Changing THE WAY WE care℠

Year 3 Review: Guatemala and Kenya Household Survey

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List of acronyms

APQ	Alabama Parenting Questionnaire
CFM	Child Functioning Module
COVID-19	Coronavirus Disease 2019
CTWWC	Changing the Way We Care
ECE	Early Childhood Education
HHS	Household Hunger Scale
N	Sample Size
OLS	Overall Life Satisfaction
OVC	Orphans and Vulnerable Children
PAPF	Parents' Assessment of Protective Factors
PFI	Protective Factors Index
SBS	Secretaría de Bienestar Social (in Spanish), Secretariat for Social Welfare (in English)
SD	Standard Deviation
SILC	Savings and Internal Lending
UNICEF	United Nations Children's Fund

USAID	United States Agency for International Development
WG-SS	Washington Group Short Set on Functioning

Glossary of terms

Alternative care: A formal or informal arrangement whereby a child is looked after (at least overnight) outside the parental home, either by decision of a judicial or administrative authority or duly accredited body, or by the initiative of the child, his/her parent(s) or primary caregiver(s), or spontaneously by a care provider in the absence of parents.

Caregiver: "A person with whom the child lives who provides daily care to the child, and who acts as the child's 'parent' whether they are biological parents or not. A caregiver can be the mother or father, or another family member such as a grandparent or older sibling. It includes informal arrangements in which the caregiver does not have legal responsibility."[1]

Care reform: The changes to the systems and mechanisms that promote and strengthen the capacity of families and communities to care for their children, address the care and protection needs of vulnerable or at-risk children to prevent separation from their families, decrease reliance on residential care and promote reintegration of children, and ensure appropriate family-based alternative care options are available.

Case management: The process of ensuring that an identified child has his/her needs for care, protection, and support met. This is usually the responsibility of an allocated social worker who meets with the child, the family, and any other caregiver(s) and professional(s) involved with the child in order to assess, plan, deliver, or refer the child and/or family for services, and monitor and review progress.

Family-based care: The short- or long-term placement of a child into a family environment with at least one consistent parental caregiver; a nurturing family environment where children are part of supportive kin and community

Family strengthening: Programs, strategic approaches, and deliberate processes of empowering families with the necessary capacities, opportunities, networks, relationships, and access to services and resources to promote and build resilience, and the active engagement of parents, caregivers, children, youth, and other family members in decisions that affect the family's life. *Changing the Way We Care* uses the term "family strengthening interventions" to refer to the services provided to families such as parenting training, cash transfers, referrals, etc.

Protective factors: Characteristics of children, families, and caregivers that enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences when a family is exposed to risks or shocks.

Reintegration: The process of a separated child making what is anticipated to be a permanent transition back to his or her immediate or extended family and community (usually of origin) in order to receive protection and care and to find a sense of belonging and purpose in all spheres of life.

[1] Better Care Net Toolkit Glossary. https://bettercarenetwork.org/sites/default/files/attachments/glossary.pdf

Reunification: The physical reuniting of a separated child with his or her family or previous caregiver.

Residential care: Any living arrangement/facility where salaried staff or volunteers ensure care for children living there. This includes large institutions and all other short- and long-term residential institutions including group homes, places of safety, transit centers, and orphanages.

Well-being: "A state of happiness and contentment, with low levels of distress, overall good physical and mental health and outlook, or good quality of life."[2]

[2] APA Dictionary of Psychology. https://dictionary.apa.org/well-being

Executive summary

Changing The Way We Care[SM] (CTWWC), launched in 2018, is an initiative designed to promote safe, nurturing family care for children. This includes reforming national systems of care for children, including family strengthening, family reintegration, preventing unnecessary child-family separation, development of alternative family-based care, and influencing and promoting family strengthening and care with other actors around the globe. CTWWC implements within a context of growing global interest in family care and care reform and as a result of an increased understanding that residential care of children is a significant problem that will be best addressed through collaboration between national, regional, and global stakeholders to develop care systems that strengthen families, prevent family separation, and promote family-based alternative care options.

In 2021, a household survey was implemented as part of CTWWC's Year 3 Review. It was designed to address the following research questions:

1. What aspects of family strengthening support do caregivers think have affected (negatively and positively) their ability to care and provide for their children?
2. What proportion of children and caregivers report selected protective factors in their life?
3. What proportion of children at risk of separation from their families, as well as children and young people who have been reunified or placed in family-based care or in independent living, are experiencing positive well-being?

Method

Sample

The household survey aimed to collect data about every child and family receiving support from CTWWC in Guatemala and Kenya (including families with reunified children and those receiving support after being identified as at risk of family-child separation). A family was considered eligible if they had begun receiving services from CTWWC before June 1, 2021. A high response rate was achieved amongst caregivers. Children aged 11 years and over were also asked to complete a self-report. A high response rate was also achieved with these children in Guatemala, whilst in Kenya the rate was only 55% as many children were at school, often in boarding facilities.

	Caregivers			Children age 11+		
	Sample	**Total Attempted**	**Response Rate**	**Sample**	**Total Attempted**	**Response Rate**
Kenya	*n*=263	295	89%	*n*=142	257	55%
Guatemala	*n*=59	61	97%	*n*=50	57	88%

Measures

The first step in the research design process was to consult children and young people with experience of living in residential care about what the household survey should include in terms of children's well-being. Two focus groups were held in Guatemala and 12 were held in Kenya with children and young adults who have lived in residential care. In both countries, participants included young people aged 11–17 who were reunified with family after living in residential care and receiving support from CTWWC. In Kenya, in addition, participants included young adults aged 18–29 who had lived in residential care more than two years prior, before CTWWC began its operations. The participants were asked about their experiences in and after residential care, and what it looks like to "have a good life" or "do well" while in residential care and after family reunification. The findings from both countries were used to inform a 44-item measure of Subjective Well-Being for use in the survey in both

countries.[3] Children completed the Subjective Well-Being Scale; a single-item measure of Overall Life Satisfaction (OLS); and a family and community acceptance scale focused on stigma, acceptance, and belonging. Caregivers completed the Washington Group Short Set on Functioning (WG-SS) to identify disability in themselves; the Parents' Assessment of Protective Factors (PAPF) instrument; the Alabama Parenting Questionnaire (APQ) subscales on parental involvement, positive parenting, and corporal punishment; the Household Hunger Scale (HHS); and the Washington Group/UNICEF Child Functioning Module (CFM) to identify disabilities in their children.

Findings

Univariate (descriptive) statistics and bivariate (independent samples: t-tests and Pearson's correlations) analyses were conducted to answer research questions. Results are presented below on the demographics of respondents and by research question themes.

Participants

Women are the vast majority of primary caregivers in both Guatemala and Kenya. **In Kenya**, around half of these women are the mother of children in their care, another 30% are a grandmother or aunt. Half of the women are also widowed or single and are often the only adult in their household. Approximately a third of caregivers are over 50 years of age and 18% have a disability. **In Guatemala**, most caregivers are the mother of the children in their care, married, and aged between 30 and 50 years. Over 15% of caregivers have a disability.

In Guatemala, the children covered by the survey are of all ages, with almost 18% having a disability. Most children have two living parents and live in the care of one or both of their parents (40% live with just their mother). Just over half of reunified children had spent less than a year in residential care. **In Kenya**, children are mostly school-going age, 15% have a disability, and many are orphans having lost one or both parents. Less than 10% of children live with both parents, with over 40% living with just their mother and another 40% living in the care of people who are not their parents. The average amount of time reunified children had spent in care was 4.5 years.

Family strengthening support

Caregivers participating in the survey were asked to consider all types of support they received from CTWWC and to report on how helpful they were as they care for their children. All types of support were rated as being helpful in both countries. Caregivers from both Kenya and Guatemala found cash transfers to be the most helpful type of support, followed by parent training. Cash transfers and parent trainings were also the most widely used type of support.

In Kenya, on average, caregivers rated the following supports from *most helpful* to *least helpful* relative to each other (the percent of caregivers participating in each is included in parentheses):

1. Cash transfers (93.9% participation).
2. Parenting training (76.4% participation).
3. Kitchen garden training (45.3% participation).
4. Home visit from a case worker, involvement in case planning to set goals for the family/child, counselling and guidance (95.1% participation).

[3] Further details about this process can be read in the report Child- and Adolescent-Defined Well-being: Designing a Household Survey with Children and Young People (September 2021).

5. Food bundles (42.2% participation).
6. Referrals to other service providers (51.7% participation).
7. Membership in a savings and loans group (SILC) (35.0% participation).

In Guatemala, on average, caregivers rated the relative helpfulness of supports as follows:

1. Cash transfers (67.8% participation).
2. Parenting training (66.1% participation).
3. Home visit from a case worker, involvement in case planning to set goals for the family/child, counselling and guidance (81.4% participation).
4. Referrals to other service providers (10.2% participation).

Caregiver protective factors

Caregivers responded to questions about their caregiving protective factors, parenting practices, and household economic stability.

In both countries, caregivers report the presence of protective factors in their lives—resilience, social connections, concrete support, and social and emotional competence of children. **In Kenya,** the overall average Protective Factors Index (PFI) score was M=2.72 (SD=0.54). From highest to lowest, protective factors are ranked as follows:

1. Social and emotional competency of children (M=3.14, SD=0.53).
2. Parental resilience (M=3.10, SD=0.53).
3. Concrete assistance in times of need (M=2.55, SD=0.74).
4. Social connections (M=2.11, SD=0.92).

Pearson's correlations revealed that in Kenya, the higher a caregiver's education level, the higher their scores on social connections ($r=.16$, $p<.05$), on concrete assistance in times of need ($r=.23$, $p<.001$), and on the overall PFI ($r=.16$, $p<.01$). Caregivers in rural households scored higher on social and emotional competency of children compared to those in urban locations (rural=3.18, urban=3.03, $p<.05$). Caregivers with disabilities had lower parental resilience scores than those without disabilities (with disabilities=2.96, without disabilities=3.13, $p<.05$). Widows also had lower scores on concrete assistance in times of need than non-widows (non-widows=2.21, widows=1.98, $p<.05$).

In Guatemala, the overall average PFI score was M=3.47 (SD=0.54). From highest to lowest, protective factors are ranked as follows:

1. Parental resilience (M=3.61, SD=0.52).
2. Concrete assistance in times of need (M=3.45, SD=0.71).
3. Social and emotional competency of children (M=3.44, SD=0.65).
4. Social connections (M=3.34, SD=0.71).

In Guatemala, female caregivers had statistically significantly higher scores on all parental protective factor subscales than male caregivers, including on parental resilience (female=3.69, male=2.94, $p<.001$), social connections (female=3.43, male=2.61, $p<.01$), concrete assistance in times of need (female=3.52, male=2.87, $p<.01$), social and emotional competency of children (female=3.51, male=2.80, $p<.01$), and overall PFI (female=3.54, male=2.81, $p<.01$).

The majority of caregivers report using positive parenting practices such as asking their child about their day, helping with homework, praising them, and rewarding good behavior. However, many are also still reporting using some form of corporal punishment. **In Kenya**, 21% of caregivers met the threshold set by CTWWC for "practicing positive parenting." The older the caregiver, the lower their

parental involvement (r=-17, p<.01). In addition, the more education the caregiver had, the higher their parental involvement score (r=.17, p<.01). The older the caregiver's age, the less often they used any type of corporal punishment (spanking: r=-12, p<.05; slapping: r=-.16, p<.05; hitting with object: r=-.24, p<.001). The higher the level of education a caregiver had, the more often they used any type of corporal punishment (spanking: r=.17, p<.01; slapping: r=.17, p<.01; hitting with object: r=.14, p<.05).

In Guatemala, 39% of caregivers met the criteria for "practicing positive parenting." The more adults living in the household, the higher the caregivers' positive parenting scores (r=.29, p<.05), but there was no correlation with parental involvement. Widows also had better parental involvement scores than non-widows (non-widows=20.0, widows=13.0, p<.01), but they did not differ on positive parenting. Male caregivers hit children with objects more frequently than female caregivers (female=0.36, male=1.50, p<.01), but females and males did not differ on the use of other corporal punishment types.

In regard to household economic stability, it was found that the majority of caregivers in both countries are not economically stable**. In Kenya**, although most households (62.4%) reported little to no hunger, there were still many households (36.9%) that had moderate to severe household hunger. Caregivers with disabilities had more household hunger than caregivers without disabilities (with disabilities=1.56, without disabilities=1.07, p<.05). Households with reunified children had less hunger than those only receiving prevention services (reunified=1.81, at-risk=1.04, p<.001), and 39.8% of caregivers of reunified families were able to save money in the past month while only 18.6% of caregivers in at-risk families had saved (p<.001). The more children in the household, the higher the rates of hunger (r=.15, p<.05). Almost all caregivers in Kenya worried about money at least sometimes (92.0%). The older the caregiver, the less they worried about money (r=-.12, p<.05). Most caregivers reported worrying about their economic situation and many were struggling to meet the needs of their children. In some instances, this is leading to children missing school and not receiving health care when it is needed. There is some indication that this situation could be worse for widows, a third of whom are the only adults in their household; while 42.6% of non-widows were able to save money in the past month, only 29.6% of widows had saved any (p<.05).

In Guatemala, most households (88.1%) were facing little to no hunger. Households with reunified children had less hunger than prevention-only households (at-risk only=1.00, reunified children=0.23, p<.05). Only about a quarter (22.0%) of caregivers reported never having worried about money in the last four weeks, while about 70% worried about money sometimes or often. Caregivers with a disability worried about money more than caregivers without a disability (disability=2.56, no disability=1.60, p<.05). Sixty-one percent of caregivers had not managed to save any money in the past month.

Child well-being

Overall, both caregiver- and child-reported child well-being and life satisfaction is positive. The well-being of children aged 2–10 was reported on positively by caregivers. **In Kenya,** there were 68 children included aged 2–10. For these children, caregivers were asked to rate their children's overall health on a scale of 0 (poor) to 4 (excellent). The average score in Kenya was 2.63 (SD: 0.83, min: 1, max: 4). Young children aged 2–4, although few in number, are accessing early childhood education and stimulation. Most caregivers felt their children liked school and were treated well there, were not overly involved in chores, and were growing well. They indicated more concern about their children having material needs to complete schoolwork and enough food to eat, and their treatment by family members. Among reunified children aged 2–10, the older the child's age at reunification, the greater their caregiver-reported well-being score (r=.29, p<.05).

Children aged 11 and above were also asked a number of questions regarding their own subjective well-being. Responses to the 44 questions were mostly positive across the range of well-being areas covered, including safety, love, family nurture, psychosocial, education, health, community relations, food, and bedding. In Kenya, around 50% of children said they were afraid of what will happen if they do not listen to their caregivers. Other lower-rated questions touched on whether children had other people to help them, had a choice of foods, and if they had education materials. The children also reported that household chores impacted their studies. Among these children aged 11 and above, children with disabilities reported lower subjective well-being than children without disabilities (no disabilities=1.57, disabilities=1.29, p<.001). Equally important is that children who had lost one or both parents also had significantly higher well-being than children with two living parents (non-orphan=1.42, orphan=1.56, p<.01). Children also rated their OLS on a scale of 0–10, where 10 represented greatest satisfaction. The mean score was 7.53 in Kenya (SD: 2.25, min: 1, max: 10). Children with disabilities had significantly lower OLS than children without disabilities (no disability=7.71, disability=6.45, p<.05). Children who lived with a non-relative adult had greater OLS than children who did not (lived with non-relative=7.36, did not live with non-relative=8.39, p<.05).

