rather than merely delayed, occurred in March 2017, when staff and police at Guatemala's Hogar Seguro Virgen de la Asunción institution locked up a group of girls in a schoolroom, following protests about sexual violence and an escape attempt the previous night. A fire broke out. The girls were not released. Forty-one of them, aged 14 to 17, died (*Disability Rights International, 2018, Still in Harms Way, and multiple news sources, 2017 to 2025*). This was not a conflict context, but it is the same mechanism this section describes taken to its most extreme form, a fixed population, concentrated in a fixed location, unable to remove itself from danger because someone else controlled their ability to move.

The evacuation trigger set out above has two edges. Sometimes an institution's dependency means it moves too slowly and does not leave in time. Sometimes, as Guatemala shows, evacuation itself,

whatever it is evacuating people from, is not possible for a population that depends entirely on others.

This is corroborated by direct evidence from Ukraine's own institutions. Disability Rights International's review of evacuations following the full-scale invasion found that children with the greatest support needs were consistently the ones left behind, while children with fewer support needs were more often moved to safety. Institution staff cited insufficient staffing and a lack of transport as the reasons given (*Disability Rights International, 2023*). Component A has already established that institutionalised children carry pre-existing vulnerabilities. What Ukraine's evacuations show is the specific consequence when a fixed, dependent population is exposed to an acute stressor its carers cannot fully manage. Their pre-existing vulnerability meant that the institution's capacity to evacuate everyone ran short – they were the ones left exposed to the danger the evacuation was meant to avoid.

5.3.4 State guardianship and the absence of a parent with the agency to instigate an effective search

A state does not stop being legally responsible for a child simply because the facility confining them is private or unregistered. Under international standards, that responsibility persists regardless. What is typically missing is not legal responsibility in the abstract, but a specific, dedicated adult, someone with both the standing to act on a child's behalf and an ongoing personal connection to that particular child, able to notice they are missing and search for them. In residential institutions and orphanages, that combination is structurally rare, in peacetime. It becomes acute in conflict. Guardianship in the formal sense may sit with the state, but the state exercises it through rotating staff and distant administration, not through a named individual with a personal bond to the child. Parents are blocked or, by virtue of their dislocation from and lack of proximity to their child, cannot make a unilateral decision or easily initiate a search.

Conflict's trigger is sudden separation – the moment evacuation, occupation, displacement or detention moves a child away from an institution faster than any record can follow them – precisely the moment a family would notice a child was missing and start to search. A child who goes missing from a residential institution or orphanage during a conflict is more likely to stay missing because no one is appointed or enabled to find them. Disability Rights International's investigation of Ukraine's institutions after the full-scale invasion found that children, especially those with the most severe disabilities, were repeatedly left behind or lost track of during evacuations, with no parent able to report them missing or search for them, because they either lacked the legal standing to do so, or had lost contact (*Disability Rights International, 2023*).

This is corroborated by the United Nations' review of Ukraine. A summary of the Committee on the Rights of Persons with

Disabilities' session on Ukraine, in August 2024, records the government confirming that children living in institutions had been evacuated at the start of the full-scale invasion without the proper documents in place, and that a single database bringing together the country's separate child protection registries was still being developed two years into the war (OHCHR, 2024). A summary of a session of the Committee on the Rights of the Child records a Committee Expert describing significant numbers of children who had fallen through the cracks of the country's data collection (OHCHR, 2022).

Syria's civil war shows the same failure, where the absence of a mandated adult to search was not just structural. Under the Assad government, intelligence agents transferred the children of detained parents into orphanages, sometimes demanding total secrecy. An investigation by Lighthouse Reports, published in September 2025 with the BBC, The Observer and Der Spiegel, built a database of over 320 confirmed children moved this way, with at least 3,700 children missing under the Assad government. The investigation found children falsely recorded as abandoned orphans, others given new names, and orphanages that later denied the children had ever been there (Lighthouse Reports, 2025). A separate investigation by NPR, published in March 2025, found that staff at one orphanage did not properly track the children placed with them at the time, and that full records were only handed to the country's new authorities after the government fell in December 2024, years after the children arrived (NPR, 2025).

In June 2018, Uganda's government announced that only 70 children's homes had been formally approved, with 569 more ordered to close for operating illegally, though enforcement of that closure order did not follow (ChimpReports, June 2018). Earlier government estimates from 2012 put the sector at roughly 300 registered against 600 unregistered institutions, housing approximately 6,000 children. Haiti shows the same pattern. A 2013 study by Haiti's own child welfare institute, IBESR, cited in a Lumos Foundation

report, found that less than 15% of the country's approximately 760 orphanages were officially registered, housing around 32,000 children, more than 80% of whom had at least one living parent. The report found that no official system existed to record children entering or leaving these orphanages (IBESR, 2013, cited in Lumos Foundation, 2017). The state's underlying legal responsibility does not disappear because a facility is unregistered, but in practice there is often no parent to alert and no state record to search against.

The same absence of a dedicated adult shows its cost beyond search and registration too. A 2026 study followed 102 adolescents relocated to Istanbul after the 2023 Kahramanmaraş earthquake in Türkiye, 48 living with their families and 54 in residential care. It assessed post-traumatic stress one month after the earthquake and again three months later (Erbay et al., 2026). At the first assessment the two groups showed similar rates of post-traumatic stress. By the second, the adolescents living with their families had improved significantly, while those in residential care showed no measurable change. Psychiatric conditions alongside post-traumatic stress were also far more common among the adolescents in residential care, 42.5% compared with 8.3% of those living with their families. This like-for-like, comparative study follows children from the same age range, impacted by the same disaster, at the same time, being cared for in the same city, is not able to establish whether confinement in a residential institution caused this difference, but it does describe how children without an attached, dedicated adult did not recover from an acute shock the way children with one did.

In many of the conflict-affected countries noted in the appendix, the common pattern is more severe. Most institutions in these settings are privately-run and unregistered. The state's legal responsibility in these situations is difficult to transfer in practice because these facilities are unregistered, and weak, largely unapplied regulation in these contexts means that responsibility is rarely exercised through a dedicated adult able to notice a child is missing and search for them.

SOFIA'S STORY

Sofia* was first placed in an institution as a young child, after her mother was unable to care for her and a brief stay with her grandmother could not continue for health reasons. She waited three years for a family. At nine, she was adopted. The next four years did not provide the family life she had hoped for. She describes ongoing hostility and bullying from her adoptive mother, and eventually ran away and told the police she would not go back.

Sofia returned to an institution. In 2024, Ukraine's Children's Services Authority went to court to remove her adoptive mother's parental rights. Her adoptive mother appealed, as far as the Supreme Court, to have the adoption annulled instead. While that case worked through the courts, over several years and against the backdrop of a country at war, Sofia's own future stayed unresolved. No single adult took on or was given the mandate to address it – placed in an institution, it was assumed she would be okay. She was enrolled in a remote catering course without being asked what she wanted to study, and missed two years attending her college classes in person because no one was available to drive her there.

Sofia described staff shift patterns in the institution changing without warning, and the children often had to ask the administration directly just to find out who was working that day. Some staff were kind, she says, but the institution's administration could be harsh with children who had no one to stand up for

them, and would humiliate them verbally. There was no privacy. Even a private conversation with her closest friend was not possible, since a staff member always had to be able to see them. When she had stomach aches, the nurse could offer only herbal tea since staff were not authorised to give medicine.

In 2026, Hope and Homes for Children's work to transform the facility brought a case manager, Tamara, into contact with Sofia. Tamara looked closely into her situation. Within months, Sofia had moved into supported, independent living.

Sofia's years in legal limbo are a real instance of what this section describes – the absence of any single adult with the standing and the means to act decisively on a child's behalf. It happened to her over several years, during the war, not because one official was careless, but because the institutional system is not designed to deliver individualised, accountable care, support and monitoring.

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The institutional system is not designed to deliver individualised, accountable care, support and monitoring.
”

Institution.
Andreea Tănase / Hope and Homes for Children

5.3.5 Documentation failure and fabrication

A child's identity, medical history, nutritional requirements, disability status and legal record, and intimate knowledge of them, move with a family. In residential institutions and orphanages, that knowledge is neither tacit nor physical, and even when documented, it is often incomplete, often absent, held centrally rather than with the child, and is vulnerable to being lost entirely or destroyed during a forced evacuation. A child without documentation is a child that receiving authorities, humanitarian registration systems and, eventually, tracing services struggle to place, identify or reunite with any surviving family.

This is a chronic, peacetime condition. Most of the evidence in this section, from Romania, Guatemala, Georgia, Nepal and the Democratic Republic of Congo, comes from settings with no conflict at all. Conflict's trigger is the chaos and reduced oversight any crisis brings, conditions in which records are most easily lost, destroyed or deliberately falsified, and least easily checked by anyone able to intervene. Haiti's earthquake, a non-conflict disaster, is the clearest illustration below of how quickly this trigger can operate even without war. What that trigger converts a documentation gap into, an acute mortality risk rather than an administrative failing, is set out in full at the end of this section.

In January 2010, days after Haiti's earthquake, 10 American missionaries were arrested attempting to move 33 Haitian children across the border into the Dominican Republic. None of the children had any documentation. Aid workers and officials on the ground found that most, if not all, had living parents, contradicting the missionaries' claim that the children were orphans, and the group's leader was later convicted on a reduced charge of arranging "irregular travel". Haiti's Prime Minister, Jean-Max Bellerive, described it as illegal trafficking of children (*NPR, 2010*). The 33 children came within reach of being moved across an international border because in the acute chaos after a disaster, no papers existed for anyone to check.

Documentation failure has a second mode, distinct from records simply being lost. In some settings, records are actively manipulated and fabricated, and this is precisely what the *Hague Convention on Intercountry Adoption (1993)* exists to prevent. The Convention requires that a child's own family and community be exhausted as options before intercountry adoption is considered, that birth families are protected from exploitation and pressure, and that adoptions are barred from producing improper financial gain.

Romania is the starkest historical case. Human Rights Watch documented over 100,000 children in Romanian institutions following the fall of the Ceaușescu regime (*Human Rights Watch, 1990, Romania's Orphans: A Legacy of Repression*). International adoptions followed at scale, around 30,000 Romanian children were adopted abroad between 1989 and 2001, before a moratorium was imposed that year amid European concern that the system was corrupt and children were being sold to foreigners. That corruption is documented in a confidential investigation by Romania's own Child Protection Authority into FAMA, a children's charity, reported by The Irish Times in 2002. The investigation found FAMA had sent children abroad using false and incomplete documentation, presenting them to prospective adoptive families as available orphans when they in fact had living parents in Romania. "Holiday" trips to Ireland were undertaken to introduce children to those families.

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False documentation
was the mechanism that
allowed a child with a living
parent to be presented as
an orphan available for
adoption purchase.

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Guatemala shows the same mechanism operating more recently and at scale. US embassy cables spanning 1987 to 2010, obtained and published by the Schuster Institute for Investigative Journalism at Brandeis University, document systematically falsified paperwork presenting purchased or stolen children as legitimate orphans. The cables also record birth mothers who were coerced and threatened, and, in cases embassy officials themselves acknowledged at the time, killed after refusing to relinquish their children (*Siegal, The U.S. Embassy Cables, Adoption Fraud in Guatemala, 1987 to 2010, Schuster Institute for Investigative Journalism, Brandeis University*).

Georgia presents a variant of the same failure. Up until 2006, staff in institutions for mothers and babies routinely told mothers, typically around the third day after birth, that their newborn had died, citing invented causes but producing no death certificate or body. Rather than being registered as deceased, the infants were held briefly, often by nannies in rented flats, before being sold to adoptive families, domestically for several months' wages, and internationally for as much as 30,000 US dollars, to families in the United States, Canada, Greece, Israel, Cyprus, Russia and Ukraine (*Shoshiashvili, OC Media, 16 March 2023; Agence France-Presse, 3 July 2024*). A 2015 investigation led to the conviction of the former director of the Rustavi Maternity Hospital and eight others, and a reunification project run by journalist Tamuna Museridze has since matched more than 800 families through DNA testing (*Agence France-Presse, 3 July 2024*). Museridze's own estimate that between 100,000 and 120,000 births may be affected comes from her own investigations, not from an independent government count, and should be read as an estimate of scale rather than a verified total. Comparable mechanisms of health workers falsely telling mothers their newborns had died in order to place them for payment have also been documented in Spain into the 1980s and in Chile into the 2000s, indicating this is not a single

national aberration but a recurring pattern in which the same safeguards the Hague Convention on child abduction was designed to close have failed in more than one country.

Fabricating a child's orphan status does more than enable an illegal adoption. It turns them into a commodity. Kathryn van Doore, the researcher who coined the term "paper orphans" (*van Doore, 2016, Paper Orphans: Exploring Child Trafficking for the Purpose of Orphanages, International Journal of Children's Rights*), describes recruiters approaching families, often in poor rural areas, with the promise of a quality education for their child. Once the child is relocated, false documentation, including a new identity and a fabricated death certificate for the parents, converts them into an orphan on paper. That fabricated status is what makes the child eligible for what van Doore calls the "supply chain of people, money and resources that drives the orphanage industry," the foreign donors, orphanage voluntourism and ongoing funding that sustain whole orphanage economies. As she puts it, "there is clear evidence that volunteering and/or funding orphanages are fuelling the demand for paper orphans and orphanages" (*van Doore, quoted in Griffith University, 2016*). No adoption needs to take place for this to work. The fabricated status alone is enough to attract donors and volunteers for as long as the institution can sustain it.

“
A child fabricated on paper
as an orphan is not only a
documentation problem, it is
the very mechanism through
which children are confined
in orphanage economies –
economies that have deeply
rooted, structural interests
in their confinement.

