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Community Medicine

ORPHANED AND ABUSED: PHYSICAL ASSAULT BY CAREGIVERS AMONG INSTITUTIONALIZED CHILDREN IN KASHMIR VALLEY – MAGNITUDE, ATTRIBUTES AND IMPACT.

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ABSTRACT ***Introduction:*** There are 140 million orphans worldwide with 214, 000 in Kashmir Valley. Many land in institutional setups, away from their families, kin and community. Research has provided evidence based and irrefutable proof that orphanage exposure is detrimental to the physical, psychological and social growth of children. These children comprise a mostly marginalized and vulnerable section of society with no one to prioritize their interests, therefore, exposing them to physical, emotional and sexual abuse. This paper aims to study physical assault by caregivers in orphanages and attributes and effects of such treatment. ***Methodology:*** The research was conducted among 450 respondents across Kashmir province by multistage simple random sampling and once the desired sample size was achieved, the study participants were asked about physical assault in the orphanages and assessed for psychiatric morbidity using the Modified Mini Scale (MMS) after following due protocol. ***Results:*** Of the 450 respondents, 68% had been subjected to physical assault in the institutions. There was a significant association of physical assault with gender, being more common among males (88.3% had faced physical assault) and orphanage setting with a higher prevalence in urban orphanages where 93.8% of the residents had experienced physical assault. Exposure to physical assault was also found to have a statistically significant association with psychiatric morbidity among the participants with 41.5% of children subjected to assault scoring more than 5 on the MMS and having a 13 times higher risk of psychiatric morbidity on binary logistic regression. 26.8% of assaulted children displayed PTSD like symptoms. ***Conclusion:*** The findings of our study indicate that orphanages are not a safe haven for children in distress. However, mere acknowledgement and articulation of their vulnerability is not enough. Initiatives and action from governments and public alike need to be invoked with an impetus to policy framing and revision.

KEYWORDS : Orphans, orphanages, physical assault, caregivers, Kashmir Valley.

Introduction

A child is defined as an individual less than 18 years of age[1]. The definition of an orphan is a child that has lost one or both parents, classifying them as a "single orphan" (maternal or paternal) or a "double orphan respectively"[2]. It is estimated that approximately 140 million children are orphans worldwide; 15.1 million of them being double orphans[3]. Of this staggering number, Asia leads with 61 million orphans and Africa contributes 52 million orphans of the global burden[4]. In absolute numbers, India is home to approximately 20 million orphan children, with UNICEF estimating the number to be 25 million[5,6]. A UK based NGO "Save the Children" reported that there are 214, 000 orphans in Kashmir with 37 % of them were orphaned due to the armed conflict[7]. "Orphanage" is the term used to refer to facilities for the short- or long-term care of a child other than in a family setting. The main push factor for development of such institutions has mostly been orphanhood but on closer inspection, there are often other drivers as well including illness, poverty, abandonment, culture, politics or societal challenges such as war, conflict, disaster and displacement or migration[8]. UNICEF estimates the number of children worldwide living in orphanages to be at least 2.2 million[9]. Orphanages include all forms of residential care, ranging from small (15 or fewer children) to large-scale institutions. There is significant concern regarding the above mentioned figures to be a gross underestimate especially since many orphanages around the world are unregistered and the children living within them are not officially tracked[10]. Depending on the region, approximately 50-90% of children living in orphanages have at least one surviving parent[8]. Considering, for example, Eastern Europe and Central Asia, a 2012 situation analysis found that 95-98% of children aged less than 3 years and in formal care were not orphans[11] and in fact had parents who for one reason or another felt they could not care for them. A similar scrutiny of orphanages in Ghana reported that between 80-90% of the children in institutional care had families that, with some support, would be able to care for them in a home environment[12].