In Guatemala, caregivers reported on the health and well-being of their children aged 2–10. They rated the overall health of children at 2.91 on average (SD: 1.18, min: 0, max: 4), on a scale of 0 (poor) to 4 (excellent). Children with disabilities had significantly poorer caregiver-rated overall health compared to children without disabilities (without disabilities=3.15, with disabilities=1.33, p<.001). Children at risk of separation also had poorer health than reunified children (at-risk=2.26, reunified=3.36, p<.01). In Guatemala, only 4 out of 14 young children are in early childhood education. Caregivers felt their children were not involved in work or chores in a way that interfered with school or sleep, were treated well at school, were safe and happy, and were growing well. There were slightly lower scores around treatment by family and community members and having the material needs to complete school work. Children without disabilities were rated as having higher well-being than children with disabilities (without disabilities=2.07, with disabilities =1.56, p<.001).

Children aged 11 and above were asked to self-report on their own subjective well-being. Responses were mostly positive across the range of well-being areas covered. Notably, in Guatemala around 50% of children said they were afraid of what will happen if they do not listen to their caregivers. Overall, the older the child was, the higher their self-reported well-being, but there were no significant group differences (i.e., looking at gender, disability status, placement type, parental care status, orphanhood status, and whether they lived with a non-relative adult). Children also rated their OLS on a scale of 0–10, where 10 represented greatest satisfaction. The mean score was 9.22 in Guatemala (SD: 1.68, min: 2, max: 10). Amongst these children aged 11–18, the older the child, the lower their OLS (r=-.28, p<.05).

Children's perspectives on life in residential care and their acceptance at home

Children (aged 11 years and above) who had returned from residential care, were additionally asked to rate their OLS when they were in care, using the same 10-point scale as above, where 10 represented greatest satisfaction. **In Kenya**, reunified children were, on average, only 0.07 points more satisfied with life now, compared to when they lived in residential care, a negligible amount in the context of the 10-point scale. On average, the life satisfaction of children with difficulties decreased while it increased for children without difficulties (with difficulties=-1.81, without difficulties=0.39, p<.05). There was also a significant difference between orphaned children (those who had lost one or both parents) and non-orphaned children; non-orphaned children's OLS decreased while orphaned children's increased (non-orphan=-1.26, orphan=0.59, p<.01). **In Guatemala**, among reunified children aged 11 and above, children were, on average, 5.5 points more satisfied with life at the time of the survey, compared to when they lived in residential care.

The same children who had returned to family care were also asked about their sense of family acceptance and community belonging. **In Kenya**, the average family acceptance score was 1.88 on a scale of 0–2 (with 2 representing higher acceptance), and the average community acceptance score was 1.63. Overall, children in Kenya report about the same life satisfaction now as they did while living in residential care. However, children with disabilities and non-orphaned children report lower life satisfaction. **In Guatemala**, the average family acceptance score was 1.95, and the average community acceptance score 1.72. The younger the age at which the child entered into care, the lower their family acceptance score ($r=.34$, $p<.05$). Relatedly, the more years a child spent in care, the lower their family acceptance score ($r=-.36$, $p<.05$).

Correlations between protective factors and child well-being

Multiple caregiver protective factors positively correlated with children's well-being **in Kenya**, particularly parental resilience ($r=.39$, $p<.001$), social and emotional competency of children ($r=.30$, $p<.001$), and positive parenting practices ($r=.25$, $p<01$). Lower household hunger scores correlated with greater child well-being ($r=-.30$, $p<.001$) and a greater ability to obtain funds in an emergency also correlated with greater child wellbeing ($r=.21$, $p<.05$). Concrete assistance was not statistically correlated with any aspect of child well-being, nor were parent involvement or worries about money.

Recommendations

The following recommendations are firstly for CTWWC's ongoing efforts in Guatemala and Kenya and will likely be useful for others working on care reform in these countries; and secondly, for future household surveys and further linked research relevant to CTWWC, its implementing agencies and partners, and other care reform actors.

Practice

1. CTWWC and partners should share key findings and key messages from caregivers and children with those involved in providing and supporting children's care and family strengthening, such as governments, non-governmental organizations, faith-based supporters, and donors.
2. CTWWC and other care reform actors should consider adapting current interventions to better support the different groups of caregivers whose particular needs were highlighted in the findings of the survey. These include women, widows, male caregivers, older caregivers, and caregivers with disabilities.
3. CTWWC and other care reform actors should consider adapting current interventions in order to ensure that no child is left behind, especially younger children and those with disabilities, when reunifying, developing family-based alternative care, or when working to prevent separation.
4. CTWWC and other care reform actors must look at how home-based support, often as part of case management, is a key intervention for families going through a reintegration process (before and after reunification) and those assessed to be at risk of separation and take up constant quality improvement to those services.

Research

5. CTWWC and other care reform actors should implement learning agendas which engage children, young people, and caregivers in a participatory and meaningful way, ideally as co-producers of learning. These efforts should dig further into areas of family strengthening and

child and caregiver well-being to learn more about the reasons behind the findings from this survey from their perspective.

6. CTWWC should repeat this survey in Year 5 of the initiative to enable the analysis of changes in results over time and to incorporate adjustments to address weaknesses identified in this initial implementation.
7. Future research studies seeking to understand the well-being of children with experience of care should make further use of the child-informed well-being tool to examine how it performs in other contexts.

Introduction

Changing the Way We Care

Changing The Way We Care[SM] (CTWWC), launched in 2018, is an initiative designed to promote safe, nurturing family care for children. This includes reforming national systems of care for children, including family strengthening, family reintegration, preventing unnecessary child-family separation, development of alternative family-based care, and influencing and promoting family strengthening and care with other actors around the globe. CTWWC is implemented by Catholic Relief Services (CRS) and Maestral International, joined, through a Global Development Alliance, by three donors (the MacArthur Foundation, USAID, and the GHR Foundation) and working with key partners such as national governments, Lumos Foundation, Better Care Network, Faith to Action, and many others. CTWWC implements within a context of growing global interest in family care and care reform, and as a result of an increased understanding that residential care of children is a significant problem that will be best addressed through collaboration between national, regional, and global stakeholders to develop care systems that strengthen families, prevent family separation, and promote family-based alternative care options.

In recent years, there has been increased understanding of the harmful impacts of residential care, particularly institutions, such that many countries have adopted laws and policies promoting safe, nurturing, family-based care aligned with global standards and best practices.[4] Global and regional momentum, in part driven by investments by larger donors such as the European Union, USAID, and UNICEF, has helped to build energy for change—care reform—at a national level. Civil society and, increasingly, young people with lived experience have been key partners of care reform at the country, regional, and global levels by piloting and modeling family-strengthening interventions; reintegration and family-based alternative care; developing and promoting standards of practice, guidance and training; and building capacity of governments, communities, and families. It is within this context that CTWWC enters with capacity, resources, and partnerships to demonstrate components of care reform across diverse contexts, building learning, best practices and innovations for global applicability. Demonstration includes verifying a theory of change; implementing effective family strengthening and care system components; related standards, guidance, and tools; monitoring/feedback and adaptation mechanisms; and documented lessons learned around how change happens and can be sustained and scaled across different contexts**.** Two of those contexts are Guatemala and Kenya. Guatemala was selected for demonstration because of the complexity of the government system; the significant, but relatively low number of children in residential care (compared to other countries); poverty and child protection as drivers for separation of children; the context of migration; and the relationship with American supporters of orphanages in Latin America. Kenya, on the other hand, was selected due to the scale of the issue, the strong political will of the government, poverty and access to education as drivers, and the existing CRS programs that could be leveraged. This diversity allows CTWWC to compare and contrast across contexts.

Guatemala

One of the key factors in determining the need to strengthen the system in Guatemala comes from past events, including the tragedy of a fire at a government-run residential care institution in 2017, a motivating factor which resulted in efforts, supported by CTWWC, to bring together care actors to establish a common language and vision about what care reform should look like in Guatemala. CTWWC has worked closely with the four government entities engaged in the care system at the national level: the Secretariat for Social Welfare (SBS), the attorney general, the judicial branch

[4] United Nations. (2009). Guidelines for the Alternative Care of Children. https://bettercarenetwork.org/international-framework/guidelines-on-alternative-care

through specialized courts, and the National Adoption Council. Progress has been noticeable in the legal sphere with the enactment of key pieces of legislation and the internal policies and procedures of these entities. CTWWC has been able to support the progress through inter-institutional working groups in strategic areas of preventing separation through family strengthening, promoting family-based alternative care, and transforming reintegration processes.

CTWWC is directly supporting family reintegration and prevention of family separation within Zacapa, a municipality in the eastern region of Guatemala, through orderly case management processes that involve the investigation of family alternatives, assessment of children and adolescents, development of care plans, and follow-up and accompaniment of families through family and community strengthening until the closure of cases. In the follow-up process, families are supported by identifying their needs and strengths, in all cases, guidance is provided on parenting practices and referral to social services. This includes close coordination with a public residential care facility where CTWWC is working with the SBS, the office of the attorney general of Guatemala, and the courts to reunify children with their families. CTWWC is also working closely with several private residential care facilities in the area and is transferring skills and tools to promote reintegration. Through a newly established Municipal Office for Children and Adolescents, CTWWC Guatemala also works to identify families at risk of separation and refer children and families to appropriate support services. With the judicial branch in Zacapa, CTWWC Guatemala has been able to develop and implement a pathway for children and adolescents who have been in residential care for five or more years to be reunified and reintegrated with families. This process has had a high success rate and is now being replicated by the judicial branch in 10 other departments, starting in Quetzaltenango and the metropolitan area with the vision of escalating it to the national level.

The COVID-19 pandemic has overwhelmed the health system and there continues to be a lack of access to vaccines, especially for the those impacted by poverty. CTWWC has adapted to support families facing greater risks and continued to support work with children in residential care and those reunified with families.

Kenya

In Kenya, the government, with the support of CTWWC, UNICEF, and other actors, has taken bold steps in the last few years to promote and coordinate family-based care for children. The cabinet secretary in charge of children's care led other senior government leaders in endorsing the new National Care Reform Strategy in August 2021, which provides a clear, coordinated framework to guide the implementation of care reform efforts for the next 10 years.

CTWWC works with others to implement care reform demonstrations in four counties, chosen in agreement with the government: Kisumu, Nyamira, and Siyaya counties in the west, and Kilifi County on the coast of the Indian Ocean (work in Siaya started shortly before the household survey was implemented and as such, no families from that county are included in the exercise). In order to ensure that demonstration learning reflects the diversity within the country, these counties represent varied sizes, locations, contexts, and previous investment in children's care. CTWWC has worked in partnership with local government and civil society to support children who returned home from residential care institutions through providing case management capacity building and supporting the monitoring of progress toward sustainable reintegration (most of the children included in this survey who were supported by CTWWC post-reunification returned to family care due to COVID-19 protocols). CTWWC is also investing in family-strengthening interventions to address the drivers of family separation. This includes training in and supporting implementation of case management, positive parenting, disability inclusion, and household economic strengthening. This support is based on needs assessments and aimed at building resilience and the active engagement of caregivers,

children, and other family members in family decision-making. At the time of the survey, around 300 families were being supported by CTWWC in Kenya.

The COVID-19 pandemic disrupted normal operations and led to joint efforts to coordinate care reform activities, especially those linked to the abrupt release of children from residential care at the onset of the pandemic in early 2020. In the three demonstration counties where CTWWC was operating at the time, 1,905 children (over 60% of children in residential care) returned home. In response, the government of Kenya and CTWWC held county-level meetings between officials from the Department of Children's Services and the managers of residential care facilities (both public and private) to gather data on numbers and locations of children and to plan support for those remaining in facilities and those that left. A priority list of highly vulnerable children and families was generated through social enquiry, informed tracing, and family assessment. CTWWC followed up with the development of case plans and provision of services. Cash transfers were provided to vulnerable households to help meet immediate, unanticipated costs of children returning home, and COVID-19-related supply needs were identified for both families and facilities. Referrals and linkages with other service providers were made to support some of the identified cases. The Department of Children's Services and the National Council for Children's Services convened virtually for monthly meetings of state and non-state actors to share progress, plans, challenges, and opportunities.

Measuring well-being

Governments and development organizations have shifted away from making policy solely by relying on one dimensional indicators like household income, recognizing that individuals hold diverse perspectives regarding which facets of life are important to their overall well-being.[5] The field of well-being research has seen two important developments in thinking: (1) human well-being is multifaceted, made up of various aspects and domains, and (2) the salient domains of well-being may differ by context and life circumstances.

Well-being can be objective or subjective. Objective well-being refers to observable indicators of life quality (e.g., yearly income, illness diagnosis), while subjective well-being (sometimes referred to as happiness or life satisfaction) is based on an individual's own perspective on their life.[6] One individual's objective and subjective well-being may not be the same: For example, a person may be "objectively" assessed as having low well-being if they have health problems or live in poverty, but subjectively, state they are satisfied with their life. Similarly, an "objective" metric might determine a child is enjoying well-being if their nutritional and educational needs are being met, even if, when asked, the child reports being unhappy with their living situation.

Conceptualizations of subjective well-being can differ by cultural context. These nuances have led some researchers to use qualitative methods, including focus groups and ranking exercises, to determine what matters to well-being according to different populations. For example, Oxfam Great Britain used participatory, qualitative methods in Scotland to create an index of well-being that could inform policymaking for the country.[7] For children, the Personal Well-Being Index – School Children was developed to measure subjective well-being in seven domains, using items like, "How happy are

[5] McGregor, A., Coulthard, S., & Camfield, L. (2015). *The role of well-being methods in development policy and practice* (No. 4; Development Progress Project Note). ODI. https://www.odi.org/publications/9657-measuring-what-matters-role-well-being-methods-development-policy-and-practice

[6] Diener, E., Oishi, S., & Tay, L. (2018). Advances in subjective well-being research. *Nature Human Behaviour*, *2*(4), 253–260. https://doi.org/10.1038/s41562-018-0307-6

[7] Walker, P., Michaelson, J., & Trebeck, K. (2012). *Oxfam Humankind Index for Scotland—Background* (Oxfam Research Report). Oxfam.

you about the things you have? Like the money you have and the things you own?" and "How happy are you about how safe you feel?"[8]

Vulnerable sub-populations, including children who live in or previously lived in residential care institutions, have unique priorities and needs.[9] Their marginalization makes their perspectives and voices even more important to elevate via participatory methods. In Europe, child welfare researchers have used participatory methods to ascertain what dimensions of well-being matter to children and young people separated from their parents due to child protection concerns, using the results to recommend improvements in national and local child protection policies.[10,11] In England, researchers used qualitative and participatory methods to create a quantitative survey of well-being for children involved in the child protection system.[12,13,14]

Unfortunately, the research team could not find any documentation of such a process being conducted with children from residential care institutions in Latin America or Sub-Saharan Africa. One systematic review of positive adjustment in children in residential care institutions found some studies used subjective well-being as outcome measures, including one developed with adults (the World Health Organization [WHO] Quality of Life, Brief Version), one developed with children in the United Kingdom (the Generic Children's Quality of Life scale), and one developed for children involved in the child protective system in the United Kingdom (the Children's Happiness Scale).[15] No measures of subjective well-being were tailored for children with experience in residential care institutions in Africa or Latin America (in fact, only seven of the 38 studies were done in Africa and four in Latin America).