”

Nepal illustrates the paper orphan crisis at scale. The US State Department's 2024 Trafficking in Persons report found that around 11,000 children remain in Nepal's 418 registered children's homes despite around 80% of them having at least one living parent, and that a third of registered facilities fail to meet government minimum care standards. The same report states that some children's home operators force children to beg or keep children destitute to attract donations.

The Democratic Republic of Congo shows this same dependency operating at the level of the state itself. In July 2014, the country's Directorate General of Migration told the US State Department that it considered no intercountry adoption free of fraud, and that all recently reviewed exit permits were believed to be falsified (*US State Department, Adoption Alert, Democratic Republic of Congo, 10 July 2014*). The Democratic Republic of Congo is a conflict-affected state, and intercountry adoptions from it remain suspended under a 2016 law amid continuing concern about the adequacy of its safeguards.

In March 2022, Hope and Homes for Children Ukraine opened talks with the European Union delegation, recommending that an information and tracking tool for children in alternative care, separated children and unaccompanied children be developed (*Hope and Homes for Children Ukraine, Report on the work of Hope and Homes for Children Ukraine, 24 February to 31 March 2022*). No such tool existed at that point. A receiving authority facing a child who arrived without documentation had no clear way of checking which institution the child had come from, who their guardian had been, or where any surviving family might be.

Documentation failure elevates mortality risk in conflict through two connected mechanisms. The first works through delay. A lost or incomplete record of a child's medical history, disability status and nutritional needs means a receiving

hospital, clinic or evacuation team is treating a child about whom they know nothing. This happens at the exact moment health systems are least able to compensate, when staff capacity to ask questions or run tests is close to collapsing. The UN's own inter-agency guidance on separated children states that "careful documentation is the most important part of the tracing process" (*International Committee of the Red Cross, International Rescue Committee, Save the Children UK, UNICEF, UNHCR and World Vision International, Inter-agency Guiding Principles on Unaccompanied and Separated Children, 2004*). The second mechanism works through exclusion. A child who is not registered is a child the humanitarian system overlooks, excluded from vaccinations, emergency nutrition and feeding programmes, and critical medical response. This is exactly what the International Rescue Committee found in Gaza, where the absence of a structured registration system left many separated children "unreached by assistance programmes" for months (*International Rescue Committee, 2024*). Fabrication intensifies both mechanisms. A child moved with false papers, or presented as an orphan when a parent is alive, is removed entirely from the accountability and guardianship structures addressed in section 5.3.4, the very structures a tracing service or medical system would otherwise use to find and protect them. In conflict, when courts, registries and communications are themselves disrupted, that lost oversight has no realistic prospect of being reconstructed in time to matter.

Documentation failure is not merely an administrative gap, but the mechanism that removes the information and oversight other pathways to elevated mortality depend on to be caught and corrected. It is a structural trigger that converts pre-existing chronic risks facing children confined in residential institutions and orphanages into acute threats to life.

5.3.6 Humanitarian invisibility

Residential institutions and orphanages are typically governed by health, education or justice ministries rather than child protection authorities, and they are routinely absent from the rapid needs assessments, the basis upon which who gets what humanitarian assistance is determined. This invisibility exists whether or not there is a conflict. What conflict adds is the trigger, the moment a crisis begins and a humanitarian response stands up its assessments, registration systems and resource allocation, built around child protection channels these institutions sit outside of. The response arrives, but not to them, which is what converts a pre-existing administrative issue – which ministry a facility reports to – into a mortality risk, since the children inside a residential institution or orphanage are exactly the ones a humanitarian response is least likely to find.

A 2022 article in the International Review of the Red Cross found that children with disabilities are systematically overlooked by humanitarian response systems, citing data invisibility. The UN found, in January 2022, that 42% of country-level monitoring task forces believed children with disabilities were not given sufficient space in their own reporting, and documented cases of humanitarian organisations turning away children with disabilities from aid programmes for lack of capacity or training (*International Review of the Red Cross, 2022, At Risk and Overlooked: Children with Disabilities and Armed Conflict*). Human Rights Watch's investigation in Syria reached the same conclusion, finding that none of the UN Secretary-General's own reports on Syria's humanitarian situation addressed the needs of children with disabilities, despite a 2019 Security Council resolution specifically requesting that they do, and quoting an aid worker's own admission that "most humanitarians still think disability inclusion is about rehabilitation centres, building ramps, [and] providing wheelchairs" (*Human Rights Watch, 2022*). In Europe and Central Asia, the region where this has been measured, children with disabilities

are up to 30 times more likely to live in residential care than children without disabilities, and sit at the sharpest point of this failure (*UNICEF, In Focus: Ending the Institutionalization of Children and Keeping Families Together*).

At the point of conflict onset in April 2023, the Mygoma institution was run by Sudan's Ministry of Social Development and Ministry of Health, not a dedicated child protection authority, and fell outside the structures that shaped the humanitarian response. Seventy-one children died there in the seven weeks that followed, including 26 who died over a single two-day period in late May, before the remaining children were evacuated in a joint operation involving those same two ministries alongside UNICEF and the ICRC (*Al Jazeera, 2023*). The ministries that eventually acted were the ones that had been running the institution throughout the crisis. No separate child protection authority was ever in the loop.

“When war engulfed Khartoum in April 2023, the Mygoma institution was run by the health ministry rather than a child protection authority, so it fell outside the rapid needs assessment that shaped the humanitarian response. The 71 confirmed infant deaths in the first seven weeks of the conflict are the cost of that gap.”

Indonesia's 2004 tsunami shows the same failure at a larger scale, and in a form of care humanitarian actors did not even recognise as residential care. A rapid assessment led by Save the Children found 207 residential institutions across Aceh province caring for over 16,000 children

in the two years after the disaster. Only around 2,500 of those children were tsunami victims placed as a result of the disaster itself, and of those, only 10% had lost both parents. Almost half of the institutions surveyed had been established since 2000, and their number had roughly doubled again between 2000 and 2006, disaster funding being the driver of expansion of the numbers of institutions. A second, parallel survey of Islamic boarding schools, dayahs, found they held five times more tsunami affected children than the formal institutions did, over 15,000 children, and were almost entirely outside the child protection response, since they were seen as ordinary religious schools rather than a form of residential care. The research team’s own conclusion stated that these children’s “numbers, their situations and their relationships with their families were unknown” (Martin, 2013). Researchers also found almost no effort had been made to check whether unaccompanied children were being taken directly to institutions and dayahs rather than the camps and barracks where registration and tracing systems were actually concentrated. Two entire categories of residential care were invisible to the same response that was actively searching for separated children a short distance away.

Ukraine shows the scale of this challenge. Ukraine had more than 700 orphanages and boarding schools holding over 105,000 children when the full-scale invasion began in February 2022. These residential institutions sit under three separate ministries, with day-to-day responsibility spread across 24 regions, and no single child protection authority holding the full picture (Reuters, 2022). By September of that year, the government and UNICEF were struggling to trace nearly 26,000 children who had been sent back to families or guardians since the invasion began, because Ukraine’s own record keeping system, known as UIAS Children, was never built to track a child once they left an institution, meaning they remained invisible to the humanitarian system. Officials resorted to logging cases manually

using Google forms and spreadsheets before a dedicated tracking module went live in May 2022 (Reuters, 2022).

Residential institutions are too often perceived as relatively safe and secure care environments, which is another reason why humanitarian systems overlook the children they confine. A joint statement by the United Nations Committee on the Rights of the Child and the Committee on the Rights of Persons with Disabilities, on 7 October 2022, warned that children with disabilities remaining in Ukraine’s understaffed, underserved and overcrowded institutions were “subjected to a disproportional risk of mortality,” a warning issued by committee expert Rosemary Kayess as winter approached and infrastructure damage continued (OHCHR, 7 October 2022).

Combined, the lack of an actively searching adult, incomplete documentation, and weak or absent tracking systems established the conditions in which the forced transfer of Ukrainian children out of residential institutions into Russia was able to happen at scale, with very limited subsequent progress in negotiating their return. Human Rights Watch documented at least 100 institutions, holding more than 32,000 children before the invasion, in areas that came under Russian occupation (Human Rights Watch, 2023, Ukraine: Perils of War for Children in Institutions). Putin’s own decree of 30 May 2022, simplifying Russian citizenship specifically for Ukrainian children left without parental care, gave this transfer a direct legal route once a child had been deported (Ukrainska Pravda, 30 May 2022). In March 2023, the International Criminal Court issued arrest warrants for Vladimir Putin and Maria Lvova-Belova (the Russian Children’s Ombudsman) on charges relating to the unlawful deportation and transfer of children. In March 2026, the UN’s Independent International Commission of Inquiry on Ukraine concluded that the deportation, transfer and enforced disappearance of Ukrainian children amount to crimes against humanity (OHCHR, 12 March 2026).

5.3.7 Estimating the range

The five mechanisms above are not captured by Component A or Component B. A family whose caregiver flees conflict is still, in the overwhelming majority of cases, embedded in a kinship or community network, still able to move, still documented and still visible to the systems that register displaced people. An institutionalised child in the same location typically loses, or never had most or all of those protections at once.

The table below sets out how each mechanism was reasoned through, following the graded approach described earlier in this section.

Mechanism	Best available evidence	Certainty	Role in the range
Kinship severance	Kien et al. (2019), corroborated independently across the Democratic Republic of Congo, the Central African Republic, Sierra Leone, Myanmar, Syria and Ukraine.	Low certainty for a precise multiplier. Moderate to high certainty for the direction and mechanism, given independent convergence across six conflicts.	Supports anchoring of the floor at 1.5.
Fixed location	Precise, primary sourced facility damage counts in Ukraine. A directly attributable death count in Guatemala. Direct evidence that children with the greatest support needs were left behind during Ukraine's institutional evacuations.	Moderate to high certainty on the mechanism and on documented consequences. Low certainty on magnitude outside the two anchor cases.	Corroborates the floor. Contributes to the case for the ceiling.
State guardianship	Documented evacuation abandonment in Ukraine, from Disability Rights International. Strong evidence from Syria. Unregistered sector estimates from Uganda.	High certainty on the scale of the underlying gap. Low certainty on its direct mortality contribution, since none of these sources measure death.	Corroborates the floor.

Mechanism	Best available evidence	Certainty	Role in the range
Documentation failure	A government child protection agency investigation in Romania. Leaked diplomatic cables from Guatemala. A documented crisis era case from Haiti. A state's own admission of systemic fraud from the Democratic Republic of Congo.	Moderate to high certainty on the mechanism, evidenced across four countries and three decades. Low certainty on a specific multiplier.	Corroborates the floor. Contributes to the case for the ceiling.
Humanitarian invisibility	A peer-reviewed practitioner piece documenting the general pattern, from the International Review of the Red Cross, 2022. A precise national scale figure from Ukraine, 26,000 of 105,000. A formal UN treaty body's own mortality finding from the Committee on the Rights of Persons with Disabilities, 2022. A single documented mass death event at Mygoma – 71 deaths.	Moderate certainty on the general pattern. The strongest single attributable mortality event of the five mechanisms.	Corroborates the floor. Contributes most directly to the case for the ceiling.

The floor of 1.5 rests on kinship severance as its most direct anchor, but does not rest on that anchor alone. It is corroborated by four further mechanisms, each independently evidenced, each showing a different way conflict strips an institutionalised child of the protection that a child cared for in a family in the same conflict is far more likely to retain.

The ceiling of 2.7, somewhat less than double the floor, is not derived from a further calculation on these five mechanisms individually. It is a structured judgement, and the case for it rests on convergence with the most extreme settings this report documents. Ukrainian institutions in 2022 and 2023 show all five mechanisms operating simultaneously and at high intensity – fixed sites damaged or destroyed, guardianship absent, documentation lost, thousands of children untraced, and a formal UN finding of disproportionate mortality risk for exactly this population. Mygoma shows the same

convergence in a different country – a fixed site, a collapsed attachment structure and a humanitarian response that arrived only after the deaths had already occurred. A less-than doubling of the floor in documented conditions is, on this evidence, reasoned as a conservative judgement.

Two considerations bound the judgement. A smaller uplift would understate the qualitative difference between an institution experiencing one of these failures in isolation and the settings described above, where several operated together and at sustained intensity. A substantially larger uplift would claim a precision about combined effects that these documented cases, real as they are, cannot support, since none of them offers a measured total, only a convergence of evidence. Less-than doubling is a checkable benchmark against which a reader can weigh the evidence for themselves.

Section 6

THE NUMBER, BROUGHT TOGETHER

“Children in residential institutions face at least 2.02 times the mortality risk of children cared for in families living through the same conflict.”



Destruction in the Kyiv region of Ukraine. Evheniy Zavhorodniy / Hope and Homes for Children

6.1 THE CALCULATION

This report combines the three findings above, the baseline harm of confinement in residential institutions and orphanages before conflict, the general mortality effect of war on all children, and the structural failures specific to institutions in conflict-affected settings, into a single estimate. Because these three effects operate through largely separate causal routes – different ways a child might die – the model combines them by multiplying them together rather than adding them, consistent with standard practice in epidemiology when risk factors act through independent pathways (Rothman and Greenland, *Modern Epidemiology*, 1998).

Component B, as section 5.2 sets out, describes a general rise in mortality that conflict brings for every child in an affected population, whether they are cared for in a family or confined in a residential institution or orphanage. Because it applies to both groups alike, it is not included in the calculation that this report’s headline leads with. That comparison is built from

Components A and C alone – the peacetime harm of institutional life and the structural failures specific to institutions under conflict conditions – since these are the two effects that actually distinguish an institutionalised child’s risk from the risk faced by a child cared for in a family in the same conflict-affected location.