Children residing in arrangements alternative to family care are one of the most vulnerable groups in a society; many of them have to experience repeated neglect, abuse or fear in these institutions[13]. With the advent of neurosciences, the importance of the early years in brain cell proliferation has been also highlighted, and early childhood is widely recognized as an extremely important phase of development[14]. The global community has begun to introspect and challenge the notion of institutionalised care arrangements – sentiments often triggered by the fact that children growing in such environments have been observed to suffer from some form of neglect. A series of systematic reviews and 50 years worth of research as well as recent insights into cognitive development has shown that institutionalised care is invariably associated with poor outcomes such as cognitive development[15,16,17]. Van IJzendoorn et al. propose that children in institutional care can be exposed to 'structural neglect', a problem which combines environmental challenges such as minimum physical resources and poor infrastructure, challenging and inadequate staffing patterns and training and insufficient caregiver-child interactions, all of which can compound the detrimental effects on child development. They further observe that the evidence on the inevitability or reversibility of such impact is still unclear. Furthermore, they postulated that lengthier periods of residence in such care were proportional to the risk of harm to physical and psychological developmental trajectories[18]. Unfortunately, the number of children being institutionalized appears to be rising. Cambodia witnessed a 75% increase in the number of orphanages during a five-year period from 2005 to 2010[19]. Recent studies on residential care in sub-Saharan Africa have also indicated a substantial growth in the number of orphanages and children enrolled therein. Uganda, for example, reported an overwhelming surge in the number of orphanages from 30 in late 1992 to an estimated 800 in 2013[20, 21]. More than 95% of these facilities were not appropriately licensed by the government to operate, and were, consequently, operating in violation of national child protection laws[22]. Parents and community members find this mushrooming of institutions acceptable probably because they are under the impression that an orphanage is beneficial to a child as it fulfils some of their basic needs, while remaining dangerously unaware of the detrimental effects it can have on a child's social, emotional, and cognitive development[23]. The role a family is able to serve in a child's life: the ability to provide a child with love, a sense of belonging, and a lifelong connection to the community cannot be

substituted by institutional care. It is within families that children learn and participate in family and cultural traditions, get acquainted with their shared history and learn important social skills that help them engage and interact as family and community members later in life[24]. The kind of warm, responsive, and reciprocal relationship between a child and an adult in a family is impossible to replicate in an institutional setting and absence of the same can hamper brain development[25].

Pioneering studies have revealed that children raised in biological, foster, and adoptive families demonstrate better physical, intellectual, and developmental outcomes as compared to children living in institutional care[26,27]. Even in small scale orphanages with relatively better caregiver – child ratio and interactions there can still be negative consequences to children's development as was demonstrated in a series of longitudinal studies of children in orphanages in Britain where it was ensured that high quality food, shelter and medical attention were provided to children in care. There was a positive child to caregiver ratio (i.e., one caregiver charged with a small number of children); however, children experienced multiple caregivers[28] and in spite of the higher quality of care provided, children were found to have identifiable negative effects. Research, therefore, purports that the quality of material components of care is not nearly as important as consistent, responsive and reciprocal child-caregiver interaction, especially in the early years, somewhat akin to family settings[29]. Children raised in large- scale orphanages often display a wide array of adverse outcomes including pervasive growth problems such as stunting and impairments in fine and gross motor skills and coordination[30,31,32]. Recent research in orphanages in Ethiopia and Rwanda reported on the caregiver-to-child ratios. Three orphanages from the Ethiopian group reported having only administrative staff[33]. The others had staff within a range that included 33 to 125 children per caregiver[34]. In Rwanda, the average ratio was found to be one caregiver to 13 children[35]. A global study conducted on violence against children found that orphanage children were some of the most vulnerable to violence, abuse and exploitation[36]. Adding to the problem is the phenomenon of 'voluntourism', as many orphanages utilize volunteers to augment caregiving capacity resulting in a constant flow of short-term volunteers which further exposes children to repeated departures and can potentially increase the risk of abuse and exploitation[37]. Evidence from Eastern Europe reveals that more children leave large-scale orphanages with disabilities than enter them, leading to the suggestion that orphanage placement can actually be a cause of disability in children[38].

The United Nations, in the Declaration of the Rights of the Child states: —the child, by reason of physical and mental immaturity needs special treatment, education and care required by his particular condition. The child shall be protected against all forms of neglect, cruelty and exploitation[39].

As most of these children lack a societal support system to uphold their rights, it becomes the duty of those who have a voice and the means, to provide a situational analysis of the circumstances of these children and to advocate for their upliftment by disseminating information to concerned authorities and international forums so that reformative measures can be instituted for the benefit of orphans and their problems addressed. With this background in consideration, the present study was conducted with the following objectives in mind.