Family strengthening, prevention, and reintegration

CTWWC's family strengthening approach[16]

Family strengthening refers to programs, strategic approaches, and deliberate processes of empowering families with the necessary capacities, opportunities, networks, relationships, access to services, and resources to promote and build resilience and the active engagement of parents, caregivers, children, youth, and other family members in decisions that affect the family's life.[3]

Family strengthening is important as a strategy to prevent family separation amongst families who are at risk, it is also critical to support families with a child who is reintegrating (after leaving alternative care, for instance) and with families who are providing alternative family-based care. Children do well

[8] Cummins, R. A., & Lau, A. L. D. (2005). *Personal Wellbeing Index – School Children (PWI-SC)*. http://www.acqol.com.au/uploads/pwi-sc/pwi-sc-english.pdf

[9] Senefeld, S., Strasser, S., Campbell, J., & Perrin, P. (2011). Measuring adolescent well-being: The development of a standardized measure for adolescents participating in orphans and vulnerable children programming. *Vulnerable Children and Youth Studies*, *6*(4), 346–359. https://doi.org/10.1080/17450128.2011.635722

[10] Bakketeig, E., Boddy, J., Gundersen, T., Østergaard, J., & Hanrahan, F. (2020). Deconstructing doing well; what can we learn from care experienced young people in England, Denmark and Norway? *Children and Youth Services Review*, *118*, 105333. https://doi.org/10.1016/j.childyouth.2020.105333

[11] Wood, M., & Selwyn, J. (2017). Looked after children and young people's views on what matters to their subjective well-being. *Adoption & Fostering*, *41*(1), 20–34. https://doi.org/10.1177/0308575916686034

[12] Ibid.

[13] Selwyn, J., Wood, M., & Newman, T. (2017). Looked after children and young people in England: Developing measures of subjective well-being. *Child Indicators Research*, *10*(2), 363–380. https://doi.org/10.1007/s12187-016-9375-1

[14] Zhang, M. F., & Selwyn, J. (2020). The subjective well-being of children and young people in out of home care: Psychometric analyses of the "Your Life, Your Care" survey. *Child Indicators Research*, *13*(5), 1549–1572. https://doi.org/10.1007/s12187-019-09658-y

[15] Wright, A. W., Richard, S., Sosnowski, D. W., & Kliewer, W. (2019). Predictors of better functioning among institutionalized youth: A systematic review. *Journal of Child and Family Studies*. https://doi.org/10.1007/s10826-019-01527-0

[16] Based on "Family Strengthening within Changing the Way We Care"

when their families do well, and families do better when they live in supportive neighborhoods and communities.

A family strengthening approach starts from the basis that every child and every family has strengths, which must be recognized whilst still addressing the challenges that children and families face. All decisions and actions should be made on an individual basis.

Evidence suggests that a range of drivers, both push and pull factors, result in children separating from their families and ending up in alternative care. Although poverty, abuse, and neglect are the main reasons for children's entry into alternative care, most families in poverty and most families in which there is abuse and neglect do not separate. It is the presence of **protective factors** that enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences when a family is exposed to risks or shocks. Protective factors are divided into five core areas:[17]

- ***Caregiver resilience:*** Managing stress and functioning well when faced with challenges, adversity, and trauma.
- ***Social and emotional competence of children:*** Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships.
- ***Social support and connections:*** Positive relationships that provide emotional, informational, instrumental, and spiritual support.
- ***Responsive caregiving:*** Understanding child development and parenting strategies that support physical, cognitive, language, social, and emotional development.
- ***Access to concrete support in times of need:*** Access to concrete support and services that address a family's needs and help minimize stress caused by challenges.

Figure 1. Protective factors

CTWWC's support to children and families

Within CTWWC's direct support to children and families in Guatemala and Kenya there are generally two categories: firstly, children and families who are supported to reunify after the child has spent a period of time in residential care (these families may include the parents of the child, but can also include extended family members) and secondly, children and families who are identified as being at risk of separation. CTWWC works with local entities and personnel, both government and civil society, to provide case management and identify necessary family strengthening interventions which may be provided directly or through referrals to other service providers.

[17] Adapted from the Center for Study of Social Policy. About Strengthening Families and The Protective Factors Framework. Accessed at: https://cssp.org/wp-content/uploads/2018/10/Core-Meanings-of-the-SF-Protective-Factors-2015.pdf

In line with global good practice, CTWWC is utilizing case management to ensure that an identified child or family has their needs for care, protection, and support met. The process of case management is the responsibility of an allocated case worker (an employee of CTWWC, a civil society partner, or government agency) who meets with family members, including children, to assess, plan, deliver, or refer for services, and monitors and reviews progress. Case planning is used throughout the process by the case worker in collaboration with the child and family to identify the goals to be reached with support. When case management is supporting the reunification and reintegration of children from residential care into family-based care the process is designed from the beginning as a whole package that begins with assessing a child and their family and works through multiple steps, including preparation and placement, towards monitoring, follow-up, and eventually, case closure. As CTWWC's prevention of separation work increases, some families have been found to need supported referrals to services and one-off types of support, thus not all families identified as having risk for separation are enrolled in case management.

In addition to family strengthening, interventions have so far included the following:

In Guatemala:

Cash transfers: Economic support modality consisting of a food exchange card for use in supermarkets with a value based on the needs of the families.

Food packages: A selection of foodstuff gifted to a family whose contents have been reviewed by a nutrition professional.

Positive parenting training: Guidance on positive parenting practices and skills delivered during home visits**.**

Referrals: Referrals by the family case worker to social or specialized services such as health, nutritional health, disability support, education, parenting schools, psychology professionals, social workers, etc.

In Kenya:

Cash transfers: Emergency economic support consisting of cash payments for up to six months until a viable income-generating activity is established or the family can cover their own needs.

Food packages: A selection of foodstuff gifted to a family whose contents have been reviewed by a nutrition professional.

Positive parenting training: Guidance on positive parenting practices and skills delivered during home visits by a case worker or through a group setting.

Referrals: Referrals by the family case worker based on assessments and case plans to social services, health care providers, disability support, education, community support, etc.

Kitchen garden training: Working with the Kenyan Ministry of Agriculture, Livestock, Fisheries, caregivers are trained and supported to establish kitchen gardens for nutrition.

Savings and loans groups (SILC): These groups mobilize caregivers to save and obtain loans within their own groups for child welfare support.

Aims of the household survey

A key part of the CTWWC theory of change is the flow of learning from the demonstration work out to the wider country, region, and international community. CTWWC is committed to building evidence in key areas related to care reform, including around outcomes for children and families, which is currently lacking in relation to reintegration, transitions to alternative family-based care, and

prevention of separation, especially in low resource settings.[18] In the design of CTWWC's monitoring and evaluation plan, a focus was placed on tracking outcomes at the child and family level through routine monitoring and periodic evaluation. CTWWC's Year 3 Review has been an opportunity for in-depth data collection, analysis, and reflection.

The overall goal of the household survey, as part of CTWWC's Year 3 Review, is to provide practitioners, service providers, and policy makers with insights into understanding the situation of children and families, whether reintegrating after residential care or receiving support to prevent separation, and the perceived difference interventions are making to their lives. Generating this information is also an important opportunity to hear from children, young people, and caregivers directly to better understand their experiences and ensure their voices are influencing the direction of care reform and family strengthening programming so that it reflects their needs and desires.

To this end, the household survey aimed to address the following research questions:

- What aspects of family strengthening support do caregivers think have affected (negatively and positively) their ability to care and provide for their children?
- What proportion of children and caregivers report selected protective factors (see Figure 1) in their life?
- What proportion of children at risk of separation from their families, and children and young people who have been reunified or placed in family-based care or in independent living, are experiencing positive well-being?
    - How might caregiver protective factors correlate with child well-being?
    - How has the perceived well-being of children changed after their engagement with CTWWC?

[18] Goldman. P.S., Bakermans-Kranenburg, M.J., Bradford, B., Christopoulos, A. et al. (2020) Institutionalisation and deinstitutionalisation of children 2: Policy and practice recommendations for global, national, and local actors. The Lancet Child & Adolescent Health. 4:8. 606-633

Method

Designing well-being measures with children

Given the limited prior work on engaging children with experience of living in residential care to design quantitative measures of child well-being in the regions in which CTWWC is working, the first step in the research design process was to consult children and young people about what the household survey should include in terms of children's well-being. Two focus groups were held in Guatemala and 12 in Kenya with children and young adults who have lived in residential care. In both countries, participants included young people aged 11–17 who were reunified with family after living in residential care and receiving support from CTWWC. In Kenya, in addition, participants included young adults aged 18–29 who had lived in residential care more than two years prior, before CTWWC began its operations. The participants were asked about their experiences in and after residential care, and what it looks like to "have a good life" or "do well" while in residential care and after family reunification. The results from these group discussions indicated that some domains of well-being were important for both the Guatemalan young people and the Kenyan young people, for example, receiving love and care from one's parents, spending time with family, and having one's basic needs met. Others were more important in one country than another, such as the emphasis in Kenya on having school fees paid for. Since the objective of this process was to create a tool general and flexible enough for use across countries, while being specific to the experiences of children who have lived in residential care, the findings from both countries were used to inform a 44-item measure of subjective well-being for use in the survey in both countries. The measure went through a member checking and cognitive testing process to ensure it was reflective of the focus group discussions and was easily understood by children in both countries. Further details about this process can be read in the report *Child- and Adolescent-Defined Well-being: Designing a Household Survey with Children and Young People* (September 2021).

This measure of subjective well-being was combined with validated tools looking at other aspects of well-being, protective factors, and parenting, as described below.

Measures

The surveys were nearly identical in Kenya and Guatemala except for language. Previously validated translations of existing instruments were utilized when available, and the country and enumeration teams also revised these translations as they saw appropriate. In Guatemala, surveys were administered in Spanish. In Kenya, enumeration teams translated key terms into Kisii, Luo, and Kiswahili, which were displayed on the survey to aid enumerators in spot-translating from English to the most appropriate language for each family.

Some survey questions were not from validated measures, but were adapted from various sources or developed specially for this exercise. Details about these questions, as well as the full survey instrument, are included in the appendix.

Validated measures are described in the sections below.

Measures about caregivers

Washington Group Short Set on Functioning

Caregiver respondents completed the Washington Group Short Set on Functioning (WG-SS) about their functional difficulties.[19] A respondent was considered as having a disability if they had "a lot of

[19] https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/

difficulty" with or "could not [function] at all" in one or more domains of functioning (the threshold the Washington Group calls "Disability 3"). The survey asked about the following domains: vision, hearing, mobility, cognition/remembering, self-care, and communication.

This tool was designed to be used cross-culturally, including in Sub-Saharan Africa and Latin America, and its development was commissioned by the United Nations Statistical Commission.

Parents' Assessment of Protective Factors

Caregiver respondents also completed the Center for the Study of Social Policy's Parents' Assessment of Protective Factors (PAPF) instrument. This measure was selected for its close correspondence with the family strengthening framework guiding CTWWC's work.

The PAPF assesses "presence, strength, and growth of parents' self-reported beliefs, feelings, and behaviors" that build a caregiver's protective factors that mitigate risks and promote well-being.[20] This tool included the constructs parental resilience (α=.82 in Kenya, α=.90 in Guatemala), social connections (α=.75 in Kenya, α=.86 in Guatemala), concrete assistance in times of need (α=.81 in Kenya, α=.85 in Guatemala), and social and emotional competency of children (α=.83 in Kenya, α=.93 in Guatemala).[21]

Each construct was measured by the mean agreement scores for nine statements to which respondents rated their agreement on a scale of 0 ("not at all like me") to 4 ("very much like me"). In addition, an overall score called the Protective Factors Index (PFI) was calculated as the respondent's mean score of all 36 statements (α=.92 in Kenya, α=.96 in Guatemala). Thus, scores could range from 0 to 4, where 4 represented higher levels of protective factors.

To our knowledge, this instrument has not been used outside of the United States before this study. The Center for the Study of Social Policy published both the English and Spanish versions of the tool.

Alabama Parenting Questionnaire

To measure parenting practices, caregiver respondents completed the Alabama Parenting Questionnaire (APQ) subscales on parental involvement, positive parenting, and corporal punishment.[22] These subscales were selected due to the CTWWC parenting trainings' emphases on positive parenting, positive discipline, and involvement in children's lives.

Caregiver respondents were presented with practices/activities and asked to rate how often they did them with any of their children, on a scale from 0 (never) to 4 (always). The parental involvement subscale consisted of six statements (α=.66 in Kenya, α=.68 in Guatemala), and the positive parenting subscale also consisted of six statements (α=.74 in Kenya, α=.44, in Guatemala). These scores were calculated as sums, such that the minimum possible score was 0 and the maximum 24, with higher scores representing higher levels of positive parenting and involvement. Parental involvement questions were only asked if the caregiver had a child between the ages of 5–17.

Three questions were about the use of corporal punishment. These were not summed into a scale, but were analyzed as separate items. Scores on each of these three questions could range from 0 to 4, with higher scores indicating more use of corporal punishment.

[20] https://cssp.org/resource/papf-user-guide/

[21] These alpha scores show a high level of reliability for each sub-score and for the overall measure. An alpha score of 0.7 or above is considered as indicating good reliability. This means that the different items within the same sub-scale produced similar results.

[22] http://labs.uno.edu/developmental-psychopathology/APQ.html

The APQ has been used in many low-resource contexts.[23]

Measures about households

Household Hunger Scale

The Household Hunger Scale (HHS) was included alongside other questions on household economic stability.[24] Caregiver respondents were asked if over the past four weeks their household ever lacked food entirely, if anyone in their household went to sleep hungry, or if anyone in their household ever went a whole day and night without eating. Each question was scored as 0 for no, 1 for rarely or sometimes, and 2 for often. The three questions were summed into a score in which 0–1 represented little or no household hunger, 2–3 represented moderate hunger, and 4–6 severe hunger.