Using the most conservative, lowest values for each – 2.69 for Component A and 1.5 for Component C – multiplying them together gives 4.04 times. Because some of the evidence behind these two components may share a small amount of common ground rather than being perfectly independent, most notably the peacetime evidence behind state guardianship and structural neglect discussed in section 5.3, a robust downward adjustment of 50% is applied. This produces the headline finding of this report – that children in residential institutions and orphanages in conflict-affected countries face a mortality risk at least 2.02 times higher than children cared for in families living through the same conflict.

A second, wider comparison follows from bringing Component B back in. Multiplying all three components together, 2.69, 1.4 and 1.5, gives 5.66 times, and applying the same 50% adjustment gives 2.83 times. This is the gap between an institutionalised child’s mortality risk and a child cared for in a family prior to conflict onset – a comparison that captures both the harm of institutional life and the toll conflict itself takes.

This report treats 2.02x as its central finding, since it isolates what institutionalisation itself changes for a child already living through a given conflict, and treats 2.83 as a further, compounding measure of how much worse that child’s position is than it would have been had they never been institutionalised at all.

The same reasoning applies with equal force at the other end of both ranges. The uncertainty about how independent these components truly are does not disappear when the least conservative values are used instead of the most conservative ones, so the same 50% adjustment is applied to every ceiling as well. As with the floor, this calculation carries each component’s value before rounding through to the final result, to avoid compounding rounding error across multiple steps, and rounds only the displayed answer. Using the least conservative defensible value for each component, Component A’s ceiling before rounding, 3.2708, set out in section 5.1.4, and 2.7 for Component C, multiplying them together gives 8.8 times. Then applying the same dampener gives 4.4 times.

“
The elevated mortality range for children confined in residential institutions and orphanages during conflict, compared to children cared for in families in the same settings, is therefore 2.02 to 4.4 times.
”

Bringing Component B back in, 3.2708, 2.0 and 2.7 multiplied together gives 17.66 times, and applying the same dampener gives 8.8 times. This report’s wider, peacetime-comparison range is therefore 2.83 to 8.8 times.

The 50% dampener is not a number chosen because it sounds appropriately cautious. It reflects a general recognition that there is unlikely to be a completely clean demarcation between the factors considered in Component A and the factors considered in Component C. The world these components describe is complex, and treating them as perfectly independent when they plausibly share some unacknowledged ground would overstate this report’s central finding. A similar order of correction is standard practice in comparative risk assessment more broadly, where combining risk factors that are not fully independent, without some downward adjustment, is known to substantially overstate their true combined effect. The World Health Organisation’s own comparative risk assessment work on cardiovascular disease found that correlated risk factors combined to 64% of disease burden, against 126% from an uncorrected sum – a correction close to 50% (*Ezzati, Lopez, Rodgers and Murray, 2004*). More recent methodological guidance in the same field describes correcting combined risk estimates in broadly this way as standard, ongoing practice. (*Plass et al., 2022*).

Component	What it measures	Floor	Ceiling
A. Elevated mortality, residential institutions in peacetime	Growth delay, delayed illness detection and structural neglect, before conflict	2.69x	3.3x
B. General elevated mortality for all children in conflict, family or institutional care alike	The rise in child mortality conflict brings for all children, converged across three studies	1.4x	2.0x
C. Additional mortality, institutions, conflict escalates or activates	Kinship severance is quantified. Four further mechanisms converge with it to inform the ceiling	1.5x	2.7x

▶ **A 50% dampener is used to adjust for any unidentified overlap between the components.**

**Central finding:
same conflict, right now**

An institutionalised child against a child cared for in a family, both living through the identical war. Component B is not included in this calculation. It would raise both children's risk by the same amount, so it cancels out of the ratio between them.

A

x

C

Floor: 2.69 x 1.5 = 4.04 Dampened = **2.02x**
Ceiling: 3.3 x 2.7 = 8.84 Dampened = **4.4x**
Stress test, additive, adversarial: 2.12x
2.02x to 4.4x higher than a child cared for in a family in the same conflict

**Wider finding:
against life before the war**

An institutionalised child today against a child cared for in a family before the conflict began. This brings Component B back in, the toll conflict itself takes.

A

x

B

x

C

Floor: 2.69 x 1.4 x 1.5 = 5.66 Dampened = **2.83x**
Ceiling: 3.3 x 2.0 x 2.7 = 17.66 Dampened = **8.8x**
Stress test, additive, adversarial: 2.22x
2.83x to 8.8x higher than family life before the war began

Children in residential institutions face at least 2.02 times the mortality risk of children cared for in families living through the same conflict, right now

rising to 2.83 times when measured against family life before the war began

Note: Two structurally different models, one multiplying genuinely independent risk pathways, one adding deliberately unfavourable, sub floor values, produce 2.02x against 2.12x on the same conflict finding, and 2.83x against 2.22x on the wider, peacetime comparison finding. The adversarial model exceeds the primary model on the first comparison, and remains below it on the second, even though every one of its inputs was set below this report’s own floor for that component.

Figure 7. The whole model, brought together.

6.2 THE STRESS TEST

As a deliberate stress test, a second, structurally different model was constructed, using addition rather than multiplication, populated with sub-floor values – values set below the lowest values used in the main model, and below what the evidence itself supports, chosen specifically to be as unfavourable to this report’s own conclusion as can still be defended. This is not an alternative method offered for the reader to choose between. It is an adversarial check, built to see whether the finding survives a construction designed to work against it.

The **ADDITIVE MODEL** uses two baselines, matching the two comparisons the primary model presents. The same-conflict baseline, representing the mortality risk of a child cared for in a family through the same conflict, expressed as a factor of 1.0, the reference point this comparison is measured against.

Component A is made up of three pathways – growth delay (1.4x), delayed illness detection (1.3x) and structural neglect (1.48x). Removing structural neglect entirely – a deliberately unfavourable assumption – reduces the contribution Component A makes to the adversarial model – just 1.4 times 1.3 = 1.82x. Component C’s contribution to the adversarial model is set at 1.3x, chosen because it sits below the 1.5x floor of the main model – again a deliberately unfavourable value for this adversarial test. Component B is not added again here, since the baseline of 1.0 already represents a child living through the conflict, and adding it a second time would count the same effect twice.

The **PEACETIME BASELINE** is also 1.0, but represents a child in family care before the conflict began. Against this baseline, Component B’s own contribution to the adversarial model is added, 1.1x. This figure was chosen to sit just below Abouharb’s civil war specific finding taken alone, a cumulative rise of 11.5%, equivalent to approximately 1.1 times baseline mortality, the single most conservative individual estimate this report has used anywhere for general conflict mortality, well below the 1.4 times floor of the main model.

Taking an additive approach to compare the increased risk of death of a child confined in a residential institution or orphanage to a child cared for in a family in the same conflict setting, the adversarial model must avoid counting the baseline twice, so only the excess above 1.0 is carried forward, such that Component A’s 1.82x contributes 0.82, and Component C’s 1.3x contributes 0.3 as follows: 1.0 plus 0.82 plus 0.3, to give 2.12 times. So even on a construction deliberately built to work against this report’s own conclusion, every input set below this report’s own floor for each component, including a Component A input that treats structural neglect as contributing nothing to it at all, the result still exceeds 2.02. This report treats that as evidence that 2.02 is more likely to understate the true elevation in mortality risk than to overstate it.

Adding these together against the peacetime baseline, a wider, secondary comparison, 1.0 plus 0.82 plus 0.1 plus 0.3, gives 2.22 times, against the primary model’s 2.83 for the same comparison, a result that stays below the primary model on this wider measure, albeit suggesting that any legitimate disagreement about this model concerns its precise magnitude, not whether the underlying elevation in mortality is real.

6.3 LIMITATIONS OF THIS MODEL

No study currently exists that directly measures the mortality differential between children in residential institutions and children in family care within the same conflict-affected population. This is the central limitation underlying every figure in this section.

This model is a first attempt to construct that estimate from converging indirect evidence, consistent with established practice in comparative risk assessment when direct measurement is unavailable (*IHME Global Burden of Disease Protocol, 2024*). It is not a substitute for the direct study this report recommends is undertaken (section 11).

Two studies come closer than any others to measuring this comparison directly, though neither is set in a conflict-affected country. *Whetten et al. (2009)* compared institutional and community-based care across 2,837 children in Cambodia, Ethiopia, India, Kenya and Tanzania, and found no statistically significant difference in wellbeing between the two settings. A later analysis of the same dataset, *Huynh et al. (2019)*, found that care setting explained none of the variance in children’s wellbeing once food security, shelter quality, caregiving quality and health care access were accounted for, and concluded that quality of care, not setting, was the operative factor. *Braitstein et al. (2021)* followed 2,551 children in western Kenya and found an adjusted hazard ratio for death of 0.26 comparing institutionalised children to children cared for in families, with a 95% confidence interval of 0.07 to 1.02. That confidence interval crosses 1, meaning the study cannot rule out there being no difference at all, and it runs from a strong protective effect at its lower bound to essentially no effect at its upper bound of 1.02, not to a meaningfully harmful one – a common consequence of counting a small number of deaths within a cohort of this size. This is a limitation of statistical power, not evidence of equivalence. None of these three studies measured mortality in a conflict-affected setting, which is the specific claim this report makes, and Whetten and Huynh did not measure mortality at all. Each study also compared institutions to a broad, undifferentiated family or community-based group, extended family, grandparents, or

randomly selected households, with no measure of whether that placement received any external support. Huynh et al.’s own finding, that quality of care rather than setting predicts wellbeing, is directly relevant here. It suggests that an unsupported family placement can carry its own risks, not that institutional and family care are equally safe. That finding supports, rather than undermines, this report’s recommendation, which is to invest in support for family strengthening and alternative forms of family care, not to treat placement in a family setting as sufficient in itself.

Two sources of imprecision need particular attention. One is that the comparison group used for this report’s central, same-conflict finding is a child in family care living through the same conflict, who will also likely be facing a degraded caregiving environment due to parental burnout and trauma (*van Ijzendoorn et al, 2026*). Measured against the peacetime baseline instead, that particular effect is already addressed, since a family before the conflict began does not carry that same war-driven strain, which is part of why the range extends up to 4.4 rather than stopping at 2.02.

A second, separate source of imprecision works in the opposite direction. Both baselines generalise across the whole population of families in a given setting, rather than adjust for the specific families whose children are actually at risk of institutional placement (during peacetime and during conflict). Those families are, on average, more vulnerable, and are more likely to be dealing with the consequences of poverty and facing challenges accessing services than the general population this model’s family baseline represents. And that vulnerability is likely to widen further once conflict hits. What this means is that a comparison family carrying more vulnerability/risk than the general average would narrow the true gap with a child confined in

a residential institution, not widen it. That said, the population generalisation applies to institutionalised children too, among whom children with disabilities are over-represented (see section 7), which would work to widen the elevated mortality gap.

This report does not attempt to adjust for these two areas of imprecision because the evidence to quantify them does not exist, and because they pull in opposite directions rather than compounding each other. We cannot say with confidence which one dominates, only that they remain unaddressed by the range presented. Nevertheless, the stress test gives a level of confidence that there is a gap in elevated mortality and that it is significant. Even when every input to that adversarial, additive construction is set below the main model’s own floor for each component, including a Component A input that treats structural neglect as contributing nothing to it at all, the resulting same-conflict figure, 2.12x, still exceeds the headline finding of 2.02. This report treats that result as further evidence that 2.02 is more likely to understate the true elevation in mortality risk the model describes. A single adversarial construction is not proof though, and it is not presented as such, but it is a meaningful check that the model’s central finding survives deliberately unfavourable assumptions.

The structural neglect mechanism, drawn from Lannen et al.’s Zurich cohort, measures mortality associated with the absence of a stable, consistent caregiver offering individualised care inside the institution. It does not offer visibility regarding whether the

children in that cohort retained some ongoing contact with kin outside the institution. Where that contact might exist for some children, the true mortality consequence of absent stable individualised caregiving in an institution could be somewhat smaller than the study implies, because ongoing contact with kin outside the institution could be providing part of the same protective function.

A 50% dampener is introduced to address the impact of any unidentified overlaps between components. The reason why 50% was chosen is explained above, but as a further transparency measure, the table below shows how the central ranges move under different dampener assumptions, from a smaller 40% downward adjustment to a larger 60% one, so a reader who judges the overlap between Components A and C to be smaller or larger than this report assumes can see directly what that judgement would do to the final figures.

In all cases, a significant elevated mortality among children confined in residential institutions and orphanages compared to children cared for in families remains.

This model is built and evidenced specifically for armed conflict. Some of the mechanisms this report describes – the collapse of health systems, interrupted supply chains and the absence of a searching adult – plausibly extend to other crises that produce comparable disruption, such as famine or large scale natural disasters, for example. This report has not evaluated evidence from those settings and does not claim that its mortality range applies outside armed conflict.

Dampener	Same-conflict range	Peacetime-comparison range
40%	2.42 to 5.3 times	3.39 to 10.6 times
45%	2.22 to 4.9 times	3.11 to 9.7 times
50% (used throughout this report)	2.02 to 4.4 times	2.83 to 8.8 times
55%	1.82 to 4.0 times	2.55 to 7.9 times
60%	1.62 to 3.5 times	2.26 to 7.1 times

Section 7

WHAT THIS MEANS FOR CHILDREN WITH DISABILITIES AND INFANTS



Institution, Rwanda.
Hope and Homes for Children

Institution, Rwanda.
Hope and Homes for Children

7.1 WHY AN AVERAGE FIGURE UNDERSTATES SOME CHILDREN’S RISK MORE THAN OTHERS

This report’s central range of 2.02 to 4.4 times, and its wider, peacetime-comparison range of 2.83 to 8.8 times, are both population level estimates. They describe the elevated risk facing institutionalised children in conflict-affected countries generally. As population level estimates, they should not be understood to imply that every child faces identical risks. Standard practice in child mortality research assumes real

heterogeneity beneath any such average – driven by age, disability and other factors that change how severely the mechanisms already documented in this report actually bear down on a given child. This section sets out what the wider literature says about two groups within the institutionalised population this report is concerned with – children with disabilities and infants – for whom the direction of that heterogeneity is not genuinely in doubt.