Aims & Objectives

1) To assess the prevalence of physical assault by caregivers among children living in orphanages in Kashmir Valley
2) To study the factors associated with physical assault by caregivers among children living in orphanages in Kashmir Valley
3) To assess the association of physical assault by caregivers with psychiatric morbidity among children living in orphanages in Kashmir Valley

Methodology

The present study was carried out in the orphanages located in selected districts of Kashmir Valley with the aim to assess the prevalence and attributes of physical assault meted out by caregivers of the orphanages to the resident children as revealed with the help of a screening tool and a prestructured questionnaire.

Study area:-

The study was conducted in both registered and unregistered (Government as well as Private) orphanages of the Kashmir Valley.

Duration of study:-

The study was conducted over a period of one year i.e. from 1st April 2014 to 31st March 2015.

Study population:-

The study population consisted of children in the 10-18 years age group living in different orphanages of Kashmir Valley. The reason for not including children younger than 10 years was the fact that they had trouble comprehending the study tools. Individuals over 18 years of age could not be included because of the 'ageing-out' phenomenon.

Study design:-

A descriptive, cross- sectional study design was adopted.

Method of sampling:-

Multistage random sampling technique was adopted to achieve the target sample size.

Sample size:-

The sample size was decided taking into account the:-

a) Prevalence rates.
b) Confidence limit of 95%.
c) Margin of sampling error 10%

The sample size was calculated by using the following equation,

$N=Z^2p(1-p)/e^2$

where, Z = 1.96 for 95 % confidence level or 5 % level of significance
p = 0.05, which gives us the maximum sample

Level of precision is 5%.

As the data mentioned in available literature on prevalence of aforementioned problems among children living in orphanages in Kashmir Valley and elsewhere was limited, the sample size was calculated by assuming the prevalence of physical assault to be 50%, giving the maximum sample size, and as such the sample came out to be 384. To avoid the influence of non-responders, a sample size of 450 was taken for the study accounting for a non-response rate of 20%.

INCLUSION CRITERIA:-

Children in the age group of 10 - 18 years residing in orphanages.

EXCLUSION CRITERIA:-

- Children suffering from mental retardation.
- Children afflicted by deaf-mutism.
- Children refusing to participate in the study.

Sampling technique:-

Multistage random sampling was adopted to achieve the target sample size. By simple random sampling, two districts from each of the three geographical zones of Kashmir Valley were selected. Thus, the study was carried out in a total of six districts. Both registered and unregistered orphanages were included in the study. A list of registered orphanages in the Kashmir Valley was obtained from the Department of Social Welfare. Further, unregistered orphanages were identified with assistance from an NGO. From each of the selected districts, one registered male and one registered female orphanage was randomly selected for the study. Similarly, one unregistered male and one unregistered female orphanage were randomly selected from each district subject to availability of appropriate number of such orphanages and consent from their respective heads to be a part of the study. The number of children in the age group of interest in each orphanage was obtained. Further, appropriate selection of subjects from each orphanage was carried out by PPS (Probability Proportionate to Size) sampling till the required sample size was achieved.

Strategy:-

Approval for conducting the study was obtained from the Institutional Ethics Committee, Sher-i-Kashmir Institute of Medical Sciences. The study was conducted after obtaining written permission from the Social Welfare Department, Kashmir Division. Informed written consent was solicited from the Heads of the Institutions selected for the study purpose (with assurance from the legal advisor of the Institutional Ethics Committee, SKIMS, that in the absence of primary caregivers, the institutional heads were capable of providing informed

consent on behalf of the wards placed under their guardianship). The weekly schedule of the children was taken and adjustments made accordingly to make them available for the study, without disturbing their teaching schedule. The nature and purpose of the study and the procedure involved was explained to the study subjects and their consent was obtained after assuring them of utmost confidentiality. Written consent was also obtained from participants who were 18 years of age but still residing in the orphanages. The study was done on one-to-one basis in a specially assigned private room.