Measures about children

Washington Group/UNICEF Child Functioning Module

Caregiver respondents completed the Washington Group/UNICEF Child Functioning Module (CFM) about each child.[25] The CFM assesses functional difficulty in various domains: hearing, vision, communication/comprehension, learning, mobility, and emotions. Questions differed for children aged 2–4 and children older than 5. A child was considered as having a disability if they had a "a lot of difficulty" or "could not [function] at all" in one or more domain.

Like the WG-SS, the CFM is used worldwide, including in the UNICEF Multiple Indicator Cluster Surveys.

Contextualized child well-being tool

As described above, we developed a set of survey questions specially designed for children age 11 and above who had lived in residential care.

Respondents were presented with 44 statements and indicated whether each statement applied to them all the time (2), some of the time (1), or none of the time (0). Items were averaged into a mean well-being score (α=.91 in Kenya, α=.90 in Guatemala) after reverse coding, if necessary. Thus, scores could range from 0 to 2, with higher scores representing greater well-being.

Overall Life Satisfaction

Child respondents were asked to rate how happy or satisfied they were with their life overall (i.e., their overall life satisfaction [OLS]) on a scale of 0 to 10, where 0 represented not at all satisfied and 10 completely satisfied.[26] A visual aid was provided to help respondents understand the scale. If the child had lived in residential care, the child was also asked to think about when they lived in residential care and rate how happy they were with their life at that time.

Family and community acceptance

Child respondents who had lived in residential care also completed a family and community acceptance scale, which was selected due to prior literature suggesting some children reunified from residential care can struggle with integration, stigma, and belonging.[27]

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[23] E.g.: Puffer et al. (2016). http://doi.org/10.1037/ccp0000076; Cluver et al. (2016). http://doi.org/10.1186/s12889-016-3262-z

[24] https://www.fantaproject.org/monitoring-and-evaluation/household-hunger-scale-hhs

[25] https://data.unicef.org/resources/module-child-functioning/

[26] Originally from Campbell (1976), *The Quality of American Life: Perceptions, Evaluations, and Satisfactions.* Widely used in the Personal Well-being Index – School Children (http://www.acqol.com.au/uploads/pwi-sc/pwi-sc-english.pdf).

[27] Roche, S. (2019). A scoping review of children's experiences of residential care settings in the global South. *Children and Youth Services Review*, *105*, 104448. https://doi.org/10.1016/j.childyouth.2019.104448

The scale was comprised of six items about family acceptance (α=.87 in Kenya, α=.91 in Guatemala), and six items about community acceptance (α=.86 in Kenya, α=.75 in Guatemala).[28] Respondents rated how true each statement was for them on a scale from 0 (not true) to 2 (very true). The means of these items were calculated to form a family acceptance score and a community acceptance score. Thus, scores could range from 0 to 2, with higher scores representing greater acceptance.

This scale was developed in Sierra Leone for use with children who had previously been recruited into armed forces.

Sample and participants

The household survey aimed to collect data about every child and family receiving support from CTWWC in Guatemala and Kenya (including families with reunified children and those receiving support after being identified as at risk of family-child separation). A family was considered eligible if they had begun receiving services from CTWWC before June 1, 2021. There were 61 eligible households in Guatemala and 295 in Kenya (see response rates below).

An index child was selected in Kenyan households that were receiving services to prevent family-child separation. In these households, case management is used for the family as a whole—the whole family has been determined to be at risk, rather than one or two specific children having been assessed to be at risk (there were no households in this category in Guatemala). In these cases, one child in the household between 2–17 years of age was randomly selected using a random number generator.

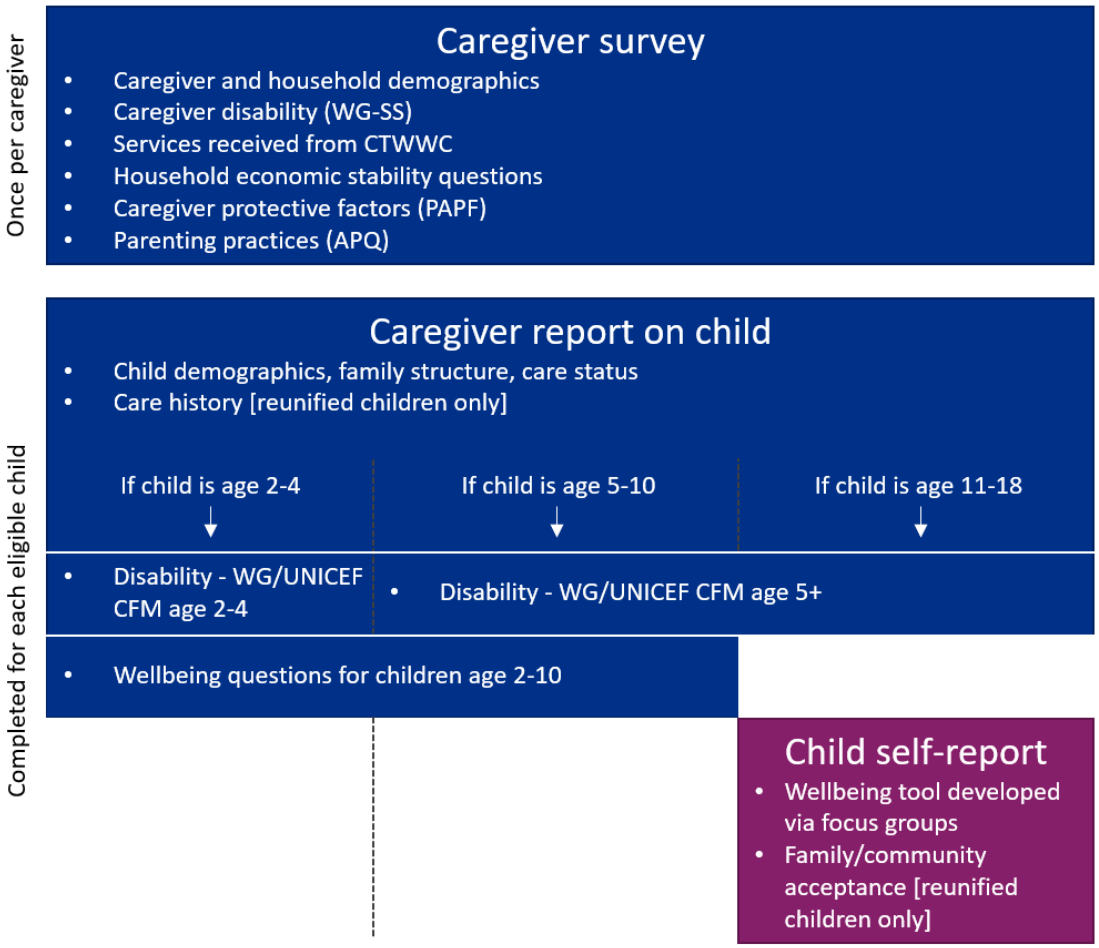
The primary caregiver within each family completed a survey about himself or herself and the household (*caregiver survey*). Primary caregivers were identified as the individuals already listed as such in CTWWC's case management and monitoring systems.

They also completed a survey about each child in their care who was receiving individualized case management support or about an index child (*caregiver report on the child*) (see Measures section for further details). It was possible for one household to have more than one child receiving individualized case management; in these cases, the caregiver completed reports for each child.

Where a child was aged 11 or older, the child was also invited to complete a survey (*child self-report*).

[28] Betancourt, T. S., Thomson, D. L., Brennan, R. T., Antonaccio, C. M., Gilman, S. E., & VanderWeele, T. J. (2020). Stigma and Acceptance of Sierra Leone's Child Soldiers: A Prospective Longitudinal Study of Adult Mental Health and Social Functioning. *Journal of the American Academy of Child & Adolescent Psychiatry*, *59*(6), 715–726. https://doi.org/10.1016/j.jaac.2019.05.026

Figure 2. Overview of survey structure



To promote trust and legitimize the survey activity, case managers first contacted households about this survey and sensitized each caregiver about the household survey via phone. Enumerators then called to formally invite them to the study and schedule interviews.

Some children were included in the CTWWC roster even though they were over the age of 17. We did not collect data about "children" aged 19 and above, but if the "child" was 18, they were retained in the sample, as they were likely enrolled for support while they were still under 18 years of age.

Response rates – Kenya

A total of 295 households were eligible to be surveyed in Kenya, and 89% (N=263) of these had the primary caregiver take a survey (see Table 1). The reasons caregivers were unable to be surveyed were: relocation to outside the county (15 caregivers), unable to be contacted (4), illness/disability (5), and other (8).

There were 257 children aged 11 and above eligible to be surveyed, and 55% (N=142) of these completed a survey. Multiple reasons existed as to why these response rates were lower compared to caregivers. Children aged 11 and over were unable to be surveyed due to being away at a boarding school (76), relocation or no longer living with the caregiver (12), returned to residential care without the knowledge of the case worker (6), found to not meet eligibility requirements upon visiting the

household or other data error (6), having run away/not being traceable (5), disability/illness (5), got married (2), and could not be reached due to being in day school (2).

Response rates – Guatemala

In Guatemala, 61 households met the inclusion criteria to be surveyed (an additional four households were not eligible to be included because they had already taken portions of the survey as part of the cognitive interviewing phase). Two primary caregivers declined to participate, so 59 households ultimately had a caregiver complete a survey (97%).

There were 57 children aged 11 and over who were eligible to complete a child survey (nine were not eligible to participate because they had participated in the cognitive interview). Of these, 50 children completed a survey (88%). Three children could not participate, and four children no longer lived in the household at the time of the survey.

Table 1. Survey response rates

	Caregivers			Children age 11+		
	Completed survey	***Total attempted***	***Response rate***	***Completed survey***	***Total attempted***	***Response rate***
Kenya total	263	295	89%	142	257	55%
Kilifi	111	114	97%	58	122	48%
Kisumu	117	142	82%	71	104	68%
Nyamira	35	39	90%	13	31	42%
Guatemala total	59	61	97%	50	57	88%

Ethics

The research protocols were approved by the Boston College Institutional Review Board in the United States and the Maseno University Ethical Review Committee in Kenya.[29] The study also received a research permit from the Kenyan National Commission for Science, Technology, and Innovation. At each household at the time of data collection, enumerators obtained verbal informed consent from caregivers, consent from caregivers for their children to participate, and consent from children.

CTWWC safeguarding leads directed the development of a detailed safeguarding protocol and decision-making flow charts. The protocols specified what actions facilitators were to take in cases of risk of harm, disclosures of maltreatment, observed child injuries, or participants becoming distressed. Enumerators were directed to report safeguarding concerns, depending on severity, to CTWWC supervisors, case managers, and/or local authorities.

The survey was programmed in CommCare such that if caregivers or children gave any answers that indicated a possible risk of harm, the enumerator received an alert that they must escalate the concern.

Due to the COVID-19 pandemic, the core research team did not travel internationally to supervise the study. All planning and development occurred via teleconference, with extensive use of the expertise and firsthand knowledge of the CTWWC country teams in order to contextualize the study protocols

[29] Laws governing research in Kenya specify that all studies conducted by international researchers must receive ethical approval from a Kenyan research ethics committee as well as one from the researchers' home country. Guatemala, however, does not have laws that required this study to undergo ethical review within Guatemala. Instead, individuals from CTWWC Guatemala reviewed the protocol for cultural appropriateness prior to submission to the U.S. review board.

and handle logistics. The Boston College Institutional Review Board and CTWWC security personnel approved the in-person enumeration activities, and guidance was provided on public health measures to be followed, including following all government mandates.

Analysis

Survey results were analyzed separately for Guatemala and for Kenya.

First, all univariate (descriptive) statistics were reported for each sample. That is, totals were reported for each country.

Second, bivariate statistics we run (i.e., we examined how two variables could be related to one another). There were two types of bivariate statistics: independent samples t-tests, which examined differences in the means of two groups, and Pearson's correlations, which examine how two continuous (numerical) variables could change with one another.

For caregiver data, independent samples t-tests were run to examine how caregivers' PAPF, APQ, and various household economic stability outcomes differed by caregiver gender, disability status, urban/rural status, widow status, and whether the household had any reintegrated children. We also examined Pearson's correlations between caregivers' PAPF, APQ, and household economic stability scores and caregiver age, number of adults per household, number of children per household, and caregiver education level. For the one binary outcome variable, whether caregivers had saved any money in the past month, cross-tabs and chi-squared tests were used to examine relationships with caregiver gender, disability status, urban/rural status, widow status, and whether the household had any reintegrated children; t-tests were run to examine their relationships with caregiver age, number of adults per household, number of children per household, and caregiver education level.

For child data, independent samples t-tests were run to examine how children's various well-being outcomes differed by gender, disability status, reintegrated vs. at-risk children, parental care status (children living with neither biological parent vs. children living with one or both parents), orphanhood status (single/double orphans vs. non-orphans), and whether or not children lived with any adult who was not their relative. Pearson's correlations between children's well-being scores and child age, age at reunification, age at entrance to residential care, and number of years spent in residential care were also examined.

Finally, to explore the third research question, Pearson's correlations were run to examine whether various children's well-being scores were correlated with various caregiver protective factors scores.

These bivariate relationships were reported in the text if they were statistically significant at the $p<.05$ level. Full statistical information for each analysis can be found in the appendix.

Initial results were reflected on by CTWWC staff and partner teams in each country during one-day workshops (one in Guatemala and two in Kenya). The aims of the workshops were to provide feedback on the results to those involved in the survey and in providing support to families to gain their insights and understanding of findings, especially the meaning within each specific context. The participants also provided suggestions for further statistical analysis that might be useful within their context.

Limitations

Though this study has many strengths, it also has several important limitations.

First, as there was no comparison group in the sampling strategy, conclusions can only be made about families in CTWWC programs and cannot be generalized to include children in residential care in entire

countries. Since children were not randomly selected to receive services from CTWWC, causality cannot be attributed to any differences between at-risk children and reunified children. In other words, we cannot say that living in residential care caused certain outcomes amongst reunified children.

Because multiple children from one household could be in the sample, when looking at caregiver and household variables' relations to child data, those with multiple children were slightly over-weighted. However, there were relatively few children from the same household, so this limitation is not a large threat to the validity of the findings.

In both Kenya and Guatemala, caregivers may not have accurately reported their receipt of CTWWC family strengthening interventions. For example, they may not have remembered that they received home visits from CTWWC, or they may not have recognized them as coming from CTWWC.

Social desirability bias also likely affected responses on several measures, especially parenting practices, corporal punishment, and the helpfulness of CTWWC interventions. It is important that future research triangulates parent report of use of corporal punishment with child reports.

It is also important to note that most families depend on the informal economy and interviewing them, with or without notice, can cause them to stop earning money, which can have repercussions on the family economy.

All trainings for individuals involved in data collection were conducted virtually. Poor connectivity and time differences sometimes made the trainings logistically difficult. In-person trainings may have been more effective and resulted in higher-quality data.

In Kenya, it was necessary to collect the survey data during a time of year when many children were away in boarding school. The fact that we could only survey approximately half of the children aged 11 and above is an important limitation to note because it is possible that children at boarding schools (who we could not survey) systematically differ from those who live at home (who participated in the survey). In addition, stakeholders in Kenya, in particular Kisumu and Kilifi, reported that it was difficult to convey some terms in languages understood by the participants.