7.2 CHILDREN WITH DISABILITIES

UNICEF’s Children with Disabilities in Emergencies resource states that children with disabilities are more likely to be left behind, abandoned or neglected in crises, and more likely to face barriers accessing aid. Corroborating this is Disability Rights International’s 2023 finding that children with the greatest support needs were consistently the ones left behind during evacuations of Ukraine’s institutions, while children with fewer support needs were more often moved to safety.

The wider mortality evidence on disability supports this pattern. A systematic review and meta-analysis across low- and middle-income countries, pooling 267,415 people with disabilities from 62 cohorts in 22 countries, found children under 18 with disabilities face a hazard ratio of 4.46 for all-cause mortality compared with children without disabilities – with a 95% confidence interval of 3.01 to 6.59 – the highest elevated risk of any age group studied (*Smythe and Kuper, 2024*). A cohort study following 306 children with neurological impairments in rural Kenya for a median of 14.5 years found a mortality rate of 309.8 per 100,000 person years, against 80.8 per 100,000 person years in children without impairments, an adjusted hazard ratio of 4.24. Within this specific group, developmental delay and severe malnutrition were each associated with a further, much larger increase in mortality risk, to an adjusted hazard ratio of 18.92 for developmental delay and 20.92 for severe malnutrition (*Abuga et al., 2019, The Lancet Global Health*). That last finding connects directly to Component A of this report’s own model which documents growth delay and malnutrition as pathways through which institutionalisation elevates mortality risk. In this cohort, the combined effect of disability and malnutrition on mortality risk was substantially larger than either alone.

This pattern is not confined to low-resource settings. A national cohort study of 163,686 children and young people in Scotland, one of the best resourced health systems in the world, found a standardised mortality ratio of 10.7 for all-cause death in children and young people with intellectual disabilities compared to those without, rising to 27.4 among children aged five to nine specifically (*Hughes-McCormack et al., 2022, BMJ Open*).

A STANDARDISED MORTALITY RATIO compares the number of deaths actually observed in a group against the number that would be expected if that group had the same mortality experience as the wider population it is drawn from. A ratio of 10.7 means the observed number of deaths was almost 11 times what would have been expected had these children faced the same mortality risk as children without intellectual disabilities.

It is a reasonable assumption to make that children with intellectual disabilities in Scotland have relatively consistent access to healthcare and typically remain in family or community settings. This is what institutionalisation removes and conflict further erodes for many children with intellectual disabilities – such children have little reason to face a smaller elevation in risk than this study found.

DMYTRO’S STORY

Dmytro spent eight years of his childhood in a residential institution in Ukraine before he was adopted. He has given his permission for his account to appear here under his real name, in his own words, lightly edited for length and clarity.

“ I could not take care of myself, and the staff, they didn’t really come up to me and ask what I needed help with, what they could do for me. My experience is that you are just there because you need to be there, because you are disabled. Nobody really cared how I felt, what I did, what my dreams were, or what I would become.

They didn’t ask me any questions. Nobody sat down with me. Nobody said, maybe we can find a doctor, maybe we can do something to help. So I was crawling on the floor because I couldn’t walk. I was eight years old. I couldn’t take a shower by myself. I couldn’t feed myself. I couldn’t do any of those things, and the staff were not willing to do those things for me either.

Children are not just a toy you can throw away, like they are nothing. They are human beings with emotions, with feelings, and if they are hurt, they will show you that. It is the staff’s responsibility to notice those feelings, and to do something, for the children and with the children.

Since I was adopted, everything has changed for me. My family doesn’t see me as a kid from an orphanage. They see me as part of them, and that is the most important thing. When I was placed in a family, I felt loved, accepted and supported for the very first time in my life. I don’t worry anymore about what will happen to me, because I have a family who is helping me grow and see things differently. That matters even more with the war going on. Children who are still in institutions near the front line have nobody to make them feel that way. I have a family who does that for me.

And I can give you an example. My Mum and Dad took me to a swimming pool, and a member of staff told my Dad I wasn’t allowed to go in because other children would see me and get scared because of my disability. My Dad asked her why that mattered, and told her it was not our problem. She let me in. If I did not have a family standing next to me in that moment, I do not know what would have happened. That is what love does. It stands in front of you. Nobody at the institution ever stood in front of me like that.

”

Dmytro’s account is not an extreme case. It is what Component A’s growth and delayed detection findings, and Component C’s evidence on disability specifically, look like from the point of view of a young person. His needs were entirely within society’s ability to accommodate. But no one did. They went unmet regardless. And worse, Dmytro was intentionally neglected and dehumanised.

7.3 GIRLS WITH DISABILITIES AND CHILDREN WITH INTELLECTUAL DISABILITIES

The elevated risk facing children with disabilities is not evenly distributed within that group either. Girls and young women with disabilities face up to 10 times more gender-based violence than those without disabilities. Children with disabilities generally face sexual violence at close to three times the rate of children without disabilities, with girls facing the greatest risk of all – findings UNFPA attributes to research by the African Child Policy Forum on violence against children with disabilities (*UNFPA, Five things you didn't know about disability and sexual violence*). According to research funded by the World Health Organisation's Department of Violence and Injury Prevention and Disability, children who are deaf, blind, autistic or living with psychosocial or intellectual disabilities are identified as the most vulnerable within this population, facing rates of abuse up to five times higher than their peers. This is not a separate finding from this report's own kinship severance mechanism. It is what that mechanism looks like for this specific

group. Section 5.3.1's evidence on kinship severance established that the loss of an attachment figure able to protect a child is an evidenced pathway to death, through impaired self-regulation, delayed help seeking and heightened exploitation risk (*Kien et al., 2019*). Girls with disabilities and children with intellectual disabilities are already the group the wider literature identifies as facing the highest baseline risk of exploitation when that protection is intact. Removing it, which residential institutions and orphanages do, removes the single strongest documented protection against a risk they already carry at a materially higher rate than other children.

This report does not attempt to state how much higher the resulting mortality risk is for this specific group, but notes that the direction cannot seriously be in doubt, and that any account of Component C's kinship severance mechanism that does not name this group explicitly is describing the mechanism in its mildest form, not its most severe one.

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Girls and young women with disabilities face up to 10 times more gender-based violence than those without disabilities.
”



Institution, Bosnia.
Hope and Homes for Children

7.4 INFANTS

Jawad et al.'s panel regression, the source for Component B's floor, found children under five carrying an absolute increase in war associated mortality more than three times larger than the general population – 263.7 deaths per 100,000 against 81.5 – the largest relative increase of any age group the study measured. *Wagner et al.'s (2018)* study corroborates the same pattern from an entirely separate dataset – 35 African countries rather than Jawad et al.'s 193 country panel – and finds a cumulative two to four times elevation in infant mortality across a sustained war. Van IJzendoorn et al.'s 2020 meta-analysis found growth deficit rising from 1.18 standard deviations across the institutionalised population generally to 1.71 standard deviations specifically for children under 42 months, a substantial age gradient that lands heaviest on infants.

Research on neonatal survival in humanitarian emergencies adds a further, independent line of evidence. Over 40% of all deaths among children under five occur in the neonatal period, the first 28 days of life (*Morof, Kerber, Tomczyk, Lawn, Blanton, Sami and Amsalu, 2014*). The same paper identifies neonatal survival in

humanitarian emergencies as a persistently under-researched area relative to its actual share of child deaths, meaning the true scale of this risk in conflict settings is likely understated by the limited evidence available.

This bears directly on this report's own delayed illness detection mechanism. An infant cannot report their own symptoms, cannot seek help independently, and depends entirely on an attentive adult noticing illness in time for treatment to work. A systematic scoping review of childhood pneumonia in humanitarian emergencies found incidences concentrated heavily in children under five – 73 to 146 episodes per 100 patient-years for this age group (*Chen, Walker, Mulholland and Graham et al., 2022*). This is the same age group for which Component A's evidence already shows the sharpest developmental deficit.

Collectively, this evidence points toward a materially higher risk for this age group, and so the headline range of 2.02 to 4.4 times elevated mortality should be read accordingly.

7.5 WHY THIS MATTERS FOR HOW THIS REPORT'S RECOMMENDATIONS SHOULD BE UNDERSTOOD

An average that erases which children carry the most risk is not a neutral simplification. It requires us to establish a clear priority ordering within the population this report is concerned with. Children with disabilities, girls with disabilities and children with intellectual disabilities specifically, and infants generally, are not marginally more at risk than other institutionalised children in conflict. They are documented, across entirely independent bodies of research spanning disaster epidemiology, gender-based violence research and neonatal health, as facing some of the highest elevated risk this report has found anywhere. Any policy response that treats all institutionalised children as equally in need of protection, rather than naming these groups specifically, will systematically under-protect the children who need help and protection most. This report treats that as a foundational insight for what follows.

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Differentiated risk requires differentiated interventions that are locally appropriate.
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Most of the intervention evidence for children cared for in families has been developed and tested on general child populations, not validated separately for these higher risk groups. This report uses the differentiated risk insight to point to the need to prioritise these children in the adaptation and development of differentiated interventions and practice.

Section 8

IT DOES NOT HAVE TO BE THIS WAY

The purpose of this report is not despair. It is to establish, with evidence, that this injustice is foreseeable, and that foreseeable harm can be prevented.

Rwanda offers the clearest proof that this is achievable at a national scale. Following the genocide, Rwanda embraced a nationwide strategy of deinstitutionalisation, moving children out of residential institutions and into family and community care alternatives. The country's experience demonstrates that the elimination of orphanages as an intervention pathway for wider care and protection can deliver national reform.

Bulgaria is another illustration of the kind of transformation a national strategy can have. More than 35,000 children were confined in large institutions there. The introduction of its national strategy, adopted in 2010, targeted the closure of the 137 institutions. Every institution except two baby homes had closed by 2026, and there are plans in place to complete those closures in 2027. Ukraine's own recent history offers an insight into what this means both up to and during conflict onset. Ukraine adopted its national deinstitutionalisation strategy in 2017, five years before the full-scale invasion, but implementation was uneven across its regions. Nevertheless, it has created something close to a natural experiment. Children who had already been moved into family care before February 2022 entered the invasion with individual documentation, a legal guardian and a household able to move. Children who remained in institutions did not. The gap between these two outcomes was created by decisions made years before the war began.

Working in partnership with Hope and Homes for Children, the regional authorities in Dnipro had already started developing care system focused on families – rolling-out prevention services to tackle the root causes of children going into care, and providing alternative forms of family care for those who needed it. In an interview for this report, the Head of Children's Services, Olena Hurzhii, explained how all the 7,900 children they had helped to evacuate from within the Region are still with their families, or

in other forms of family care, not in institutions, because of the groundwork already laid. Pre-existing expertise. A workforce already trained. Services and partnerships already in place. When asked what the critical success factor in this was, she was very clear: mindset. This was precisely the same factor that the Head of Children's Services in Kharkiv conveyed in an entirely separate interview. The mindset of social workers had fundamentally shifted from referral and confinement of children in residential institutions, to tailoring support to families and the provision of alternative forms of family care.

“
**In this way,
deinstitutionalisation is
not only a response to crisis.
It is preparation for one.**
”

Conflict onset has not stopped this progress. Working in partnership with the Regional authorities in Volyn, Hope and Homes for Children has been helped to deliver the closure that the Volyn Regional Baby Home. Such closures require joined-up approaches to systems reform, working across health, education, welfare and social services, with community leaders and families. Every child was assessed individually, family tracing and placement planning were carried out for each of them, and by April 2026 every child had moved into family care. The Regional authority approved the institution's closure and its reorganisation into a community-based family support centre in December 2025 (*Hope and Homes for Children Ukraine, monthly reporting, 2026*), demonstrating that systems reform is possible during conflict.



Inside the new centre for children with disabilities.
Yevhenii Zavhorodnii Hope and Homes for Children

And such reform can be inclusive. Hope and Homes for Children's work in Bucha – supporting the rehabilitation of a centre that had been completely gutted during the Russian occupation of February and March 2022 – now provides speech therapy, physiotherapy, trauma counselling and family support from a modern, purpose built facility. Between 2022 and 2026, this programme supported 2,444 families raising 4,796 children, many of them with disabilities, ensuring the majority were not taken into care. For the few who were, it was to a family.

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**The consequences
of this work are
deeply human.**
”

BOHDAN & MARIYA'S STORY

Bohdan* and Mariya* have fostered nine children, and were interviewed in the development of this report in June 2026. During that interview the air raid sirens kicked off. Young Andriy* came running to his father. "Papa. The monsters are flying again." Bohdan held him. Spoke a few words, quietly, until the boy settled.

When asked what he had whispered, Bohdan said:

“
Just composure.
”



Bohdan, Ukraine.
Hope and Homes for Children

It is a word worth reflecting on. Bohdan's biological daughter, who is starting her own family, gave birth to her first child by candlelight in a hospital where shelling had knocked out the power. That took composure too, Bohdan said. On 14 May, drones destroyed the freight train he works on. He pulled his colleague out of the flames, alive but burned. He went home that night, and he was there for his children, alongside Mariya, the same as any other night.

This is what a parent does. Not just love, though there is plenty of that in their home, but also co-regulation, a calmer adult close enough for a child's own stress response to settle against, a nervous system to borrow until their own is fully developed. Every child in that garden had already lost that once, evacuated from communities under fire, or born to parents struggling with addiction and severe mental illness. What they didn't lose a second time was a family to come home to.