Study tools:-

The Modified Mini Scale, a validated mental health screening instrument, was used to identify children with psychiatric morbidity and those with moribund/suicidal ideation and PTSD like symptoms as revealed by responses to questions # 4, 14 and 15 of the scale. These children required further psychiatric evaluation and were referred to the Department of Psychiatry at SKIMS Medical College and Hospital, Bemina. The MMS items are derived from the Diagnostic and Statistical manual IV (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID) and the Mini International Neuropsychiatric Interview (M.I.N.I.). The MMS comprises of 22 questions, the scoring for which determines the need for further assessment. Physical assault was defined as incidents that involved actual physical contact between recipient and caregiver including slapping, kicking, caning or spanking. Other forms of disciplinary measures such as yelling, making children run around the courtyard, lifting heavy objects or helping with day to day activities in the orphanages like cooking, cleaning, laundry, doing the dishes, etc were not included in the definition of physical assault. No invasive procedures were involved.

DATA ANALYSIS:-

The data thus generated was analyzed using SPSS version 20 software. Appropriate statistical methods (Chi-square test and logistic regression test) were applied as per requirement. Chi-squared tests were used for categorical variables, and Fishers exact tests were used in place of x2 for independence when one or more cells in a table had an expected count of less than 5 whenever required. P value < 0.05 was taken as significant.

Results

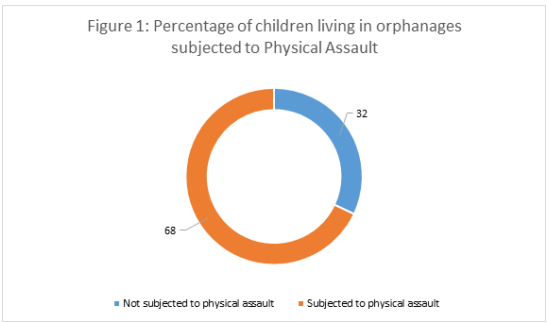

Figure 1 depicts that 68% of the respondents had been subjected to physical assault by caregivers in the orphanages.

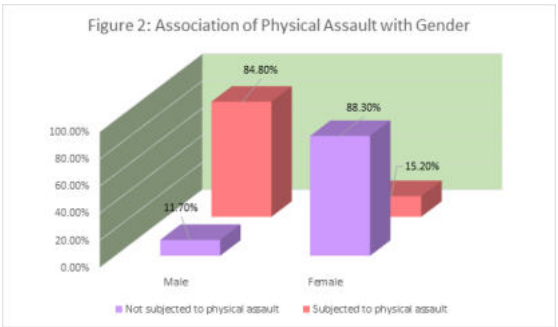

Table 1: Association of physical assault by caregivers among children living in orphanages with respect to gender.

Subjected to physical assault in orphanage	Males		Females		P Value
	No.	%	No.	%	< 0.001
No	38	11.7	105	84.8	
Yes	287	88.3	19	15.2	
Total	325	100	125	100	

Table 1 and Figure 2 depict the association of physical assault in orphanages with respect to gender. It was found that the physical assault was more among males (88.3%) as compared to females (15.2%). The overall association between the physical assault and gender was found to be statistically highly significant (p<0.001).

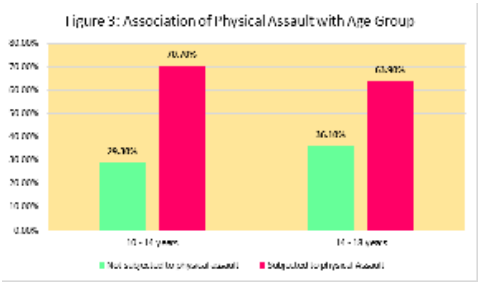

Table 2: Association of physical assault by caregivers among children living in orphanages with age group.

Whether subjected to physical assault	Age Group				P Value
	10 – 14 years		14 – 18 years		0.127
	No.	%	No.	%	
No	79	29.3	65	36.1	
Yes	191	70.7	115	63.9	
Total	270	100	180	100	

Table 2 and Figure 3 depict the association of physical assault in orphanages with age group with no statistically significant difference demonstrated between age groups at a p value of 0.127. However, the statistics did display an alarming trend of overwhelming prevalence of physical assault across age groups with 70.7 % of children aged 10 – 14 years subjected to physical assault as were 63.9 % of children in the 14 – 18 year age bracket.