In Guatemala, the survey's small sample size limited the power to detect differences between groups or correlations between variables. Stakeholders also reported that calling the survey an "evaluation" caused respondents to feel social workers' and parents' performance was being evaluated, thus affecting their responses. Parents may have feared that if they answered honestly, their family could be separated. This was exacerbated by the survey enumerators' scant information on the context of the families they interviewed. Also, in Guatemala, some families had not received follow up visits for several months. These were mainly emergency cases referred by SBS to CTWWC. For these cases, CTWWC only undertook the family assessment and case plan preparation. Follow-up was provided by SBS. Many of these cases were not followed as closely as the cases supported by CTWWC in the demonstration area and often went unvisited for a long time due to lack of resources or high workloads. It was decided that conducting the survey with these families was inappropriate.

Results: Kenya

Participant characteristics

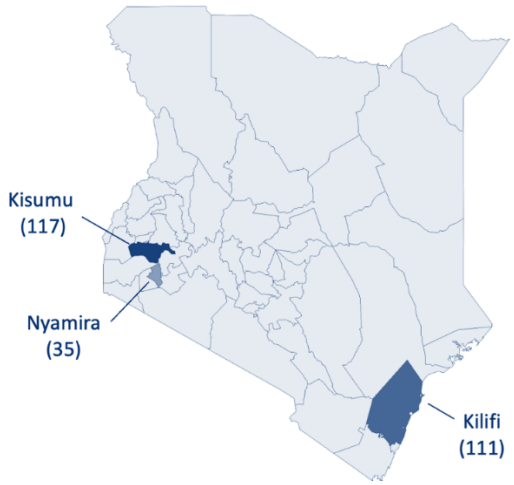
Regions

The breakdown of participants in Kenya by county and sub-county can be found in Table 2 below.

Table 2. Number of participating households per county and sub-county, Kenya

COUNTY AND SUB-COUNTY	*N*	*% OF COUNTY*	*% OF TOTAL*
Kilifi			
Malindi	43	38.7%	
Kilifi North	32	28.8%	
Kilifi South	22	19.8%	
Magarini	12	10.8%	
Ganze	2	1.8%	
Kisumu			
Kisumu Central	38	32.5%	
Nyakach	23	19.7%	
Kisumu East	20	17.1%	
Kisumu West	14	12.0%	
Nyando	8	6.8%	
Seme	8	6.8%	
Muhoroni	6	5.1%	
Nyamira			
Nyamira South	16	45.7%	
Nyamira North	14	40.0%	
Masaba North	4	11.4%	
Manga	1	2.7%	
Total	**263**		**100%**

Figure 3. Map of county locations and number of participating households, Kenya



Household characteristics

In Kenya overall, 71% of the 263 households were rural while the rest were urban. This varied among the three counties, with 100% of households in Nyamira county being rural (Table 3). Overall, 16.4% of households were receiving only prevention services, while the rest had a reunified child. Kisumu county had a much higher rate of prevention households at 25%, compared to around 9% in Kilifi and Nyamira.

The mean number of children per household in Kenya was 3.7 (SD: 2.0, min: 1, max: 11) (Figure 4), and the mean number of adults was 2.7 (SD: 1.8, min: 1, max: 12) (Figure 5). There was little variation between the counties. As shown in Figure 5, 29.7% of households had two adults, closely followed by those with one adult (26.6%).

Figure 4. No. of children per household, Kenya

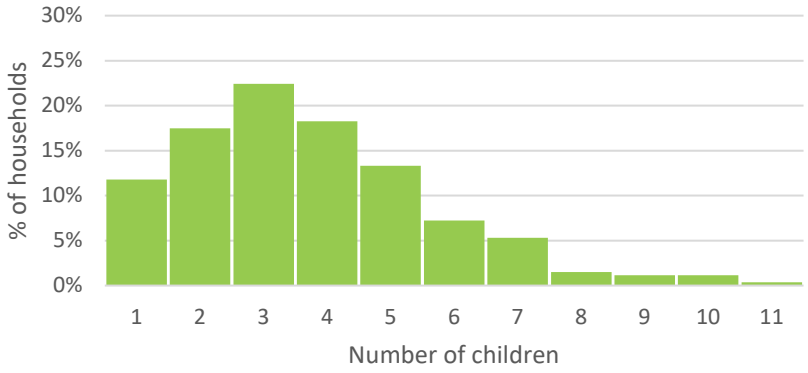


Figure 5. No. of adults per household, Kenya

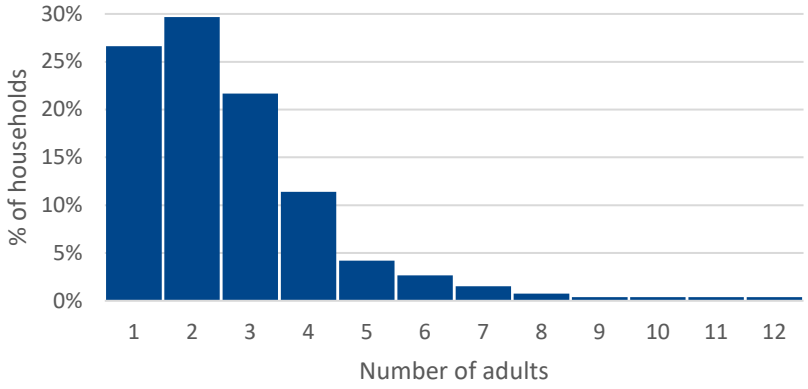


Table 3. Household characteristics, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
Urban/rural status								
Urban	76	28.9%	48	41.0%	0	0%	28	25.2%
Rural	187	71.1%	69	59.0%	35	100%	83	74.8%
Household type								
Reunification	216	82.1%	83	70.9%	32	91.4%	101	91.0%
Alternative care	4	1.5%	0	0%	0	0%	0	0%
Prevention only	43	16.4%	30	25.4%	3	8.6%	10	9.0%
	MEAN	***SD***	***MEAN***	***SD***	***MEAN***	***SD***	***MEAN***	***SD***
No. of children per household	3.7	2.0	3.4	1.8	3.8	1.7	4.0	2.2
No. of adults per household	2.7	1.8	2.4	1.4	2.6	1.6	2.9	2.1

Caregiver demographics

A majority (82.5%) of the 263 caregiver respondents were female (Table 4). The mean age of the caregiver respondent was 44.7 years (SD: 13.1, min: 17, max: 80) (Figure 6).

According to the WG-SS, 18.3% of primary caregivers had a disability (Table 4). In Kisumu County, one quarter of caregivers had a disability, compared to around 12% in Kilifi and Nyamira. Individuals could have difficulties in more than one domain; the most common across Kenya was difficulties with mobility (24 caregivers), followed by vision (18), cognition (12), hearing (8), self-care (4), and finally communication (3).

About 80% of caregivers had not completed a level of education higher than primary school (Table 5). Notably, in Kilifi County, 58% had not completed their primary education.

It was most common for the primary caregiver to be widowed (43.7%) (Table 6). About a third (34%) of widows were the only adult in their household compared to 21% of non-widows who were the only adult in their household.

Figure 6. Caregiver age, Kenya (n=263)

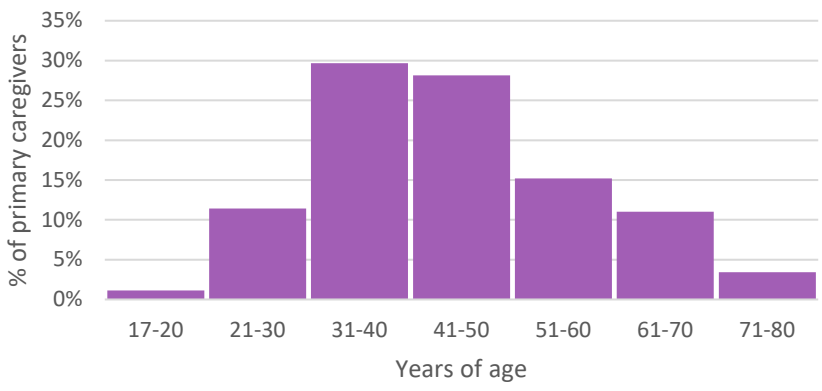


Table 4. Primary caregiver demographics, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Caregiver sex								
Female	217	82.5%	107	91.5%	22	62.9%	88	79.3%
Male	46	17.5%	10	8.6%	13	37.1%	23	20.7%
Disability status								
Disability	48	18.3%	30	25.6%	4	11.4%	14	12.6%
No disability	215	81.7%	87	74.4%	31	88.6%	97	87.4%
	MEAN	*SD*	*MEAN*	*SD*	*MEAN*	*SD*	*MEAN*	*SD*
Caregiver age (years)	44.7	13.1	44.5	13.2	48.9	13.5	43.5	12.7

Table 5. Primary caregiver education level, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Less than primary	82	31.5%	13	11.1%	6	17.1%	63	58.3%
Primary	130	50.0%	82	70.1%	18	51.4%	30	27.8%
Secondary	37	14.2%	16	13.7%	11	31.4%	10	9.3%
Higher than secondary	11	4.2%	6	5.1%	0	0%	5	4.6%
Total	**260**	**100%**	**117**	**100%**	**35**	**100%**	**108**	**100%**

Table 6. Primary caregiver marital status, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Married/living together as if married	97	36.9%	34	29.1%	19	54.3%	44	39.6%
Single/never married	14	5.3%	5	4.3%	0	0%	9	8.1%
Widowed	115	43.7%	63	53.9%	16	45.7%	36	32.4%
Divorced/separated	37	14.1%	15	12.8%	0	0%	22	19.8%
Total	**263**	**100%**	**117**	**100%**	**35**	**100%**	**111**	**100%**

Child demographics

The survey collected information about all of the 318 children (aged birth to 18) identified by CTWWC as receiving case management with support from CTWWC. This information was provided by the primary caregiver.

In Kenya, 270 children (84.9%) were reintegrating from residential care, six children (1.9%) were considered to be in alternative care placements, and 42 children (13.2%) were in families receiving services for prevention of separation (Table 7). As mentioned above, there was a higher proportion of families receiving prevention services in Kisumu County and therefore a higher proportion of children.

About half (47.5%) of these children were female (Table 7). The mean age of children was 13.1 years (SD: 3.6, min: 1, max: 18) (Figure 7).

According to their caregivers' answers on the WG/UNICEF CFM, about 15.0% of children in Kenya were disabled (Table 7). No children between the ages of 0 and 6 had a disability. Children could have difficulties in more than one domain; the most common difficulty was in making friends (13 children), followed by anxiety (9), and then seeing (8) and remembering (8), learning (7), depression (7), behavior (7), concentrating (6), accepting change (5), walking (4), communication (4), self-care (3), and hearing (2).

Figure 7. Child age, Kenya (n=318 children)

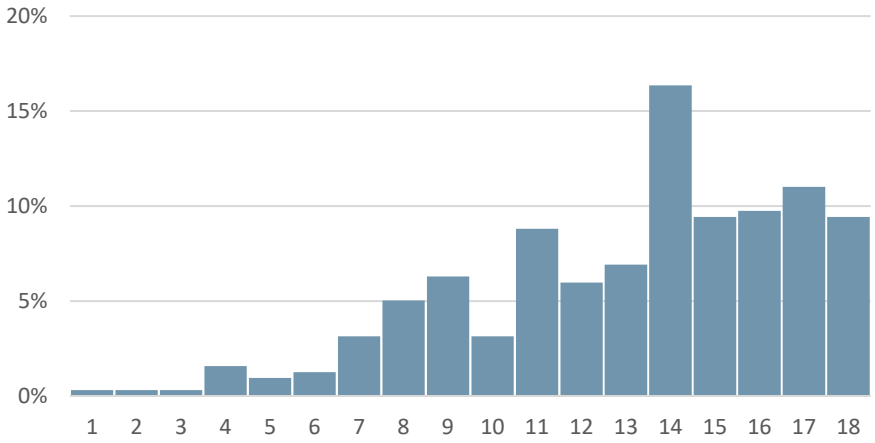


Table 7. Child demographics, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
Case type								
Reintegration	270	84.9%	94	71.8%	37	92.5%	139	94.6%
Alternative care	6	1.9%	6	4.6%	0	0%	0	0%
At-risk	42	13.2%	31	23.7%	3	7.5%	8	5.4%
Sex								
Male	167	52.5%	77	58.8%	24	60.0%	66	44.9%
Female	151	47.5%	54	41.2%	16	40.0%	81	55.1%
Disability status[30]								
Disability	45	14.9%	26	20.2%	1	2.5%	18	12.9%
No disability	258	85.2%	103	79.8%	33	82.5%	122	87.1%
	MEAN	***SD***	***MEAN***	***SD***	***MEAN***	***SD***	***MEAN***	***SD***
Age	13.1	3.6	13.4	3.3	11.7	2.6	13.3	4.1

Child's relationship to household

The primary caregiver (who was responding to the survey) was most frequently the child's biological mother (Table 8). Only 8.8% of the children were living with both of their biological parents and almost half (42.3%) of children were not living with either of their parents (Figure 8).

[30] For most questions, it was possible for the respondent to refuse to answer the question or respond with "do not know." These missing data points were relatively few, but could affect the totals and denominators of the data presented.

Out of the children without a disability, 40 (15.5%) had a primary caregiver with a disability. On the other hand, 33.3% of children with disabilities had a primary caregiver with a disability. Parental care status (i.e., whether they lived with one or both biological parents or with someone else) and a child's relationship to their primary caregiver did not vary between the children with and without disabilities.

While it was common for children to live with at least one biological sibling (67.6% of children), many also lived with other children (Table 10). Across Kenya, 24.5% of the children lived with a cousin, and 9.7% lived with a child related to them in a way besides cousin or sibling. In addition, 53 children (16.7%) were living with an adult who was not related to them by blood. These often included a step-parent or caregiver's romantic partner—true of 8.2% of children.

It was common in Kenya for children to have lost a parent; 70.8% were either a single or double orphan (Table 11). Reunified children were more likely to be orphaned than at-risk children (Table 12). However, not all of the children's orphanhood status was known, because in some cases the respondent did not know whether or not a child's parents were alive. In Kenya, 27 children's fathers' statuses were unknown and seven children's mothers' statuses were unknown.

If a child's parent was alive, but they did not live with them, the caregiver was asked about the child's frequency of contact with the parent. Out of the 75 not living with a living father, 68.0% never contacted him, while only 6.7% were in contact every day or nearly every day (Table 13). Out of the 44 children not living with a mother who was alive, 40.9% of them were never in contact while 13.6% were in contact almost every day or every day (Table 14).