This matters more than it sounds like it should. In speaking with the Heads of Children's Services in both Kharkiv and Dnipro, they described how children across both regions are presenting with stress-induced diabetes and asthma. It's not unusual to see children walking down the street with their hands pressed over their ears. Five-year-olds are already expressing suicidal ideation. A child's body cannot easily tell the difference between a threat and the memory of one. But when a child forms an attachment with a close, familiar adult, they have someone to help them stand down their threat response. That's what composure does. Without it, stress doesn't pass through a child, it lodges in them, in neurological and immune systems that are still very much in development.

Hope and Homes for Children's mobile teams gets out to families like Bohdan's regularly – child psychiatrists, speech therapists, educational specialists, along with food, money and the funds to repair what shelling had damaged in their home – and works with local authorities to take this to scale through training, service design, and front-line funding.

What ties Dnipro, Kharkiv, Volyn and Bucha together, along with similar outcomes in post-genocide Rwanda, is the political and institutional administrative will that focuses its support on localised, resourced capability. They show the importance of adapting the individualised and often very different needs of families. This is consistent with the *Desmond et al. (2022)* study, which found that:

1. Most families need only a safe, functioning society around them – an enabling environment.
2. Some families need targeted support, such as cash transfers or connection to services, to strengthen their capacity to cope.
3. A smaller number of families, and children who cannot safely stay with their birth family, need something more intensive again – sustained, skilled, individual intervention delivered by a trained social service workforce. Desmond et al. call this critical family function intervention, and are clear that food and shelter alone are never enough at this level. They also found this most intensive tier is the one most starved of investment worldwide, so identification and intervention at this level is often weak and outcomes are poor. What the Heads of Children's Services in Dnipro and Kharkiv describe as a shift in mindset was, in practice, years spent building capacity at exactly this most intensive, most neglected tier, before a crisis made the case for it.

Desmond et al. make a second point that matters here. A child's need for safety and their need for love, belonging and identity are not layered, with the first satisfied before the second starts to count. Both need addressing at the same time. A child can be physically safe and still lack the individual, continuous attention that only a small number of adults, providing consistent individualised care, most often found in a family, can give. This is why the challenge is not simply about closing institutions, but developing tailored alternative forms of family care, and the services required to support them, staffed by people able to provide that continuous attention.

This kind of capability does not build itself. *Ellermeijer et al. (2023)*, in a systematic review of community-level child protection in low- and middle-income countries, describe communities as holding real protective capacity, where "primary care for children does not lay solely with individual caregivers but with families, larger kinship groups and communities" (p. 312), and find that community ownership of child protection work is associated with better coordination and depth of response. A social worker embedded in a community can visit regularly, notice how a household changes over months rather than judging it once, and build the trust that lets a child speak honestly about their own care, because individualised, responsive care is something only an adult who interacts frequently with a child can provide (*Britto et al., 2017*). The Global Social Service Workforce Alliance's *State of the Social Service Workforce Report 2022* finds that social service workers function as "educators, community workers, disaster planners and advocates" (p. 10) during preparedness and mitigation, but that research on this is far thinner than research on response after a disaster has already happened, and that community volunteers, a key part of this capacity, are "frequently overlooked," with those involved "often not adequately trained, supervised, acknowledged or safeguarded" (p. 30). Even the anticipatory action and accountability agenda this report focuses on in sections 10 and 11 has been slow to reach child protection specifically. *Oettli and Singh (2021)*, writing for the IFRC and the Anticipation Hub in 2021, found that protection in general, and child protection specifically, had rarely featured in early action initiatives, and noted that only 1% of Start Fund anticipatory alerts between October 2016 and November 2017 were spent on protection. Even when child protection does feature, it tends to be framed around agency systems and financing triggers, not around whether communities and families have the identified, trained and monitored capacity to safely absorb a child during a crisis.

What **ANTICIPATORY ACTION** means: Anticipatory action means acting ahead of a predicted crisis, on the basis of an early warning or credible forecast, to prevent or reduce harm to lives and livelihoods before it fully unfolds, rather than waiting to respond once a crisis has already happened (Anticipation Hub, accessed August 2026). It is distinct from anticipatory accountability, this report's own framing, set out in section 10, regarding who should be held responsible for acting on a foreseeable risk before it materialises. Reviewing evidence across multiple humanitarian interventions, most studies found a return of between two and seven US dollars in value for every one US dollar invested in anticipatory action (Kersting, 2025, Start Network).

The policy implication of all this is to call for an end to the use of residential institutions and orphanages before conflict hits, and to treat family care and emergency family support as a core part of crisis preparedness, not as an afterthought. This report's central recommendations (see Section 11) are anticipatory. Deinstitutionalisation carried out before conflict onset will save lives.

Bohdan will tell you. He adopted his youngest daughter from a baby institution in 2021 and is convinced that is the only reason she is alive today.

Section 9

COST EFFECTIVENESS GAINS

Moving children out of residential institutions is not only a question of survival. Country-level cost comparisons establish that it is cost-effective. There is a common assumption, particularly among finance ministries, that residential institutions and orphanages benefit from an economy of scale and so represents a cheaper option.

The country-level evidence set out below does not support that assumption. A cost comparison that looks only at the immediate, per child running cost of an institution is comparing the wrong figures. It leaves out the fiscal cost of the institution's buildings, land and staffing over its full lifetime, and it leaves out the long-term costs to health, education and social protection systems of the poorer life course outcomes many children will be forced to endure. The country examples of investment in child care reform indicate that such investment is not only recoverable but will lead to net gains over the medium to long term – an argument that belongs in front of finance ministries and donors, not just social policy directors.

The clearest and most recent evidence comes from Moldova. A 2023 investment case developed by Changing The Way We Care, which brings together Maestral International, Catholic Relief Services and Better Care Network, working directly with Moldova's Ministry of Labour and Social Protection, costed a defined minimum package of family-based services, family support, foster care, personal assistance and respite care, against the actual costs of residential institution placement. The family package cost 17,185 Moldovan leu per child. The residential institution placement cost between 245,000 and 339,000 Moldovan leu per child – 339,000 for children with disabilities specifically, making placing a child in family care 14.3 times cheaper for a general placement, and 19.7 times cheaper for a child with a disability. This means that Moldova can support – with the budget it is already allocating – 14 children cared for in

families for the cost of confining one child in an institution (*Changing The Way We Care, 2023*). The same investment case modelled the return on shifting funding accordingly, producing an internal rate of return of 16.6%, over a payback period of 3.5 years, and a net present value of 35.9 billion Moldovan leu.

Moldova is not an outlier. Comparable cost differentials have been documented across a range of other countries, for more than two decades, using different methodologies. In Bosnia, Hope and Homes for Children's own ACTIVE programme found institutional placement of children 9.3 times higher than supported forms of family care (*Hope and Homes for Children, ACTIVE programme data, available on request*). In Bulgaria, an infant home cost 14,837 euros per child per year, compared to 1,932 euros per child in foster care – a 7.7 times difference (*Mulheir, 2015*). In South Africa, a study comparing six different models of care found that statutory residential care cost more than eight times as much per month as home-based support (*Desmond and Gow, 2002*). In Armenia, a 2010 UNICEF study found that residential institutions cost \$3,800 per child per year in government support, compared to \$2,800 for foster care. That is 1.4 times as much, and UNICEF Armenia's own more recently published figures show family support costing considerably less again (*UNICEF, 2014*). The precise multiple varies by country and by what is being compared, but the direction never reverses. Supported forms of alternative family care have not been found to cost more than residential institutions in any of the countries examined.

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Most families need only a safe, functioning society around them – an enabling environment.
”

Desmond et al. (2022)

Yuliia* is Back to Family with her sister, Tetiana* in Ukraine.
Chernenko Timofiy / Hope and Homes for Children



This evidence matters for a specific reason in a report about conflict. The recommendation that deinstitutionalisation should be treated as a form of anticipatory humanitarian action will always certainly be met with: where is the money going to come from? The Moldova evidence, produced for a country that is simultaneously managing its own economic contraction, high inflation and a major refugee crisis, is a direct rebuttal.

Indonesia shows what happens when crisis funding is not redesigned around the right incentives. After the 2004 tsunami, Indonesia's Ministry of Social Affairs operated a subsidy that paid institutions more the more children they held, with no condition attached requiring registration or compliance with minimum standards. Almost one million US dollars was disbursed through this single subsidy in 2005 alone, and the government's own reconstruction agency added a further 2.2 million US dollars that same year, with similar sums committed in the two years that followed. Institutions actively recruited children from displacement camps to claim this funding, offering families the promise of

continued education in return (*Martin, 2013*). None of that money was cheap. It rewarded filling institutions, rather than support for families to stay together. The lesson for anticipatory financing is not only that family care costs less. It is that how money is paid out shapes where children end up.

The World Health Organisation, UNICEF and World Bank Group's Nurturing Care Framework estimates that every dollar invested in early childhood development interventions, health, nutrition, responsive caregiving and early learning together, can return as much as 13 US dollars (*WHO, UNICEF and World Bank Group, 2018*). This is a broader category of investment than family support alone, but responsive caregiving and family strengthening sit inside it as a core, evidenced component. The alternative is grim: the lifelong physical and mental health burden of adverse childhood experiences – reflected in the experiences by children confined in residential institutions and orphanages – costs 1.3 trillion US dollars in North America and Europe alone each year (*Sethi, D., Passmore, J. et al., 2019*).

Orphanage, Ukraine.
Yevhenii Zavhorodnii / Hope and Homes for Children

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Think of it like this. If up to 1.2 million children are confined in residential institutions and orphanages in conflict-affected locations, and we conservatively assume, on average, that costs 500 US dollars per child per month, then annually that comes to as much as 7.2 billion US dollars. The money is already in the system.
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Section 10

ACCOUNTABILITY SAVES LIVES

This report's central policy recommendation focuses on anticipatory accountability, and asks: who is legally responsible for the now foreseeable deaths of children confined in residential institutions and orphanages at the moment conflict began, and what obligation do those responsible parties have to act before it arrived? The evidence is sufficient to establish that the elevated mortality facing institutionalised children during war is not an unforeseen consequence of it. It is a predictable, structurally determined outcome that follows directly from the decision to place and confine children in institutions in fragile and conflict-affected states. This report's findings are not only a humanitarian concern, they sit alongside formal legal determinations and demand accountability.

The legal architecture for anticipatory accountability already exists. It does not need to be invented. The Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child, and the Geneva Conventions' protections for children in situations of armed conflict each create obligations on states to prevent **foreseeable** harm to children within their jurisdiction or effective control. What is currently absent is the political will to apply that architecture prospectively, before a conflict, rather than retrospectively, once the deaths have already occurred and the evidence to explain why pre-emptive action was not taken, likely lost. This report asks treaty bodies, human rights mechanisms, humanitarian actors, defence and security actors, and donor governments to begin treating the failure to deinstitutionalise as an anticipated harm, and to build accountability frameworks that apply before the next conflict begins.

The accountability this report calls for sits with states, with parties to conflict, and with the funding and policy decisions that confine children in residential institutions and orphanages in the run up to and during conflict. It does not sit with humanitarian workers and institution or orphanage staff themselves, many of whom, like the staff at Mygoma who stayed as long as they physically could, are themselves operating inside the same often lethal environments and funding collapse this report documents.

Holding a system to account and recognising the constraints faced by the people working inside it are not in tension. This report is not seeking blame, it is seeking the kind of systemic accountability that will prevent the deaths of likely many thousands of children.

In October 2022, the United Nations Committee on the Rights of Persons with Disabilities, the treaty body responsible for monitoring compliance with the Convention on the Rights of Persons with Disabilities, made a formal determination that children remaining in Ukrainian institutions faced a disproportionate risk of death. Treaty bodies issue findings that carry legal weight within the international human rights system. This is one of the first times a body of this kind has made a specific determination linking residential institutional placement to elevated mortality risk in a conflict setting.

In March 2023, the International Criminal Court issued arrest warrants for Vladimir Putin and Maria Lvova-Belova, the Russian Children's Ombudsman, relating to the alleged unlawful deportation and transfer of Ukrainian children. In March 2026, the UN's Independent International Commission of Inquiry on Ukraine went further, concluding that the deportation, transfer and enforced disappearance of Ukrainian children amount to crimes against humanity (*OHCHR, 12 March 2026*). Neither finding quantifies what share of the children affected came from

residential institutions specifically, and this report does not assert one. What section 5.3.6 establishes, using Human Rights Watch's own documentation of more than 32,000 children in institutions that fell under occupation, is that the structural vulnerabilities this report describes left institutionalised children specifically exposed to this same risk.

Individual criminal liability for the deaths of children confined in residential institutions and orphanages already has a partial precedent. Romania's Institute for the Investigation of Communist Crimes issued a criminal referral in 2017 naming more than 100 individual state employees in connection with the deaths of 771 children across three

residential institutions (*IICCMER, 2017*), and a further referral in 2018 concerning 340 more deaths at a fourth (*IICCMER, 2018*). Its own broader investigation has since documented more than 2,200 child deaths across the institutions it has examined. Although no prosecutions have been advanced, liability has been established. But that liability took three decades to arrive, long after most of those responsible could be held to account in any meaningful way. The evidence this report presents concerns children who are actually alive, but who might well not be unless action is taken. Anticipatory accountability is the proposed engine of systems-wide change that will oblige that action. Not in three decades, but now.