Table 3: Association of physical assault by caregivers among children living in orphanages with duration of stay in orphanage.

Whether subjected to physical assault	Duration of Stay in Orphanage				P Value
	≤ 1 year		>1 year		0.166
	No.	%	No.	%	
No	26	26.3	118	33.6	
Yes	73	73.7	233	66.4	
Total	99	100	351	100	

Table 3 depicts the association of physical assault in orphanages with duration of stay in orphanage. It was observed that the physical assault was more among children with a stay duration of less than or equal to 1 year (73.7%) as compared to those with a stay duration of more than a year in the orphanage (66.4%). The overall association between the physical assault and duration of orphanage stay was found to be statistically insignificant (p 0.166) even though the overall prevalence remains quite high.

Table 4: Association of physical assault by caregivers among children living in orphanages with type of orphanage.

Whether subjected to physical assault	Type of Orphanage				P Value
	Registered		Unregistered		0.062
	No.	%	No.	%	
No	139	33.1	5	16.7	
Yes	281	66.9	25	83.3	
Total	420	100	30	100	

Table 4 depicts the association of physical assault in orphanages with type of orphanage. It was found that the physical assault was more among residents of unregistered orphanages (83.3%) as compared to inmates of registered orphanages (66.9%). The association between the physical assault and type of orphanage was found to be statistically insignificant (p 0.062).

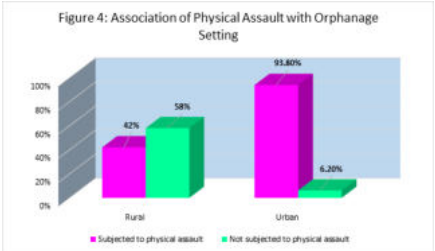

Table 5: Association of physical assault by caregivers among children living in orphanages with orphanage setting.

Whether subjected to physical assault	Orphanage Setting				P Value
	Rural		Urban		<0.001
	No.	%	No.	%	
No	130	58	14	6.2	
Yes	94	42	212	93.8	
Total	224	100	226	100	

Table 5 and Figure 4 illustrate the association of physical assault in orphanages with orphanage setting. It was detected that children living in orphanages in an urban setting were more likely to be subjected to physical assault with percentage prevalence towering at 93.8% as compared to children living in orphanages in a rural setting where the prevalence of physical assault was 42%. This difference was found to be statistically significant with a p value < 0.001.

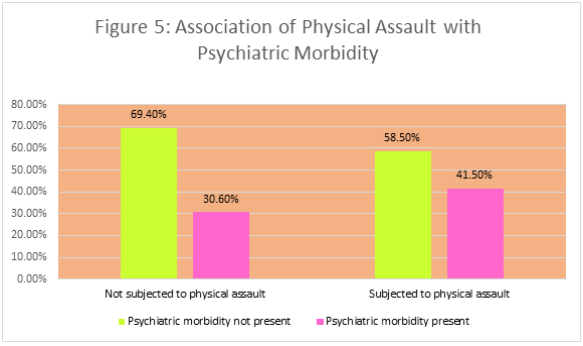

Table 6: Association between physical assault and psychiatric morbidity in orphanages.

Subjected to physical assault in orphanages	Without psychiatric morbidity		With psychiatric morbidity		Total	
	No.	%	No.	%	No.	%
No	100	69.4	44	30.6	144	100
Yes	179	58.5	127	41.5	306	100
P Value	0.026					

Table 6 and Figure 5 depict the association between physical assault and psychiatric morbidity in orphanages. It was revealed that 41.5% of the participants who were subjected to physical assault had psychiatric problems as compared to those who were not subjected to any kind of physical assault in orphanages (30.6%). The overall association between the physical assault and psychiatric morbidity was found to be statistically significant (p=0.026).

Table 7: Association of physical assault with psychiatric morbidity by binary logistic regression.

Parameter		P value	Odds Ratio (OR)	95% CI for OR		Reference
				Lower	Upper	
Physical Assault	Yes	0.000	13.305	5.155	34.339	No

Table 7 depicts that on binary logistic regression (multivariate analysis), a statistically significant association was observed between the prevalence of psychiatric morbidity among children living in orphanages and physical assault (p<0.001) with children who had been subjected to physical assault having a 13.306 times higher risk of having psychiatric morbidity as compared to children who were not subjected to physical assault.