Table 8. Relationship between child and their primary caregiver, Kenya

	KENYA		**KISUMU**		**NYAMIRA**		**KILIFI**	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
Biological mother	156	49.1%	80	61.1%	13	32.5%	63	42.9%
Biological father	20	6.3%	3	2.3%	4	10.0%	13	8.8%
Grandparent	53	16.7%	22	16.8%	13	32.5%	18	12.2%
Aunt/Uncle	47	14.8%	8	6.1%	5	12.5%	34	23.1%
Sibling	16	5.0%	3	2.3%	1	2.5%	12	8.2%
Other relative	9	2.8%	5	3.8%	1	2.5%	3	2.0%
Stepparent/romantic partner of biological parent	6	1.9%	4	3.1%	0	0%	2	1.4%
Non-relative foster parent	7	2.2%	5	3.8%	1	2.5%	1	1.0%
Other non-relative	4	1.3%	1	0.8%	2	5.0%	1	1.0%
Total	**318**	**100%**	**131**	**100%**	**40**	**100%**	**147**	**100%**

Figure 8. Child's parental care status, Kenya

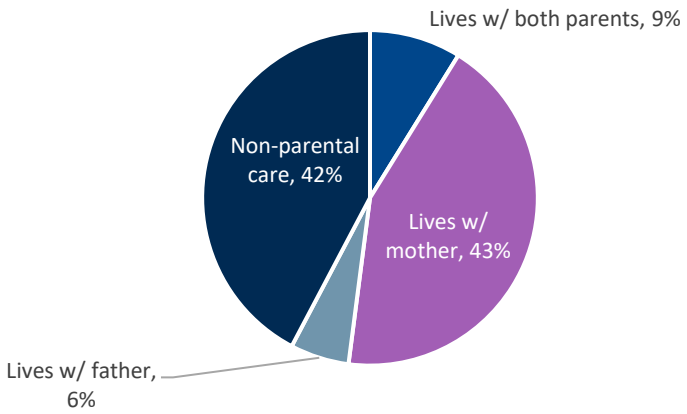


Table 9. Child's parental care status, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Parental care (living with both parents)	28	8.8%	14	10.7%	3	7.7%	11	7.5%
Maternal care (living with mother)	137	43.2%	70	53.4%	11	28.2%	56	38.1%
Paternal care (living with father)	18	5.7%	4	3.1%	3	7.7%	11	7.5%
Not living with either parent	134	42.3%	43	32.8%	22	56.4%	69	46.9%
Total	**317**	**100%**	**131**	**100%**	**39**	**100%**	**147**	**100%**

Table 10. Frequency of living with different types of individuals in their household, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Children								
Biological sibling (same parents)	215	67.6%	84	64.1%	26	65%	105	71.4%
Half-sibling (one parent the same)	33	10.4%	14	10.7%	2	5%	17	11.6%
Cousin (children of a relative)	78	24.5%	31	23.7%	16	40%	31	21.1%
Other relative child	31	9.7%	10	7.6%	7	17.5%	14	9.5%
Unrelated children	11	3.5%	5	3.8%	2	5%	4	2.7%
Adults								
Non-relative adults (any type)	53	16.7%	24	18.3%	7	17.5%	22	15.0%
Their caregiver's romantic partner (non-relative)	26	8.2%	10	7.6%	7	17.5%	9	6.1%
Denominator	**318**		**131**		**40**		**147**	

Note: Children could live with more than one type of individual.

Figure 9. Child's orphanhood status, if it was known whether or not parents were living, Kenya

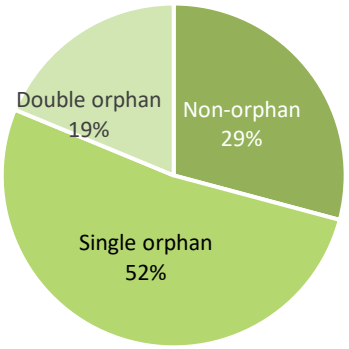


Table 11. Child's orphanhood status, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Non-orphan (both parents alive)	84	26.4%	40	30.5%	4	10.0%	40	27.2%
Paternal orphan (father deceased)	114	35.9%	56	42.8%	11	27.5%	47	32.0%
Maternal orphan (mother deceased)	36	11.3%	10	7.6%	6	15.0%	20	13.6%
Double orphan (both parents deceased)	54	17.0%	15	11.5%	10	25.0%	29	19.7%
Unknown	30	9.4%	10	7.6%	9	22.5%	11	7.5%
Total	**318**	**100%**	**131**	**100%**	**40**	**100%**	**147**	**100%**

Table 12. Child's orphanhood status, disaggregated by at-risk and reunified children, Kenya

	AT-RISK		REUNIFIED	
	N	*%*	*N*	*%*
Non-orphan (both parents alive)	18	41.9%	66	24.0%
Paternal orphan (father deceased)	16	37.2%	98	35.6%
Maternal orphan (mother deceased)	0	0%	36	13.1%
Double orphan (both parents deceased)	5	11.6%	49	17.8%
Unknown	4	9.3%	26	9.5%
Total	**43**	**100%**	**275**	**100%**

Table 13. Frequency of contact with living non-resident father, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Never	51	68.0%	23	71.9%	1	25.0%	27	69.2%
Less than once a month	6	8.0%	3	9.4%	0	0%	3	7.7%
At least once a month	9	12.0%	2	6.3%	1	25.0%	6	15.4%
At least once a week	4	5.3%	1	3.1%	0	0%	3	7.7%
Every day/almost every day	5	6.7%	3	9.4%	2	50.0%	0	0%
Total	**75**	**100%**	**32**	**100%**	**4**	**100%**	**39**	**100%**

Table 14. Frequency of contact with living non-resident mother, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Never	18	40.9%	11	61.1%	1	100%	6	24.0%
Less than once a month	7	15.9%	2	11.1%	0	0%	5	20.0%
At least once a month	10	22.7%	3	16.7%	0	0%	7	28.0%
At least once a week	3	6.8%	1	5.6%	0	0%	2	8.0%
Every day/almost every day	6	13.6%	1	5.6%	0	0%	5	20.0%
Total	**44**	**100%**	**18**	**100%**	**1**	**100%**	**25**	**100**

Care histories of reunified children

For children reunified after living in residential care (n=272 children[31]), their primary caregivers also gave information about their care histories. It should be noted, as explained above in the Kenya background section, that children in Kenya mostly returned home due to COVID-19 protocols which caused the partial and temporary closure of residential care facilities.

The caregiver was asked how old the child was the first time they entered the residential care institution, as well as how old they were when they most recently came to live with them permanently. The mean age at which children entered care in Kenya was 7.4 years old (SD: 4.1, min: 0, max: 17) (Figure 10) and the mean age of reunification in Kenya was 12.1 years old (SD: 4.0, min: 0, max: 18) (Figure 11). Taking the difference of these two ages, roughly speaking, children in Kenya spent an average of 4.7 years in care, with some children spending as many as 15 years in care (SD: 3.9, min: 0, max: 15) (Figure 12).

About a fifth, or 18.8%, of the reunified children lived with someone other than their current primary caregiver before they entered residential care (Table 16). Reunified children had lived in a variety of settings throughout their lives before entering residential care, including with their biological parents (65.8% of children) and other relatives' homes (28.5%) (Table 17).

There were 146 (54.9%) children who lived in residential care with one or more of their siblings prior to reunification (Table 18). Out of these, the majority (128, or 87.7% of those who lived with siblings) came with at least one sibling to live in their current caregiver's home. When asked if the child was in contact with anyone from their residential care institution, most in Kenya (72.8%) said yes (Table 19).

Finally, the survey sought to determine whether children moved in and out of care during the period of time they were in residential care. The primary caregivers of reunified children were presented with the following question:

"Think back to the whole period of time [child] lived in the residential care institution (between ages [age of entrance] to [age of reunification]). Did [child] ever leave the residential care institution to live with you or another family member, but then return to the residential care institution again?"

This was true of 28.7% of reunified children, according to their primary caregivers. When asked how often this happened, most said a few times a year (Table 20). As a follow up, caregivers of children who moved between residential care and family/current placement were asked if this movement in and out of care happened due to the COVID-19 pandemic. Forty-one (52.5%) said yes, meaning

[31] There were 275 children labeled as having lived in residential care in the dataset, but due to a technical problem with the survey, for three of these children, no data related to reunification were collected.

caregivers of 15.1% of all reunified children in Kenya considered that they had moved in and out of care due to COVID-19 (Table 21).

Figure 10. Reunified children's age at entrance to care, Kenya (n=261, 11 skipped)

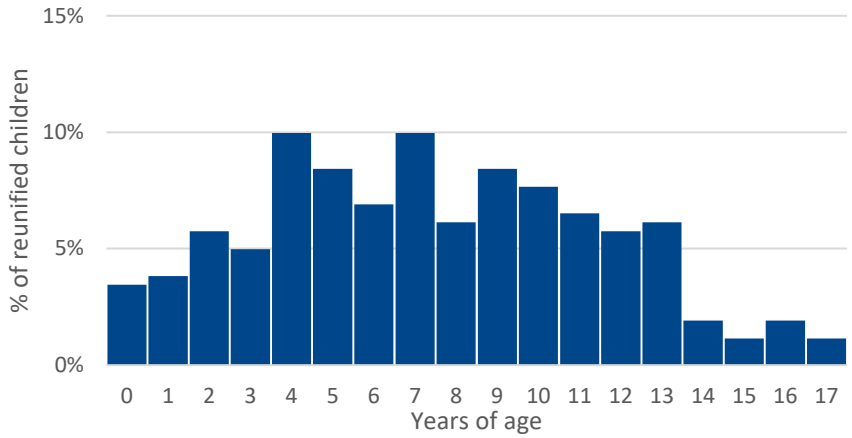


Figure 11. Reunified children's age at reunification, Kenya (n=249, 23 skipped)

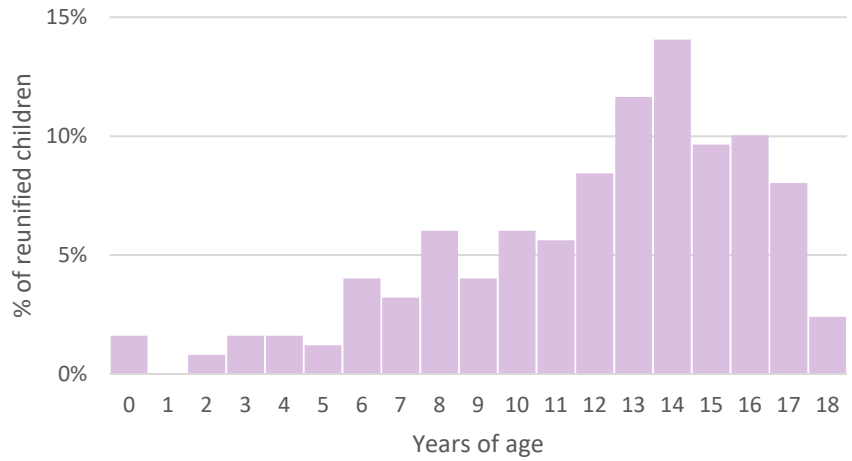


Figure 12. Reunified children's approximate years in care, Kenya (n=249, no data for 23)

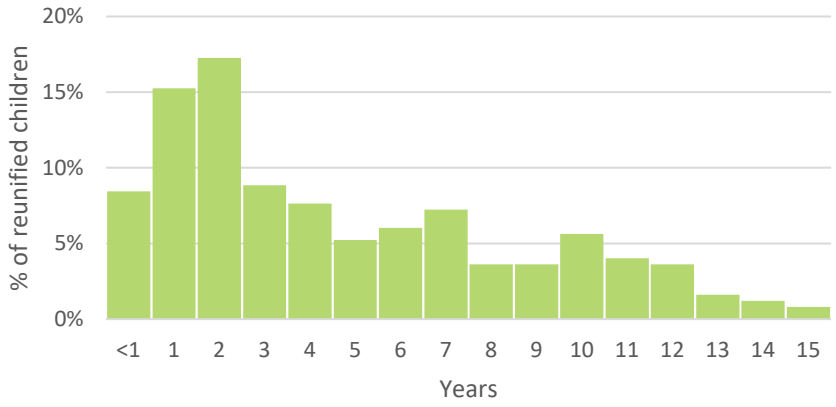


Table 15. Reunified children's age of entrance/exit to care and approximate years in care, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	MEAN	*SD*	*MEAN*	*SD*	*MEAN*	*SD*	*MEAN*	*SD*
Age at first entrance to care (years)	7.4	4.1	8.6	3.7	7.6	3.8	6.5	4.2
Age at last reunification (years)	12.1	4.0	12.5	3.6	9.8	4.0	12.3	4.1
Approx. years in care	4.7	3.9	4.0	3.6	2.2	1.6	5.8	4.1

Table 16. Who reunified children lived with prior to entering residential care, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Lived with respondent	211	81.2%	76	83.5%	27	90.0%	108	77.7%
Lived with someone else	49	18.8%	15	16.5%	3	10.0%	31	22.3%
Total	**260**	**100%**	**91%**	**100%**	**30**	**100%**	**139**	**100%**

Note: Twelve caregivers did not know.

Table 17. Reunified children's living arrangements before residential care, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Biological parents' home	173	66.0%	58	62.4%	23	76.7%	92	66.2%
Other relatives' home	75	28.6%	21	22.6%	5	16.7%	49	35.3%
Non-relatives' home	3	1.1%	2	2.2%	0	0%	1	0.7%
Another institution	6	2.3%	3	3.2%	0	0%	3	2.2%
Other	15	5.7%	10	10.8%	4	13.3%	1	0.7%
Denominator	**262**		**93**		**30**		**139**	

Note: Children could live in more than one type of place. Ten caregivers did not know.

Table 18. Reunified children's siblings, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Lived with sibling(s) in residential care								
Yes	146	54.9%	35	36.8%	18	56.2%	93	66.9%
No	120	45.1%	60	63.2%	14	43.8%	46	33.1%
Came with any sibling(s) to current family								
Yes	128	87.7%	29	82.9%	15	83.3%	84	90.3%
No	18	12.3%	6	17.1%	3	16.7%	9	9.7%

Table 19. Reunified children's current contact with individual from their residential care institution, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
Not in contact with individuals from residential care institution	63	24.1%	11	11.8%	12	41.4%	40	28.8%
In contact with houseparent/social worker/case worker	147	56.3%	53	57.0%	7	24.1%	87	62.6%
In contact with other children	68	26.1%	33	35.5%	3	10.3%	32	23.0%
In contact with director	53	20.3%	26	28.0%	8	27.6%	19	13.7%
In contact with volunteer	29	11.1%	17	18.3%	5	17.2%	7	5.0%
In contact with supporter	10	3.8%	1	1.1%	0	0%	9	6.5%
In contact with other individual	8	3.1%	3	3.2%	0	0%	5	3.6%
Denominator	**261**		**93**		**29**		**139**	

Note: Children could be in contact with more than one type of individual. Eleven respondents in Kenya did not know if children had contact with anyone.