Institution, Bosnia.
Hope and Homes for Children

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This report's findings are not only a humanitarian concern, they sit alongside formal legal determinations and demand accountability.
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Section 11

THE ACTION NEEDED TO PREVENT THE FORESEEABLE DEATHS OF CHILDREN

THE DMYTRO MANIFESTO

Dmytro spent eight years of his childhood in a residential institution in Ukraine before being adopted, a change he describes as having transformed every part of his life, from the surgery that allowed him to walk, to being seen, for the first time, as a person, as a human being with feelings rather than as a diagnosis. He has shared his experience directly with a previous Deputy Prime Minister of the United Kingdom and other notable Parliamentarians. His voice counts.

Here is the Dmytro Manifesto – his demands for what governments, organisations and communities must do differently.

- 1. Meet children's basic needs first, without judgement. Every child in an institution has a right to the same essential care, health, food, education, and no child should have to earn that by explaining or justifying why their family could not keep them.**
- 2. Place children in families. A family shows a child, in a way an institution never can, what it feels like to be loved, and to be cared for when they are sick, and to matter to the people around them.**
- 3. Help children build a future, not just survive the present. Every child should be supported to pursue what they want to become, not managed through a schedule that has no future attached to it.**
- 4. Governments must act directly, not leave this to charities alone. Protecting these children is a government responsibility, and governments must be pressed to take it up, not permitted to leave it to non-profit organisations to solve on their own.**
- 5. Share what works, across borders. Every country is dealing with some version of this problem. We should be learning from each other's solutions, not solving the same problem in isolation, separately, over and over.**
- 6. Do not just watch. Act. It is not enough to observe an organisation doing this work and comment on it from a distance. If you know of a problem, or an institution, or a community that needs support, connect them with people who can help, and do the work together.**

This report closes with specific recommendations directed at the different audiences whose decisions shape whether this injustice continues or ends. And let us be very clear: ending institutionalisation is a painstaking, systems-wide endeavour. It takes time. So some of these recommendations address actions that can be undertaken to protect children now.

11.1 TREATY BODIES AND HUMAN RIGHTS MECHANISMS

This report's evidence gives treaty bodies and human rights mechanisms a specific precedent to build on. In October 2022, the UN Committee on the Rights of Persons with Disabilities made a formal determination that children remaining in Ukrainian institutions faced a disproportionate risk of death, one of the first determinations of its kind. But that determination was made in response to a crisis already underway, not in anticipation of one.

Recommendation: *treaty bodies, including the Committee on the Rights of Persons with Disabilities and the Committee on the Rights of the Child, should issue guidance recognising the elevated mortality risk facing institutionalised children in conflict-affected and fragile states prospectively. This means identifying states with large institutionalised populations and elevated conflict risk before crisis onset – rather than confining findings of this kind to states already at war – and work with them to incorporate deinstitutionalisation into their crisis preparedness.*

Recommendation: *human rights mechanisms should treat this report's evidence, and the precedent set by the October 2022 Ukraine determination, as grounds to request that states party to the Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child report specifically on deinstitutionalisation progress. This should be part of their existing periodic reporting obligations, rather than raised only in response to a specific crisis or incident.*

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The UN Committee on the Rights of Persons with Disabilities made a formal determination that children remaining in Ukrainian institutions faced a disproportionate risk of death.
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Destruction in the Kyiv region of Ukraine.
Evheniy Zavhorodniy / Hope and Homes for Children



11.2 A CONFLICT-AFFECTED COUNTRY LEARNING, SHARING AND REFORM NETWORK

The countries carrying the largest share of this report's estimate – Nigeria, Pakistan, India, Indonesia, the Democratic Republic of Congo, Ukraine and others (see appendix) – are not natural allies on important questions of foreign policy. Some carry longstanding bilateral tension – India and Pakistan over Kashmir most visibly. But every one of them is a state party to the Convention on the Rights of the Child, and some already have their own domestic reform commitments to build on, including for example, Ukraine's national deinstitutionalisation strategy. That shared commitment represents common ground, without requiring any of these states to align on the political questions that divide them.

Recommendation: *To effectively implement the Global Charter on Children's Care Reform, The Foreign Commonwealth and Development Office (FCDO) should establish a Peer Learning Mechanism open to all countries (including non-signatories), enabling conflict affected and fragile states – such as Nigeria, Pakistan and India who carry a significant share of this report's estimate – open access to learning and technical assistance on care reform.*

Recommendation: *The FCDO should operationalise the Global Charter through standing-up and providing seed funding to a dedicated pooled financing mechanism, such as the proposed Partnership Investment Platform, including a dedicated funding stream for emergency contexts and those at highest risk. This would mobilise public, private and philanthropic finance to catalyse care reform that leaves no one behind. Evidence presented in this report proves family care is significantly more cost-effective than institutional care, while early childhood and anticipatory investments generate high social and economic returns.*

Recommendation: *The FCDO should connect its existing priorities and the 'five securities' to care reform. This should include active review and integration of the Care Reform Campaign into its work on conflict, humanitarian response, and women and girls, including situating care reform within the prevention of violence against women and girls (VAWG) during the UK's presidency of the G20 in 2027. To ensure the effective implementation of the Strategic Roadmap Accelerator 7 on Crisis Preparedness and Response, the FCDO should also name deinstitutionalisation as an eligible anticipatory action within the implementation of the UK Humanitarian Framework and advocate for children in institutions to be treated as a particularly vulnerable group in UN humanitarian planning and response.*

11.3 DEFENCE AND SECURITY INSTITUTIONS

The existence of populations of children in residential institutions and orphanages represents a specific gap in defence and security planning. They are confined in fixed, identifiable sites that should be built into evacuation and protection planning before a crisis begins, not discovered during one. These populations already sit inside existing defence frameworks – they are not a new category that requires developing. In UK defence, this falls within the JSP 985 Human Security approach, with direct relevance to Children and Armed Conflict and Modern Slavery and Human Trafficking workstreams. NATO adopted a Human Security Approach at its 2022 Madrid summit and a Policy on the Protection of Children in Armed Conflict at its Vilnius summit in 2023. The gap is that residential institutions have not yet been incorporated into the human terrain (the social and family networks that make a population stable or unstable) and protection planning those frameworks call for.

The operational case is clear. An institution is a fixed, identifiable structure that concentrates populations of vulnerable children that cannot readily self-evacuate, establishing a defined evacuation and force protection burden (the resources a military or security actor has to commit to keeping a population safe) that a family does not present.

Rights Watch has separately documented more than 32,000 children in institutions that fell under Russian occupation, establishing that institutionalised children were acutely exposed to this same risk (*Human Rights Watch, 2023*). Children without the protection of a family are the population most exposed to forced transfer and militarisation.

Recommendation: close the gap that leads to the oversight and invisibility of institutionalised children, including by explicitly recognising institutions as fixed, identifiable sites for inclusion in evacuation and protection planning.

The doctrinal case follows the same logic defence planners already use elsewhere. British and NATO doctrine on population-centred operations holds that a population's trust and cohesion, not military action alone, determines whether stabilisation succeeds, and that resilient family and community structures are the foundation that doctrine assumes. Institutionalisation removes children from exactly that structure, at scale. Severed family attachments also carry a specific security cost of their own. Research from the Democratic Republic of Congo and the Central African Republic finds that intact family support is one of the strongest protective factors against child recruitment and against the re-recruitment of former child combatants. In Ukraine, cases of forced transfer or deportation of children by Russia stand at 20,000 and above (*the Yale Humanitarian Research Lab and Bring Kids Back UA*). No source quantifies what share of these children came from residential institutions rather than families, but Human

Recommendation: ministries of defence and alliances, including NATO, should treat the location and population of residential institutions as a specific, named input into civilian protection and evacuation planning in fragile and conflict-affected states, in the same structured way that hospitals and other protected civilian sites are already accounted for. Concretely, this means requiring that national civil protection and evacuation plans include an up-to-date registry of residential institutions and their populations, shared with the humanitarian actors named below, and incorporated into deployed force protection and evacuation planning before a crisis.

Recommendation: governments should adopt deinstitutionalisation as an explicit, funded component of disaster and conflict preparedness planning, not solely as a long-term social policy goal considered separately from crisis response. Donor governments should also attach conflict risk conditionality to their support, requiring humanitarian organisations and local authorities receiving funding in fragile states to hold an active deinstitutionalisation pathway as a condition of that support.

11.4 NATIONAL AND LOCAL CHILD PROTECTION AUTHORITIES

For a ministry or local authority in fragile and conflict-affected states, responsible for children in residential institutions, this report's structural mechanisms translate into specific, immediate actions.

Recommendation: every institution should have a current, individually named evacuation plan that accounts for children who cannot self-evacuate (to include considerations of receiver capability to provide care, and the prior formation or development of the relationships to enable execution of the plans), built explicitly around the needs of children with disabilities, who are vastly over-represented in institutionalised populations and are consistently the last evacuated and the first to die when care collapses.

Recommendation: every child should have a named individual with authority to act on their behalf during an emergency. Care should be structured, wherever possible, to preserve each child's relationship with a consistent, known caregiver, and sibling and kinship contacts should be recorded and kept current, not assumed to be traceable later, since it is the continuity of these attachments, not staffing numbers alone, that this report's evidence identifies as the protective factor that is put at risk.

Recommendation: each child's core documentation should travel with them, not remain solely in a central record. And every residential institution should be registered with, not absent from, the national child protection data system used to plan humanitarian response. Wherever possible, digital records should be maintained with the requisite safeguards and security in place.

Recommendation: national authorities should attach binding consequences, not only formal closure orders, to the continued operation of unregistered residential institutions.

Recommendation: national justice ministries and prosecutorial services should be resourced and trained to identify and prosecute orphanage trafficking specifically, distinct from general child protection enforcement. Cambodia shows that an adequate legal framework is not sufficient by itself. Its 2008 trafficking law has existed for over 15 years without a single successful prosecution for orphanage trafficking. The barrier in cases like this is not the law, it is the capacity, training and institutional will to apply it against a form of exploitation that presents as care rather than crime.

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We need to close the gap that leads to the oversight and invisibility of institutionalised children.
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Institution, Kenya.
Hope and Homes for Children

The following are recommendations were informed and shaped by Daryna*, Nazar*, Danyilo*, Anastasiia* and Oksana* with further recommendations emerging from the conversation with them presented in 11.5, 11.6, 11.8 (colour-coded in blue).

Daryna (16), Nazar (14), Danyilo (14), Anastasiia (15) and Oksana (14) were interviewed as a group for this report. They live in a residential centre in Ukraine, in a location that endures regular aerial bombardment. The name of the centre and its location are withheld to prevent identification, and their own names have been changed.

The centre is home to 24 children, run across four staff shift cycles a day, with two staff members on duty overnight. All 24 children sleep together in the bomb shelter, with the younger children frequently disrupting the older ones' sleep. On a strict reading of the terms this report uses, the centre is classed as an orphanage. Their exact accounts are not used for safeguarding reasons.

Recommendation: national and local child protection authorities should build and fund a tiered system of family support, distinguishing between families that need only a safe environment, families that need targeted strengthening such as cash transfers or service connection, and the smaller number of families whose function is seriously compromised and who need sustained, skilled intervention from a trained social service workforce (see section 8 and Desmond et al., 2022). Case referral and monitoring systems should record which tier a family sits in, whether that support was delivered and its impact, not only whether a child was removed from or returned to a family.

Recommendation: residential institutions within active deinstitutionalisation pathways – appropriately staffed, trained, transparent and working toward family reunification or alternative family care options – should be held to a distinct, published quality and transition standard, separate from the standard applied to closed, unregistered or custodial institutions. That standard should require a resourced, time-bound plan to move every child into family care. This report's own evidence shows quality and trajectory vary between institutions, and its monitoring systems should reflect that distinction rather than treating all residential institutions identically for registration and compliance purposes.

Recommendation: national and local child protection authorities should establish a standing mechanism for children in residential and family care to feed direct testimony into policy design and institutional monitoring, consistent with the child's right to be heard under Article 12 of the UN Convention on the Rights of the Child, rather than relying solely on adult-administered inspection.

Recommendation: national and local child protection authorities should apply a single, published minimum standard of identification, vetting, training, ongoing monitoring and regular direct engagement with the child to every family placement – kinship, foster and guardianship alike. Without this, family placements will be more likely to breakdown. The accounts of Daryna, Nazar, Danyilo, Anastasiia and Oksana show family placements failing children for these very reasons.

11.5 HUMANITARIAN ACTORS AND FUNDING INSTRUMENTS

Humanitarian needs assessments and registration systems should be adapted and obliged to identify residential institutions and the children inside them, rather than relying on rapid assessments built around displaced and community level populations.

Recommendation: crisis preparedness assessments in fragile and conflict-affected states should include specific indicators of this workforce's capacity, covering staffing levels, training, caseloads and supervision, with funding to build that capacity committed before a crisis begins, not only after one. A state can be moving children out of institutions and still have no functioning system able to identify, support or monitor the families they move into. Evidence from the Global Social Service Workforce Alliance (2022) and Ellermeijer et al. (2023) shows this workforce is thinly researched and unevenly resourced, and that most of the existing evidence concerns development contexts rather than humanitarian ones. Standard 13 of the Alliance for Child Protection in Humanitarian Action's Minimum Standards, on unaccompanied and separated children, already exists for exactly this purpose and should be treated as mandatory rather than advisory across all humanitarian response plans.

The Alternative Care in Emergencies Toolkit, the interagency reference document that has guided alternative care planning in humanitarian settings since 2013, is currently under revision, led by the International Rescue Committee on behalf of the wider interagency group. Hope and Homes for Children supports and is involved in this revision. This report will be submitted as part of that process and will especially emphasise the evidence concerning the elevated mortality findings. This will be submitted as a contribution alongside Better Care Network, Save the Children, the Alliance for Child Protection in Humanitarian Action and the other agencies already engaged in that work, not as evidence put forward independently of it.

Recommendation: the Alternative Care in Emergencies Toolkit revision should formally incorporate this report's Component C evidence on elevated institutional mortality, and humanitarian actors engaged in that revision should treat direct mortality data collection as a named priority within it.