Additionally, 22.9% of children subjected to physical assault within the orphanages displayed a moribund or suicidal ideation as evidenced by the response to Q#4 of the Modified Mini Scale. This association, however, was not found to have a statistical significance with a p value 0.131.

On the contrary, a statistically significant association was demonstrated between physical assault and prevalence of PTSD like symptoms, evidenced by affirmative responses to Q# 14 and 15 of MMS, with a p value of 0.043 and 26.8% of children who had experienced physical assault in the institution obtaining a score of 2 in comparison to 18.1% of children who had not been subjected to physical assault in the orphanages[40].

DISCUSSION

Most of the data supporting or refuting the observations of this research article was obtained from a systematic review conducted by Lorraine Sherr, Kathryn J. Roberts and Natasha Gandhi[41]. Commencing the examination of institutionalisation through a prism of neglect, violence literature deems institutionalization as a form of neglect and purports that such neglect itself is a neglected type of maltreatment as far as scientific research is concerned[42]. A 2015 study carried out in Tanzania observed the baseline reporting of physical maltreatment to be 93%[43]. In the current study, this percentage was found to be 68%. Another study conducted among institutionalized children in 5 low and middle income countries noted that 50.3% of the participants reported physical or sexual abuse. The study, however, did not reveal any gender based differences even though younger age groups were more prone to abuse[44]. These findings partly contradict our study results where male respondents reported a significantly higher prevalence of physical assault at 88.3% in comparison to 15.2% of female respondents and partly concur with the findings of the present study where 70.7% of study subjects aged 10 – 14 years were subjected to physical assault in comparison to 63.9% of subjects belonging to the 14 – 18 year age bracket. A 2014 study from Tanzania compared experiences of abuse among children institutionalized from 0 to 4 years of age with those institutionalized between 5 – 14 years of age and reported an 89% prevalence of abuse experienced at least once, with the prevalence being greater among those institutionalized at birth[45]. Thus, this study also supports the observations of our study that younger children are more vulnerable to physical abuse. A comprehensive nation-wide research activity in the Netherlands in 2014 among adolescents in institutional care, foster care and the general population found the risk of physical abuse highest in the former category as compared to the latter two categories. The study also reported a gender based difference in assault exposure along the lines of our study with 31% of males and 18% of females reporting physical abuse[46]. A 2013 study in a large cohort of children in the age bracket of 7 – 20 years with 1391 participants demonstrated overwhelming findings that 39.5% of the respondents recorded severe punishments including beatings by the staff and 80% of them further maintained that they had been exposed to abuse multiple times. This study also demonstrated a male preponderance, similar to findings reported in our study[47]. A 2013 study by Pinto and Maia among 86 institutionalized children revealed that 36% reported emotional abuse and 57% reported emotional neglect. This study further noted physical abuse for 34.9 %, physical neglect for 45.3% and sexual abuse among 21% of the study participants[48]. All the above mentioned studies, in addition to the current study findings, elucidate the impending pressing need for extensive advances and refinements in the contemporary orphanage setup so as to ensure a safer, more enabling environment for the residents of these institutions in addition to measures to reintegrate them into society by providing vocational opportunities and addressing stigma and discrimination. The framing and implementation of such procedures will require investment of time and finances as well as political and general population commitment. This should, however, not serve as a deterrent for tackling this issue with the urgency it demands keeping in alignment with the concept of parens patriae.

Recommendations

The study revealed certain glaring lacunae in the current system which need to be addressed at the earliest to ensure children living in orphanages do not face neglect and persecution and the adverse effects that such circumstances might have on their physical and mental health. Following are the recommendations that the authors opine would benefit children living in institutions:

1) Deinstitutionalization and reunification would give the entire system an overhaul. 12.7% of the study participants in the present study were social orphans, abandoned by their families owing to reasons like poverty, drug abuse, alcoholism or incarceration. These children usually have some immediate or extended family who, however, are unable to provide for the child. Numerous studies, notably the Bucharest Early Intervention Project, have demonstrated that any duration of institutionalization is harmful for children. Family or foster home settings have been proven to be an improvement over the orphanage experience. Efforts must be made to rehabilitate children within their families or foster families who in turn are provided with the necessary means to fulfil the child's requirements.
2) Establishment of a robust Social Services Scheme / Department along the lines of social services schemes in the Americas and Western Europe where dedicated and professional service providers visit the habitations of the children assessing the situation of the child for any neglect or violence and evaluating the utilization of state allocated resources by adults responsible for the

upbringing of the child.