Table 20. How often reunified children moved between residential care and family/current placement, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
Never	186	70.7%	65	69.1%	26	86.7%	95	68.4%
Once a month or more	26	9.9%	10	10.6%	1	3.3%	15	10.8%
A few times per year	50	19.0%	19	20.2%	2	6.6%	29	20.9%
About once a year	1	0.4%	0	0%	1	3.3%	0	0%
Less than once a year	0	0%	0	0%	0	0%	0	0%
Total	**263**	**100%**	**94**	**100%**	**30**	**100%**	**139**	**100%**

Note: Nine respondents in Kenya did not know.

Table 21. Reason for moving in and out of care, for reunified children who had moved in and out of care, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
Due to COVID-19	41	52.5%	14	46.7%	2	50.0%	25	56.8%
Not due to COVID-19	37	47.4%	16	53.3%	2	50.0%	19	43.2%
Total	**78**	**100%**	**30**	**100%**	**4**	**100%**	**44**	**100%**

Family strengthening support

All caregivers (n=263) were asked if their household had received family strengthening support from CTWWC. Most caregivers reported that they had received home visits, cash transfers, and parenting training (Table 22). Around half reported also being referred to another service. Around a third of families were also members of a savings and loans group. Kitchen garden training had also been provided to many families in Kisumu and Nyamira (however this was not a common intervention in Kilifi County since the dry climate and poor soil are not suitable to gardening). About 80% of families in Nyamira, 45% in Kilifi, and 28% in Kisumu reported receiving food bundles. In Kisumu, food bundles were not prioritized as it was deemed that the cash transfers were sufficient.

If the caregiver reported that they received a service, they were also asked to rate how helpful the service was for taking care of their children. A score of 0 corresponded to "didn't help at all," 1 meant "helped a little," and 2 was "helped a lot." All interventions were rated as being helpful, receiving average ratings between 1.58 and 1.81 (Figure 13). Caregivers rated cash transfers as the most helpful service. Parenting training was rated as the second most helpful, closely followed by home visits, kitchen gardens, and food bundles.

Table 22. Caregivers' reported receipt of family strengthening interventions for their household, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
Home visit from a case worker, involvement in case planning to set goals for the family/child, counselling and guidance	250	95.1%	111	94.9%	33	94.3%	106	95.5%
Cash transfers	247	93.9%	115	98.3%	34	97.1%	98	88.3%
Parenting training, either within home visits or as part of a group	201	76.4%	106	90.6%	25	71.4%	70	63.1%
Referrals to other services providers (such as health care, microfinance, disability support, etc.)	136	51.7%	46	39.3%	17	48.6%	73	65.8%
Kitchen garden training	119	45.3%	80	68.4%	24	68.6%	15	13.5%
Food bundles	111	42.2%	33	28.2%	28	80.0%	50	45.1%
Membership of a savings and loans group (SILC)	92	35.0%	44	37.6%	16	45.7%	32	28.8%

Figure 13. Caregivers' rating of the helpfulness of family strengthening interventions received, Kenya (scale of 0–2, with 2 representing most helpful)

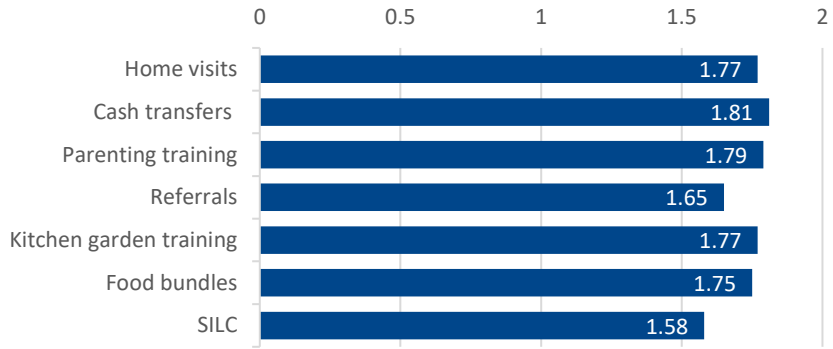


Table 23. Caregivers' rating of the helpfulness of family strengthening interventions, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	MEAN	*SD*	*MEAN*	*SD*	*MEAN*	*SD*	*MEAN*	*SD*
Cash transfers	1.81	0.45	1.90	0.38	1.82	0.39	1.69	0.53
Parenting training, either with home visits or as part of a group	1.79	0.45	1.92	0.33	1.80	0.41	1.59	0.55
Kitchen garden training	1.77	0.53	1.81	0.53	1.92	0.28	1.33	0.62
Home visit from a case worker, involvement in case planning to set goals for the family/child, counselling and guidance	1.77	0.47	1.87	0.41	1.82	0.46	1.65	0.52
Food bundles	1.75	0.48	1.91	0.29	1.89	0.42	1.56	0.54
Referrals to other services providers (such health care, microfinance, disability support, etc.)	1.65	0.51	1.78	0.47	1.82	0.39	1.53	0.53
Membership of a savings and loans group (SILC)	1.58	0.56	1.70	0.55	1.75	0.45	1.31	0.54

Caregiver protective factors

Protective factors examined in the household survey included caregiving protective factors, parenting practices, and economic stability (see Figure 14 for brief definitions and introduction for a fuller discussion).

Caregiving protective factors

The mean scores on the PAPF measures are presented in Table 24 below as a baseline from which CTWWC aims to measure future change. Although there are no set cut offs that indicate whether a score should be considered high, medium, or low, higher scores indicate a greater degree of protective factors. The items from which these scales are calculated are included in the appendix on page 106.

Figure 14. PAPF definitions

Parental resilience: Managing stress and functioning well when faced with challenges, adversity, and trauma.

Social support and connections: Positive relationships that provide emotional, informational, instrumental, and spiritual support.

Access to concrete support in times of need: Access to concrete support and services that address a family's needs and help minimize stress caused by challenges.

Social and emotional competence of children: Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships.

These scores can only be meaningfully interpreted when in analysis with other variables (e.g., looking at differences in PAPF scores between groups). All analyses of the PAPF scores in relation to caregiver characteristics can be found in the appendix (Tables 77 and 78) with the statistically significant associations reported below.

Notable results of correlations revealed that in Kenya, the higher a caregiver's education level, the higher their scores on social connections ($r=.16$, $p<.05$), on concrete assistance in times of need ($r=.23$, $p<.001$), and on the overall PFI ($r=.16$, $p<.01$). Caregiver age, number of adults per household, and number of children per household were not correlated with PAPF scores. Caregivers in rural households also had significantly higher mean scores on social and emotional competency of children compared to those in urban locations (rural=3.18, urban=3.03, $p<.05$). Caregivers with disabilities had lower parental resilience scores than those without disabilities (with disabilities=2.96, without

disabilities=3.13, p<.05). Widows also had lower scores on concrete assistance in times of need than non-widows (non-widows=2.21, widows=1.98, p<.05).

Table 24. PAPF scores, Kenya (scale of 0–4 with 4 representing greater protective factors)

	KENYA			KISUMU			NYAMIRA			KILIFI		
	MEAN	*SD*	*N*	*MEAN*	*SD*	*N*	*MEAN*	*SD*	*N*	*MEAN*	*SD*	*N*
Parental resilience	3.10	.53	262	3.05	0.52	117	3.39	0.35	35	3.06	0.55	110
Social connections	2.11	.92	262	2.11	0.82	117	2.38	0.96	35	2.02	0.99	110
Concrete assistance in times of need	2.55	.74	263	2.65	0.66	117	2.85	0.54	35	2.34	0.82	111
Social and emotional competency of children	3.14	.53	263	3.08	0.55	117	3.38	0.46	35	3.12	0.50	111
Overall Protective Factors Index (PFI)	2.72	.54	263	2.72	0.51	117	3.00	0.40	35	2.64	0.58	111

Parenting practices

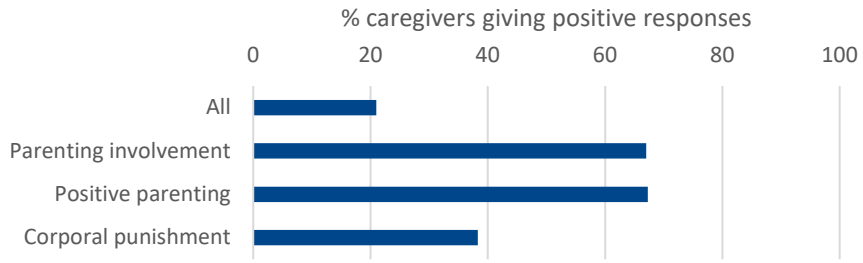
Of caregivers who had reported receiving parenting training in Kenya, 21% met the threshold set by CTWWC for practicing positive parenting skills (Table 25).[32] This is a key outcome indicator in CTWWC's monitoring plan. Since the parenting training was still a relatively new intervention in Kenya at the time of the survey this result can be seen as baseline against which future measures can be compared.

Table 25. Indicator table for CTWWC Outcome 8: Positive parenting, Kenya

Percentage of caregivers who had received training in positive parenting who are subsequently assessed as practicing positive parenting skills	**N**	**%**
Kenya overall	**195**	**21%**
Household type: At-risk	33	24%
Reintegrating	158	21%
Alternative family care	4	0%
Sex of caregiver: Male	31	29%
Female	164	20%

[32] In order to be assessed as "practicing positive parenting," a caregiver needed a score of 15+ on Positive Parenting; a score of 15+ on Parental Involvement, if they were eligible for those questions; a "never/almost never" answer on spanking; a "never" answer on slapping on face; a "never" answer on hitting with objects.

Figure 15. Composite results for indicator Outcome 8: Positive parenting, Kenya



Note: Positive responses to all questions asked in subscales (e.g., always or often for parental involvement and positive parenting subscales, and never for slap or hit, never or almost never for spank for corporal punishment questions).

The average scores on the parental involvement and positive parenting subscales of the APQ are presented in Table 26 below as a baseline. Although there are no set cut offs that indicate whether a score should be considered high, medium, or low, higher scores represent more parental involvement (actions such as talking and playing with child) and more positive parenting (actions such as praising or rewarding child for good behavior or being helpful). The items of which these scales consist are included in the appendix on page 107.

As with the PAPF measure, they should only be interpreted at this stage in relation to other variables (e.g., looking at differences in scores between groups). Such analysis showed that in Kenya, the older the caregiver was, the lower their parental involvement ($r=-17$, $p<.01$). In addition, the less education they had, the higher their parental involvement ($r=.17$, $p<.01$). Other correlations (involving number of adults per household, number of children per household) were not statistically significant. None of these characteristics correlated with positive parenting. There were also no statistically significant differences in the mean parental involvement or positive parenting scores when looking at caregiver gender, disability status, widow status, urban/rural status, and households with reunified vs. at-risk children.

Caregivers were asked about how frequently they used methods of corporal punishment with their children (see appendix). The distributions of answers to these corporal punishment questions of the APQ are presented in Figure 16 and Table 27 below. Most caregivers reported that they never or almost never use corporal punishment. It is likely that this is an under-report of the use of corporal punishments since this is known to be a sensitive topic.

For these, “never” was coded as 0 and “always” as 4, allowing them to be used in bivariate analyses. These analyses revealed that the older the caregiver, the less often they used any type of corporal punishment (spanking: $r=-12$, $p<.05$; slapping: $r=-.16$, $p<.05$; hitting with object: $r=-.24$, $p<.001$). The higher the level of education a caregiver had, the more often they used any type of corporal punishment (spanking: $r=.17$, $p<.01$; slapping: $r=.17$, $p<.01$; hitting with object: $r=.14$, $p<.05$). Number of children and number of adults per household were not correlated with frequency of use of corporal punishment. There were no statistically significant differences in the frequency of use of corporal punishment when looking at caregiver gender, disability status, widow status, urban/rural status, and households with reunified vs. at-risk children.

The results on positive parenting suggest that caregivers need continued support in parenting education. Older caregivers and caregivers with lower education levels have both strengths and weaknesses in their parenting practices, and in some cases, being highly involved in children’s lives may not preclude the use of harsh discipline.

Table 26. APQ parental involvement and positive parenting scores, Kenya (possible range: 0 – 24)

	KENYA			KISUMU			NYAMIRA			KILIFI		
	MEAN	*SD*	*N*	*MEAN*	*SD*	*N*	*MEAN*	*SD*	*N*	*MEAN*	*SD*	*N*
Parental involvement	15.88	3.96	258	15.96	3.32	113	18.65	3.78	34	14.47	4.03	104
Positive parenting	15.51	4.05	250	15.66	3.68	114	17.21	5.46	33	15.27	3.97	110

Figure 16. APQ corporal punishment results, Kenya (possible options of never, almost never, sometimes, always)

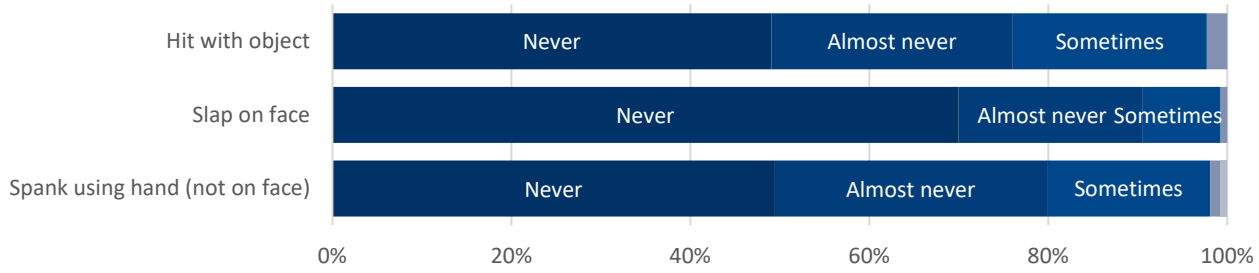


Table 27. APQ corporal punishment results, Kenya

		KENYA		KISUMU		NYAMIRA		KILIFI	
		N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Spank children on body with hand	Never	130	49.4%	56	47.9%	19	54.3%	55	49.6%
	Almost never	80	30.4%	35	29.9%	8	22.9%	37	33.3%
	Sometimes	48	18.3%	24	20.5%	6	17.1%	18	16.2%
	Often	3	1.1%	1	0.9%	1	2.9%	1	0.9%
	Always	2	0.8%	1	0.9%	1	2.9%	0	0%
Slap children on face with hand	Never	184	70.0%	76	65.0%	19	54.3%	89	80.2%
	Almost never	54	20.5%	31	26.5%	8	22.9%	15	13.5%
	Sometimes	23	8.6%	9	7.7%	7	20.0%	7	6.3%
	Often	2	0.8%	1	0.9%	1	2.9%	0	0%
	Always	0	0%	0	0%	0	0%	0	0%
Hit children with object	Never	129	49.1%	48	41.0%	14	40.0%	67	60.4%
	Almost never	71	27.0%	38	32.5%	13	37.1%	20	18.0%
	Sometimes	57	21.7%	30	25.6%	6	17.1%	21	18.9%
	Often	6	2.3%	1	0.9%	2	5.7%	3	2.7%
	Always	0	0%	0	0%	0	0%	0	0%
	Total	**263**		**117**		**35**		**111**	

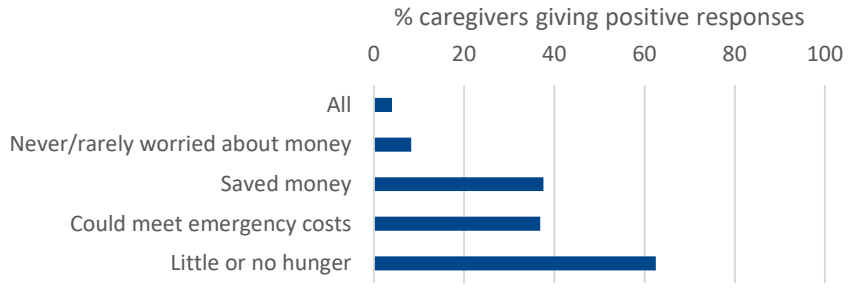
Household economic stability

Only 4% of households who had received some form of household economic strengthening (e.g., cash transfers) met the criteria set by CTWWC for being considered economically stable [Table 28]).[33] This is a key outcome indicator in CTWWC's monitoring plan. Although this is a low level of economic stability amongst the households being supported, it should be remembered that the main economic strengthening approach was an emergency cash transfer provided rapidly in response to children's reunification from residential care as a result of COVID-19 protocols. It is clear from the results above on family strengthening interventions (page 29) that caregivers found this to be a helpful intervention, likely to have helped them meet the immediate needs of unexpectedly receiving a child back home. These results will provide a useful baseline against which future measurements can be compared as further support is provided to families to build economic stability.