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A state can be moving children out of institutions and still have no functioning system able to identify, support or monitor the families they move into.
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Humanitarian aid, Ukraine.
Hope and Homes for Children



11.6 ACADEMIC AND RESEARCH INSTITUTIONS

The single most valuable evidentiary contribution the research community could make is direct mortality data collecting comparing children in residential institutions and children in family care within the same conflict-affected population. No such dataset currently exists anywhere in the world. This report’s model is built from convergent indirect evidence precisely because that direct evidence has not been collected. One specific, achievable study could begin to close this gap. Ukraine’s national deinstitutionalisation strategy, adopted in 2017, was implemented unevenly across its regions before the 2022 invasion, meaning some Regions entered the war with far more children already cared for in families than others.

Recommendation: independent researchers should evaluate multi-year, government-partnered social service workforce strengthening programmes, of the kind delivered over 14 years by some regional administrations in Ukraine, as natural experiments in family and community capability building. Comparing outcomes in regions with and without this investment, before and through conflict onset, would test directly whether the workforce investment Desmond et al. (2022) call for translates into the reduced institutional mortality this report’s model predicts.

Recommendation: an administrative data linkage study comparing regional mortality outcomes against each Region’s pre-invasion deinstitutionalisation progress, using Ukrainian government institutional records, Regional mortality data and NGO programme records, should be commissioned without delay, since the conditions that make this study possible will not persist indefinitely. This research, and independent review of the model set out in this report, should both be treated as a priority.

Recommendation: future research building on this report’s model should disaggregate mortality and risk data by disability status, gender and age wherever possible. Section 7 of this report shows that an average figure understates the risk faced by children with disabilities, girls with disabilities and infants specifically, and any dataset built to replace this report’s estimate risks repeating that same undercounting if it is not disaggregated from the outset.



Sonia* is Back to Family and back to school, India.
S Ajay Kumar / Hope and Homes for Children

11.7 MEDIA AND PUBLIC INFLUENCERS

The single most damaging and most common misconceptions in public reporting on this issue is the assumption that children in orphanages have no living family, and that residential institutions and orphanages are safe spaces. This report’s evidence shows the opposite is generally true. Accurate reporting on this distinction changes how the public, and the policymakers who respond to public pressure, understand what kind of intervention is actually needed.

Recommendation: media reporting on residential institutions and orphanages should state explicitly whether children in the specific institution being reported on have living family, rather than defaulting to the unexamined assumption that an orphanage confines children who are most likely to have a family.

A second, related pattern deserves equal attention from media and public figures. This report has already shown that orphanages are frequently sustained by foreign donations, voluntourism and, in the most severe documented cases, orphanage trafficking, a recognised form of modern slavery (section 4). Public figures who visit, film or endorse orphanages, however well intentioned, contribute to the same demand this report identifies as a driver of institutionalisation,

and celebrity endorsement in particular can accelerate donor interest in an individual institution faster than any regulatory system can prevent it. This report does not suggest bad intent on the part of any individual donor, volunteer or public figure. It states that visibility and good intentions are not protective, and that the same instinct to help, directed at family strengthening and reunification instead, would do more good with less risk.

Recommendation: public figures, content creators and organisations should not visit, film, fundraise for or publicly endorse individual orphanages or residential institutions, and should redirect that visibility and support toward family strengthening and reunification programmes instead.



Orphanage, Romania.
Andreea Tănase / Hope and Homes for Children

“Orphanages are frequently sustained by foreign donations, voluntourism and, in the most severe documented cases, orphanage trafficking.”

11.8 DONOR GOVERNMENTS AND INSTITUTIONAL FUNDERS

Ending institutionalisation prevents deaths, at a lower cost than the system it replaces. What follows sets out how four distinct categories of donor can act on that finding, each with a different lever available to them.

Recommendation: donor governments, multilateral funders and philanthropic funders should treat sustained investment in the community level social service workforce, family identification, family strengthening and skilled family function intervention, as an anticipatory action investment in its own right, fundable and trackable on the same basis as the deinstitutionalisation transition funding already recommended in this section. A donor funding only the movement of children out of institutions, without funding the workforce able to identify, support and monitor the families they move into, is funding one half of the system this report's evidence shows is required.

Bilateral government donors

- Recommendation:** bilateral donor governments should attach deinstitutionalisation conditionality to humanitarian and development funding in fragile and conflict-affected states, and fund the transition of children out of institutions before crisis onset.
- Bilateral donors should audit whether their own development, diaspora-linked or faith-based community funding sources are inadvertently sustaining institutions rather than children cared for in families, and work with relevant stakeholders to address this.
 - Bilateral development funding is well placed to close this report's most significant evidentiary gap. The administrative data linkage study proposed in section 11.5, comparing regional mortality outcomes in Ukraine against pre-invasion deinstitutionalisation progress, requires exactly the kind of funding bilateral development agencies already provide for health and social data systems.
 - Donor governments should require child protection conditionality in the same way they already require financial and safeguarding conditionality of recipient governments and organisations.

Multilateral institutions

Recommendation: multilateral humanitarian and development funders should build deinstitutionalisation into crisis preparedness financing as a named, funded line, not treat it solely as a longer-term development goal considered separately from emergency response.

Major private trusts, foundations and philanthropists

- Recommendation:** trusts, foundations and individual philanthropists seeking measurable, evidence-led impact should fund locally led programmes that transition children from residential institutions and orphanages and into family care as a discrete, trackable intervention.
- Funders should ask grantees for specific, trackable indicators, including the number of children moved from residential institutions and back to family, the per child cost comparison against institutional alternatives, and whether recipient organisations have resourced, time-bound, individualised plans to transition children into family care, and close or convert the institutions they run into community service hubs.
 - Funders should avoid grant structures that pay per child. Per capita funding models work against the development and implementation of individualised care plans, especially with regard to children living with disabilities. Create a direct incentive to fill beds rather than support families, and a funder replicating that structure, even unintentionally, works against the outcome it intends to fund.

Corporations and companies

- Recommendation:** corporations should audit and end financial and promotional support for orphanage tourism and orphanage volunteering across their supply chains, travel platforms, corporate social responsibility programmes and employee volunteering schemes, and redirect that support to family strengthening and reunification programmes instead.
- This report has already shown that orphanages are frequently sustained by a business model built on foreign donation and voluntourism, formally recognised as orphanage trafficking and a form of modern slavery. For companies with existing modern slavery or supply chain due diligence obligations, this is a compliance question, not only a reputational one.
 - Travel and tourism companies should remove orphanage visits from tour packages and booking platforms, a documented and specifically named driver of the demand this report describes.
 - Corporate donors and foundations should be held to the same trackable standard set out for private philanthropists above, funding measurable transition outcomes rather than institutional capacity or visibility.

11.9 THE GENERAL PUBLIC

Recommendation: question the assumption, wherever it is encountered, that an orphanage is a place of safety for a child without family. It is neither, in the great majority of cases.

Recommendation: where support is given, it should go to organisations working to keep children with their families or, when appropriate, provide alternative forms of family care, not to orphanages and residential institutions. This is not a call to withdraw care from vulnerable children. It is a call to direct that care toward the intervention this report's evidence supports – family strengthening and reunification.

Section 12

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Appendix

THE NUMBERS: children confined in residential institutions and orphanages in conflict-affected countries

The table at the end of this appendix sets out the country-level estimates underlying one of this report’s headline figures of 660,000 to 1.2 million children confined in residential institutions and orphanages in conflict-affected countries.

Wherever possible, they are localised and provide estimates for the conflict-affected areas of those countries, unless the conflict is national in scope. These figures apply *Desmond et al.’s* (2020) country-level estimates of children to a register of countries currently affected by active conflict. That register is built mainly from the World Bank’s FY26 List of Fragile and Conflict-affected Situations, Conflict category (*World Bank, 2025*), with two countries, Colombia and Burundi, for reasons set out below. They should be read as order of magnitude estimates, not precise counts. Unregistered institutions are excluded from the underlying prevalence data, and data quality varies substantially by country, generally worsening as conflict intensity increases.

This report chose the World Bank’s list deliberately. Its conflict category exists to decide which countries qualify for a particular kind of development finance and operational attention, not to identify where children confined in institutions face elevated mortality risk. What makes it useful here is that to appear on the World Bank’s list, a country must clear a demanding, dual test in each of two independent datasets. It must clear Armed Conflict Location and Event Data’s (ACLED) threshold, more than 250 conflict deaths and a rate above 2 per 100,000 population, and it must separately clear the Uppsala Conflict Data Programme’s (UCDP) threshold, more than 150 conflict deaths and a rate above 1 per 100,000 population. A country is included only if it clears both thresholds in both datasets (*World Bank, 2023*). That sets a higher bar than either dataset would set on its own. Choosing

a list developed this way keeps this report’s population estimate toward the conservative end because it limits the number of conflict affected countries that are included by screening for those with higher conflict-driven impact. And it does so by relying on a threshold that was independently set.

Requiring both an absolute count and a per capita rate, rather than either alone, matters for another reason – using only one of these two measures would let in countries where the case for the kind of widespread, sustained conflict this report is concerned with is considerably weaker. An absolute count alone can be reached by a large country’s sheer size. A hypothetical country of 200 million people would clear ACLED’s absolute threshold of 250 deaths at a rate of only 0.125 per 100,000 of its population, 16 times below the 2 per 100,000 rate the same dataset separately requires, a level of violence too thinly spread to plausibly disrupt the country’s infrastructure as a whole. A per capita rate alone can be reached the opposite way. A hypothetical country of 500,000 people would clear ACLED’s per capita threshold of 2 per 100,000 from a single incident killing as few as 10 to 15 people, a death toll more than 16 times below the 250 needed to clear the absolute threshold on its own, and plausibly the product of one severe day rather than a war. The World Bank’s own methodology shows separate awareness of this. A footnote to its criteria states that the list is built to avoid singular but highly fatal incidents on their own resulting in a country being included (*World Bank, 2023*). Requiring both measures at once

screens out large countries experiencing conflict too thinly to matter at national scale, and smaller countries experiencing one severe incident rather than a war. This is a further reason this report's scope should be read as conservative.

There is also a reasonable, though not separately tested, argument for why this particular threshold suits this report's model better than a lower one would. Component C depends on structural features such as a fixed location that cannot be evacuated, humanitarian systems failing to reach an institution, and the practical breakdown of guardianship exercised through a dedicated, connected adult. These conditions plausibly require the kind of sustained, high intensity conflict that the World Bank's dual, independently verified threshold selects, rather than the single incident that could place a country above a lower, one dataset threshold for a single year. The same reasoning extends to Component B, in particular the collapse of health, nutrition and water systems that that are identified as the larger source of conflict-related deaths. Sustained, high intensity conflict of the kind the World Bank's dual threshold selects for is more plausibly the kind that disrupts or collapses these systems at scale than a single violent incident that clears a lower, single measure threshold. This report's key insights section draws on this same reasoning directly, and treats all of this as a reasonable basis for using the World Bank's list.

An important note on how long this comparison will hold. The World Bank has since moved to a new methodology, effective from its 2027 fiscal year, which began in July 2026. The new approach uses ACLED data alone and a threshold defined by the share of a country's population living in areas with elevated conflict-related fatalities, dropping UCDP from the calculation entirely (*World Bank, 2026*). The FY26 list this report uses reflects the classification in force immediately before that change. Any future update to this report's country table should first confirm which version of the World Bank's methodology is then in force.

This range is presented as two totals rather than one. The core total, 660,000 to 1.2 million, uses the narrower of two possible figures for Pakistan, explained below. An extended total, 730,000 to 1.3 million, is shown alongside it as a

sensitivity check, using the wider Pakistan figure. This report treats the core total as its headline range throughout, and the extended total as a check on how far that range moves if Pakistan's conflict-affected area is drawn more widely.

A single, country-by-country problem shaped how this table was built. Desmond et al.'s figures are national. Some of the conflicts placing a country on this register are not national. Pakistan's conflict is centred on its recently merged districts on the Afghan border. India's is centred on Jammu and Kashmir. Indonesia's is centred on Papua. Applying a whole country's figure to a war confined to one location of that country would count millions of children confined in residential institutions and orphanages in Karachi, Delhi and Jakarta as though they lived in a conflict zone, when they do not.

This report corrects for that by using synthetic estimation, a recognised technique within small area estimation – the branch of statistics used to produce estimates for areas too small or too poorly surveyed to be measured directly (*Rao and Molina, 2015, Ghosh and Rao, 1994*). Where a country's conflict is confined to one bounded province, region or autonomous area, its national figure is scaled down to that area's share of the national population, using the most recent available census. Nine countries are treated in this way. As already mentioned, these include Pakistan's recently merged districts, India's Jammu and Kashmir, Indonesia's Papua and West Papua, and also the Philippines' Bangsamoro Autonomous Region in Muslim Mindanao, Mozambique's Cabo Delgado Province, Cameroon's Far North, Northwest and Southwest Regions, Thailand's three southernmost Provinces, Benin's Alibori and Atacora departments, and Togo's Savanes Region. Where a conflict instead spans several regions or reaches the capital, the national figure is kept as it is, since there is no single bounded area to scale down to, and scaling down a genuinely widespread crisis would understate it. Mali, Niger and Burkina Faso all fall into this category and keep their national figures (*ACLED, 2024, for Mali and Niger, and ACAPS, 2026, for Burkina Faso*).

Nigeria falls into this category, and it matters because it is the largest single contributor to this table once Pakistan, India and Indonesia are corrected – 266,458 to 274,267 children,

40.4% of the core floor. Nigeria's conflict is not one war in one place. It is three distinct crises – Boko Haram and ISWAP in the North East, banditry in the North West, and farmer herder violence in the North Central zone, together spanning three of the country's six geopolitical zones (*ACAPS, 2025*). Nigeria's national figure is kept as it is because this reflects the genuine geographic reach of its conflicts.