3) Better system of monitoring and supervision of orphanages regarding treatment and well-being of the resident children including audit of fund flow and expenditure within orphanages.
4) A comprehensive programme for training of care givers in orphanages, who often have been recruited without any induction or orientation, regarding the special needs of their wards that comprise a vulnerable, marginalized, neglected and almost forgotten population. Equipping caregivers with the necessary understanding of the orphans' state of mind and a sense of compassion towards them could go a long way in reducing the prevalence of assault by caregivers in the institutions and enable them to handle any breaches of discipline without resorting to violence.
5) More international attention and support for Kashmir as the two decade long conflict is the major cause of orphanhood in the first place. Of the 450 participants in the present study, 83.6% were paternal orphans. 26.5% of the study population had been orphaned directly as a result of the armed conflict. It was observed that several of the participants felt they had been wronged and disturbingly nurtured vengeful and homicidal urges towards whom they thought to be perpetrators of this injustice. In such situations, the authors tried to neutralize such emotions. The fact, however, remains that both India and Pakistan should be prevailed upon by the international community to maintain peace in the region. The suffering of these children has been convoluted as 'bilateral and internal affairs' for too long.

Limitations

Though all possible measures were taken to reduce the limitations of the study, this could not be altogether avoided. Following are the main limitations of the present research project:

1) Gender representation in the study group was slightly skewed with 125 female participants and 325 male respondents. The reason for this was a lesser number of orphanages for females and a reluctance to send females away from the aegis of the family in the mostly conservative Kashmiri households.
2) There was a lesser representation from unregistered orphanages as such institutions do not appear on the records and are difficult to track down. Furthermore, such institutions generally do not consent to be part of research activities.

CONCLUSION

The year 1959 was touted as a landmark in child welfare that would usher in a new era, recognizing the special needs of children and annunciating their rights as the UN Declaration of the Rights of the Child was adopted on 20th of November 1959.This declaration was followed in 1989 by the Convention on the Rights of the Child, documents to which 196 countries, including India, are signatories. The purpose was to clearly spell out the rights of children so as to enable them to grow into healthy adults and productive members of their respective communities. The documents encompass various aspects of childhood such as security, nutrition, medical care, education, protection and relief in times of disaster, freedom, dignity, understanding, tolerance, friendship and peace irrespective of the color, sex, religion, nationality and social status. The first and the foremost right mentioned, however, is the right to an atmosphere of affection and security, wherever possible, in the care and responsibility of parents. The effects of institutionalization and separation from a family setting have already been discussed in this paper. While the fact remains that owing to factors such as extreme poverty, illness, war and disasters, a significant proportion of children are not able to exercise and enjoy these rights despite being in family care, they do have the advantage of someone looking out for them. However, going even by conservative estimates, a sizable cohort of children is being completely overlooked with the vision of a normal childhood free of abuse and neglect unimaginable and unattainable. Physical assault and its repercussions are only one among the several issues that scientific and general community need to be perturbed about as far as orphanage exposure is concerned. There is abundant literature available highlighting the afflictions of this vulnerable group including poor housing and nutrition, health affairs, psychiatric problems, suicidal ideation and PTSD inter alia. It would not be an overstatement to say that the world is collectively failing these children who have been left at the sympathy and mercy of those who take them in, whether at a stage of the continuum of family based care options or orphanages. This research article would like to bring attention towards the urgent need for a multifaceted and multipronged strategy in addressing the countless challenges these children encounter so as to return to them some semblance of a normal life wherein they too have the opportunity to realize their full potential and transform into socially and economically productive adults and fully functional members of the society without any stigma and discrimination or any impedimenta of traumatic experiences holding them back.

Disclosure Statement

There was no conflict of interest that needs to be declared.

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