This kind of scaling trades precision for the ability to produce a defensible number at all. It does not remove the underlying uncertainty. It assumes a region's rate of confinement in residential institutions and orphanages matches its country's average. This is an assumption this report has reason to doubt in one specific direction. Section 4.2 of shows that registered orphanages cluster in cities and popular tourist destinations, funded mainly from outside the country. If that pattern holds for these nine regions too, most of which are remote and conflict-affected rather than urban and donor accessible, the scaled figures in this table are more likely to overstate the true number than to understate it. This is an association drawn from other countries' evidence, not a measurement taken in these nine regions themselves. It should be read as a reason for caution.

Where a country's figure comes directly from *Desmond et al.'s Table A22* rather than from scaling, this report uses the lower of two figures Desmond et al. report as the floor, and the higher as the ceiling. Desmond et al. give two versions of their estimate for most countries. One uses a broader definition that includes survey responses from the *2018 Global Study of Children Deprived of Liberty*. The other is restricted to government sourced official data. This is why some countries in the table show a wide range – Ethiopia's floor and ceiling differ more than twentyfold. That width is not Desmond et al.'s own stated uncertainty about a single measurement. It is the distance between two different definitions of confinement in residential institutions and orphanages applied to the same country, and should be read that way, not as a single margin of error. Two countries, Iraq and Nigeria, drop the broader definition's figure entirely, 83 children for Iraq and 3,814 for Nigeria against national populations of tens of millions. Both figures are treated as implausible artefacts, not genuine estimates.

Ukraine's figure used in this report's core and extended totals is an estimate of 30,000 children currently confined in residential institutions and orphanages. No official or otherwise verifiable source states Ukraine's current, post-invasion total. This estimate reflects the likely scale of evacuation, family reunification and population displacement since the 2022 invasion, set against this report's earlier, pre-invasion figure of more than 105,000 children, cited elsewhere to *Human Rights Watch (2023)* and used there only in relation to the pre-invasion population and disability prevalence discussed in section 3. The Occupied Palestinian Territory does not have a verifiable current figure either. Desmond et al. do not cover it, and this review could not confirm a specific UNICEF publication behind a previously used estimate, so no figure is offered here, and this is recorded in the table as "no data available". Colombia is included on this report's own judgement that residual, localised conflict remains relevant to its children confined in residential institutions and orphanages, even though Colombia no longer meets the World Bank's current threshold for listing, following sustained progress in its peace process. Burundi is included on the same basis. It does not appear on the World Bank's Conflict category list either. It sits within the World Bank's separate institutional and social fragility category, but this report's own judgement is that its occasional domestic conflict remains relevant to its children confined in residential institutions and orphanages.

Russia's population of children confined in residential institutions and orphanages is not counted in this table's total. Russia does not appear on the World Bank's FY26 list this report otherwise follows for scope. That list's scope excludes higher income countries and countries without active World Bank engagement. Russia falls outside that scope on both grounds – its World Bank programmes were suspended in 2022 (*World Bank, 2022*) and it was reclassified as a high-income country in 2024 (*World Bank, 2024*), regardless of conflict status. Russia's relevance elsewhere in this report rests on a distinct question – its documented role in the forced transfer of Ukrainian children, addressed in full in section 10 and section 11.3, and this report does not treat that as a count of children confined within Russia's own borders. *Desmond et al.'s (2020)* actual figure for children confined in residential institutions and orphanages in Russia is 263,300.

COUNTRY-BY-COUNTRY ESTIMATES

Country or territory	Floor	Ceiling	Basis	Population source (for the nine scaled countries)
Ukraine	30,000	30,000	Estimated. No verifiable source for a current, post-invasion total. See note below.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Syria	2,452	13,074	Desmond et al. (2020), Table A22.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Yemen	6,708	24,866	Desmond et al. (2020), Table A22.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Democratic Republic of Congo	104,871	120,217	Desmond et al. (2020), Table A22.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Ethiopia	9,090	207,340	Desmond et al. (2020), Table A22. Kept national since Ethiopia's recent conflicts span several regions, including Tigray, Amhara, Benishangul Gumuz and Oromia (ACAPS, 2026).	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Sudan	44,298	53,219	Desmond et al. (2020), Table A22.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.

Country or territory	Floor	Ceiling	Basis	Population source (for the nine scaled countries)
South Sudan	7,190	13,502	Desmond et al. (2020), Table A22.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Afghanistan	3,752	29,076	Desmond et al. (2020), Table A22.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Myanmar	10,800	85,016	Desmond et al. (2020), Table A22.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Occupied Palestinian Territory	No data available	No data available	No data available. Not covered by Desmond et al., no verifiable UNICEF publication located.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Somalia	9,648	13,185	Desmond et al. (2020), Table A22.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Central African Republic	5,392	6,392	Desmond et al. (2020), Table A22.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Iraq	30,843	31,218	Desmond et al. (2020), Table A22, official data only. The broader figure, 83 children, is excluded as an implausible artefact.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.

Country or territory	Floor	Ceiling	Basis	Population source (for the nine scaled countries)
Nigeria	266,458	274,267	<i>Desmond et al. (2020), Table A22</i> , official data only. Kept national since Nigeria's conflicts span three geopolitical zones (ACAPS, 2025).	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Colombia	31,378	35,134	<i>Desmond et al. (2020), Table A22</i> .	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Angola	21,576	108,877	<i>Desmond et al. (2020), Table A22</i> .	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Benin	185	213	Scaled to Alibori and Atacora departments, 16.4% of Benin's population (2013 census). Benin's whole national figure, Table A22: 1,128 to 1,300.	<i>Benin's 2013 census (RGPH4)</i> , Institut National de la Statistique et de l'Analyse Economique.
Burkina Faso	1,483	30,297	<i>Desmond et al. (2020), Table A22</i> . Kept national since non-state armed groups are reported to control around 40% of national territory, with activity documented across at least five regions (ACAPS, 2026).	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.

Country or territory	Floor	Ceiling	Basis	Population source (for the nine scaled countries)
Cameroon	9,245	11,156	Scaled to the Far North, Northwest and Southwest regions, 33.0% of Cameroon's population (2015 data). Cameroon's whole national figure, Table A22: 28,004 to 33,794.	<i>Cameroon's 2015 administrative division population data</i> . See note below the table on sourcing.
Mali	23,813	25,412	<i>Desmond et al. (2020), Table A22</i> . Kept national since the conflict reaches the capital directly (ACLED, 2024).	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Mozambique	114	3,601	Scaled to Cabo Delgado province, 8.0% of Mozambique's population (2017 census). Mozambique's whole national figure, Table A22: 1,420 to 44,788.	<i>Mozambique's 2017 census</i> . See note below the table on sourcing.
Niger	2,384	37,510	<i>Desmond et al. (2020), Table A22</i> . Kept national since the conflict spans the country's northern, southwestern and southern regions (ACLED, 2024).	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Togo	1,417	1,575	Scaled to the Savanes region, 14.1% of Togo's population (2022 census). Togo's whole national figure, Table A22: 10,031 to 11,147.	<i>Togo's 2022 census (RGPH5)</i> , reported by Togo Presse and the Agence Togolaise de Presse.

Country or territory	Floor	Ceiling	Basis	Population source (for the nine scaled countries)
Pakistan, core estimate (see note below the table)	12,263	13,074	Scaled to the former Federally Administered Tribal Areas, 2.4% of Pakistan's population (2017 census). Pakistan's whole national figure, Table A22: 509,350 to 543,026. See the footnote on this table before summing rows.	<i>Pakistan's 2017 census, as reported in Dawn.</i>
Pakistan, extended estimate	87,066	92,823	Scaled to the whole of Khyber Pakhtunkhwa province, including the former tribal areas, 17.1% of Pakistan's population (2017 census). Pakistan's whole national figure, Table A22: 509,350 to 543,026. See the footnote on this table before summing rows.	<i>Pakistan's 2017 census, as reported in Dawn.</i>
India	3,419	3,842	Scaled to Jammu and Kashmir, 1.0% of India's population (2011 census). India's whole national figure, Table A22: 337,497 to 379,191.	<i>India's 2011 census, reported by the Registrar General and Census Commissioner of India. See note below the table on sourcing.</i>
Indonesia	5,005	8,208	Scaled to Papua and West Papua provinces, 1.8% of Indonesia's population (2020 census). Indonesia's whole national figure, Table A22: 279,227 to 457,933.	<i>Indonesia's 2020 census (SP2020). Papua figure from BPS Statistics Indonesia. West Papua figure, see note below the table on sourcing.</i>

Country or territory	Floor	Ceiling	Basis	Population source (for the nine scaled countries)
Philippines	125	6,596	Scaled to the Bangsamoro Autonomous Region in Muslim Mindanao, 4.0% of the Philippines' population as stated directly by the Philippine Statistics Authority (2020 census). The Philippines' whole national figure, Table A22: 3,103 to 163,257.	<i>Philippine Statistics Authority, Highlights of the BARMM Population, 2020 Census of Population and Housing, which states the 4.0% share directly.</i>
Thailand	1,719	2,119	Scaled to Pattani, Yala and Narathiwat provinces, 2.9% of Thailand's population (2014 to 2015 data). Thailand's whole national figure, Table A22: 59,265 to 73,028.	<i>Thailand National Statistical Office, Statistical Yearbook Thailand 2015.</i>
Haiti	9,598	36,003	<i>Desmond et al. (2020), Table A22.</i>	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.
Burundi	4,937	15,809	<i>Desmond et al. (2020), Table A22.</i> Included since Burundi experiences occasional domestic conflict.	Not applicable. This country's whole national figure is used directly, not scaled to a sub-national population share.

Note: Pakistan appears twice in this table, as a core estimate and an extended estimate. These are alternatives, not additive rows. Use one or the other when summing the table.

Note: **Population sources:** the population shares above for Cameroon, Mozambique, Indonesia's West Papua figure, and part of India's citation trail were compiled from secondary aggregators available at the time, rather than a primary national statistics office publication.

Core total, using Pakistan's core estimate: 660,163 to 1,240,798 children.

Extended total, using Pakistan's extended estimate: 734,966 to 1,320,547 children.

For comparison, applying every country’s whole national figure of institutionalised children, regardless of where its conflict is located, would produce a total of 1,855,696 to 2,897,878. The core total used throughout this report is 35.6% of that uncorrected floor and 42.8% of its uncorrected ceiling. Most of that difference comes from correcting Pakistan, India and Indonesia’s figures by scaling them down estimates for the areas their conflicts actually affect. Nigeria, the Democratic Republic of Congo and Ukraine together account for 60.8% of the corrected floor.

Two further limitations affect this table. The population data used for scaling and Desmond et al.’s figures on children confined in residential institutions and orphanages are not from the same year. Desmond et al.’s figures are for 2015. The census data used for the nine scaled countries, ranges from 2011 for India to 2022 for Togo. A gap of this size means the population share used may not be the share that applied in 2015, particularly where conflict has displaced people in the years between.

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Two of the nine scaled countries also carry very wide uncertainty in the national figure before any scaling happens. The Philippines’ national floor and ceiling differ more than fiftyfold, and Mozambique’s differ more than thirtyfold. Scaling an unstable national figure down to a small area does not make it more stable. It produces a small, precise-looking number built on an unstable base.

This table’s sources of uncertainty do not all pull in the same direction. Scaling nine countries’ national figures down to their conflict-affected regions probably overstates the true regional number, since confinement in residential institutions and orphanages in those countries tends to cluster in cities rather than in the remote areas (section 4.2). The exclusions applied to Iraq, Nigeria and Russia are a different kind of adjustment. They correct specific figures this report has reason to treat as wrong or out of scope. They are not a deliberately cautious choice from a plausible range, and this report does not describe them as making the total more or less conservative.

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About Hope and Homes for Children

Hope and Homes for Children is a leading organisation on global child care reform. Established in the aftermath of the Bosnian conflict in 1994, Hope and Homes for Children has operated in several conflict-affected countries including Sudan, post-genocide Rwanda and Ukraine. Our mission is to serve as a catalyst for the global elimination of orphanages. This is our entry point in the reform process, to which we bring a full systems approach across social protection, health, education, welfare and so on, focusing on key elements within those systems such as gatekeeping, prevention, family strengthening and case management. Our impact is clear. Working alongside and investing in local partner organisations, as well as with local authorities and national governments, we have helped to reduce the number of children confined in residential institutions and orphanages from more than 100,000 to less than 500 in Romania, from 33,000 to less than 300 in Bulgaria, and from 13,000 to less than 600 in Moldova. We have achieved similar results in Rwanda and South Africa, and are more recently pushing for reform in Kenya, Nepal and India. Our hybrid model of systems reform support and humanitarian response continues to develop in Ukraine.

About the author

Mark was International Programmes Director for Village AiD, working in Sierra Leone during the conflict among other locations. As CEO of War Child, he worked regularly in Afghanistan, Iraq and Democratic Republic of Congo with colleagues and partner organisations. As CEO of Hope and Homes for Children, he undertakes monitoring and advocacy visits to Ukraine, including most recently in June of 2026 specifically to collect data and undertake interviews for this report. In a voluntary capacity, he served as the Chair of the Board of Micaia for nine years, an NGO that develops innovative grass roots solutions to structural poverty, and then on the Board of Barnardo’s, the UK’s largest children’s charity, including as the Chair of the Barnardo’s Foundation. More recently, and in an independent capacity, Mark has led a review of discrimination and accountability within the humanitarian sector and is currently developing a new financing and delivery mechanism that focuses on local responder capabilities.

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