Table 28. Indicator table for CTWWC Outcome 7: Economic stability, Kenya

Percentage of caregivers who received economic support who are subsequently assessed as being economically stable	N	%
Kenya overall	**252**	**4%**
Household type: At-risk	40	0%
Reintegrating	208	5%
Alternative family care	4	0%
Sex of caregiver: Male	45	2%
Female	207	4%

Figure 17. Composite results for indicator Outcome 7: Economic stability, Kenya



Note: Positive responses are: "never" or "rarely" to "In the past four weeks how often were you worried about money?"; "Yes" to "Have you managed to save some money within the past month?" (Response Y/N); "It would be hard but we could" or "It would be easy" to "If you were facing an emergency, how difficult would it be for your family to get 7,500 Kenyan shilling?"; and "little to no hunger" score on HHS.

Caregivers were asked a variety of questions to assess their household economic stability. Although most (62.4%) had little to no hunger, there were still many households in Kenya (36.9%) that had moderate to severe household hunger (Table 29).

Caregivers with disabilities had more household hunger than caregivers without disabilities (with disabilities=1.56, without disabilities=1.07, p<.05**Error! Reference source not found.**). Households with reunified children had less hunger than those only receiving prevention services (reunified=1.81,

[33] In order to be assessed as "economically stable," a caregiver needed: a "never"/"rarely" response on "worried about money"; a "yes" response on "did you save any money"; a "hard"/"easy" response on "If you were facing an emergency"; and a "little to no hunger" score on the HHS.

at-risk=1.04, p<.001). There were no differences on household hunger scores by caregiver gender, widow status, and urban/rural household status. The more children who were in the household, the more hunger the household had (r=.15, p<.05). Household hunger was not correlated with caregiver age, education, or number of adults in the household.

Almost all caregivers in Kenya worried about money at least sometimes (92.0%) (Table 30). The older the caregiver, the less they worried about money (r=-.12, p<.05). How often a caregiver worried about money was not correlated with their education level or the number of adults or children in the household. There were no differences on how much caregivers worried about money by caregiver gender, disability status, widow status, urban/rural household status, or whether the household had any reunified children.

When asked, a little more than half of caregivers reported that they had not managed to save any money in the past month (Table 31). While 42.6% of non-widows had saved money, only 29.6% of widows had saved any (p<.05); 39.8% of caregivers of reunified families had saved money while 18.6% of caregivers in at-risk families had saved (p<.001). Saving money did not significantly differ for caregivers based on their gender, urban/rural status, disability, number of children or adults in their household, caregiver age, or caregiver education levels.

When asked how difficult it would be to obtain about $70 USD[34] in an emergency, about two thirds (63.4%) said it would be impossible (Table 32). The older the caregiver was, the easier they said they would find it to obtain funds (r=-.14, p<.05). Widows said they would have a harder time obtaining funds than non-widows (non-widows=0.46, widows=0.31, p<.05). This measure was not correlated with caregiver education or number of adults or children in the household, and there were no differences on this outcome by caregiver gender, disability status, urban/rural status, or whether the household had any reunified children.

Caregivers were also asked about their ability to pay for expenses related to education, including transport, uniforms, and other fees. Over a third (36.7%) of caregivers in Kenya had children who had missed school due to inability to pay (Table 33).

Caregivers were asked similar questions about health care. Out of those who needed health care services for their children (177 caregivers), 63.8% were able to pay for them and 24.9% were not (Table 34). Worryingly, some caregivers (11.3% of those who needed health care) did not seek health care for children even though they needed it.

Finally, caregivers were asked about other unexpected household expenses they had encountered besides children's health and education expenses. Out of caregivers who encountered an unexpected household expense in the last three months (157 caregivers), 56.1% could not afford the expense (Table 35).

Overall, it is clear that caregivers in Kenya are struggling economically: Most caregivers reported worrying about their economic situation and many are struggling to meet the needs of their children. In some instances, this is leading to children missing school and not receiving health care when it is needed. There is some indication that this situation could be worse for widows, a third of whom are the only adults in their household.

[34] This survey question was adapted from a question used in South Africa in the Parenting for Lifelong Health evaluation. Since in South Africa the question asked about the equivalent of $70 USD, we used this amount (7,500 Kenyan shillings) in our study as well.

Table 29. Household Hunger Score (HHS), Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
Little to no hunger	164	62.4%	76	65.0%	21	60.0%	67	60.4%
Moderate hunger	91	34.6%	39	33.3%	12	34.3%	40	36.0%
Severe hunger	6	2.3%	2	1.7%	2	5.7%	4	3.6%
Total	**263**	**100%**	**117**	**100%**	**35**	**100%**	**111**	**100%**

Table 30. How often caregivers worried about money in the past four weeks, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***N***	***%***	***N***	***%***	***N***	***%***	
Never	9	3.4%	4	3.4%	2	5.7%	3	2.7%
Rarely	12	4.6%	9	7.7%	2	5.7%	1	0.9%
Sometimes	110	41.8%	38	32.5%	17	48.6%	55	49.6%
Often	132	50.2%	66	56.4%	14	40.0%	52	46.9%
Total	**263**	**100%**	**117**	**100%**	**35**	**100%**	**111**	**100%**

Table 31. Caregivers who had saved any money in the last month, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
No	166	63.1%	67	57.3%	24	68.6%	75	67.6%
Yes	97	36.9%	50	42.7%	11	31.4%	36	32.4%
Total	**263**	**100%**	**117**	**100%**	**35**	**100%**	**111**	**100%**

Table 32. Ability to obtain 7,500 KSh ($70 USD) in an emergency, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	%	***N***	***%***	***N***	***%***	***N***	***%***
It would be impossible	166	63.4%	76	65.0%	25	71.4%	65	59.1%
It would be hard but we could	89	34.0%	36	30.8%	9	25.7%	44	40.0%
It would be easy	7	2.7%	5	4.3%	1	2.9%	1	0.9%
Total	**262**	**100%**	**117**	**100%**	**35**	**100%**	**110**	**100%**

Figure 18. Ability to pay for children's education expenses in the past three months, Kenya

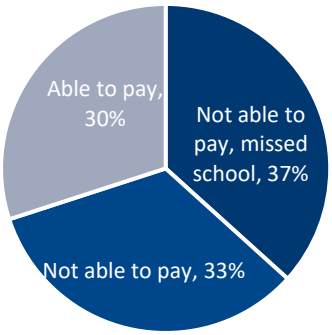


Table 33. Ability to pay for children's education expenses in the past three months, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	%	***N***	***%***	***N***	***%***	***N***	***%***
Not able to pay in full, causing children to miss school	88	36.7%	39	35.5%	13	40.6%	36	36.7%
Not able to pay in full, but children did not miss school	80	33.3%	34	30.9%	14	43.8%	32	32.7%
Expenses fully paid	72	30.0%	37	33.6%	5	15.6%	30	30.6%
Total	**240**	**100%**	**110**	**100%**	**32**	**100%**	**98**	**100%**

Note: Five caregivers had no children enrolled in school in their household, 15 did not have any costs associated with education, and 3 did not know.

Figure 19. Ability to pay for children's health care services in the past three months, for those who needed health care services for their children, Kenya

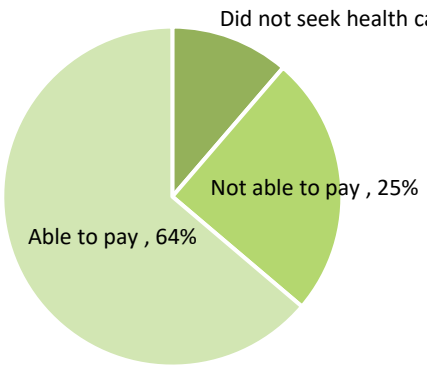


Table 34. Ability to pay for children's health care services in the past three months, for those who needed health care services for their children, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
Children needed health care but caregiver did not seek it	20	11.3%	5	5.3%	1	5.0%	14	22.6%
Children needed health care but caregiver not able to pay for it	44	24.9%	19	20.0%	3	15.0%	22	35.5%
Children needed health care and caregiver able to pay for it	113	63.8%	71	74.7%	16	80.0%	26	41.9%
Total	**177**	**100%**	**95**	**100%**	**20**	**100%**	**62**	**100%**

Note: Eighty-five caregivers did not have any children who needed health care and one declined to answer.

Figure 20. Ability to pay for unexpected household expenses in the past three months (other than children's health and education), out of those who had unexpected expenses arise, Kenya

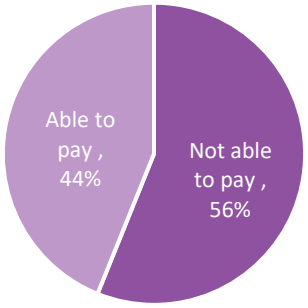


Table 35. Ability to pay for unexpected household expenses in the past three months (other than children's health and education), out of those who had unexpected expenses arise, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***
Not able to pay	88	56.1%	52	65.8%	11	50.0%	25	44.6%
Able to pay	69	43.9%	27	34.2%	11	50.0%	31	55.4%
Total	**157**	**100%**	**79**	**100%**	**22**	**100%**	**56**	**100%**

Note: One hundred six caregivers did not have any unexpected household expenses.

Child well-being

Early childhood education

For children (in case management or the index child for families at risk of separation with no individualized case management) aged 2–4, caregivers were asked if their child was enrolled in any sort of early childhood education (ECE) program. There were seven children aged 2–4 in Kenya. Their caregivers reported that all seven (100%) were enrolled in ECE programs.

Also, for children aged 2–4, caregivers were asked if anybody over age 15 had engaged in ECE stimulation activities with the child in the past three days. These activities included reading books or looking at picture books, telling stories, singing songs or lullabies, taking the child outside, playing with the child, and naming/counting/drawing things with the child. All seven of the children had received at least two of these stimulation activities.

Education for children aged 5 and older

Caregivers were asked about school enrollment for children aged 5 and older. In Kenya, 93.8% of children were enrolled in school (19 children were not enrolled) (Table 36). The reasons they were not enrolled were as follows: child does not like school (5); pregnancy, parenting, or marriage (5); no money for school fees, materials, or transport (3); child ran away (2); child is too sick to attend school (1); child already completed school (1); child has disabilities and defaulted (1); reason unclear (1).

For children enrolled in school, caregivers were also asked if the child had been absent for four or more days in the last month. This was true of 15.4% of the children enrolled in school in Kenya. These children had usually missed school due to lack of money to cover expenses or due to illness (see table 37).

Table 36. School and ECE enrollment and attendance, Kenya

	KENYA		KISUMU		NYAMIRA		KILIFI	
	N	**%**	***N***	**%**	***N***	**%**	***N***	**%**
Enrolled in ECE (children 2–4)	7	100%	1	100%	N/A	N/A	6	100%
Not enrolled in school (children 5+)	19	6.2%	9	7.0%	3	8.1%	7	5.0%
Missed 4+ days of school (children 5+ enrolled in school)	44	15.4%	26	21.9%	5	14.7%	13	9.8%

Table 37. Reasons children missed four or more days of school, Kenya

	KENYA	
	N	**%**
No money for school fees, materials, transport	20	45.5%
Child is too sick to attend school	14	31.8%
Child does not like school	5	11.4%
Laundry/dirty clothing	2	4.5%
Child needs to care of sick household member	1	2.3%
To give birth	1	2.3%
To follow up on birth certificate	1	2.3%
Total	**44**	**100%**

Caregiver-reported well-being for children ages 2–10

There were 68 children (in case management or the index child for households with no case management) aged 2–10 in Kenya. For these children, caregivers were asked to rate their children's overall health on a scale of 0 (poor) to 4 (excellent). The average score in Kenya was 2.63 (SD: 0.83, min: 1, max: 4) (Table 38). This overall health score did not have any statistically significant relationships with any child characteristics, including child age, years in care, age at reunification, age

at entrance to care, child sex, child disability status, at risk vs. reunified children, parental care status, orphanhood status, and whether children lived with any non-relative (Tables 85 and 86).

Then caregivers answered 10 questions about various domains of their children's well-being. These questions were on a scale of 0 to 2, where 2 represents greater well-being. In Kenya most caregivers felt their children liked school and were treated well there, were not overly involved in chores, and were growing well (Table 39). They indicated more concern about their children having material needs to complete schoolwork, enough food to eat, and their treatment by family members.

These 10 items were averaged to create an overall well-being score for children aged 2–10, allowing CTWWC to analyze well-being scores by child characteristics (Tables 85 and 86)**Error! Reference source not found.**. This measure was not correlated with children's age at the time of the survey. Among reunified children aged 2–10, the older the child's age at reunification, the greater their caregiver-reported well-being score (r=.29, p<.05). However, this measure was not correlated with years in care or age at reunification, and mean scores did not differ amongst boys and girls, children with and without disabilities, at-risk and reunified children, children in parental and non-parental care, non-orphans and orphans, and children who did or did not live with a non-relative adult.

Table 38. Caregiver rating of overall health of children aged 2–10, Kenya (scale of 0 to 4, with 4 representing best health)

	KENYA			KISUMU			NYAMIRA			KILIFI		
	MEAN	*SD*	*N*	*MEAN*	*SD*	*N*	*MEAN*	*SD*	*N*	*MEAN*	*SD*	*N*
Overall health	2.63	.83	67	2.36	0.79	22	2.73	1.01	11	2.76	0.78	34

Table 39. Well-being questions for children aged 2–10, Kenya (scale 0–2, with 2 representing greatest well-being)[35]

	KENYA		
	MEAN	*SD*	*N*
School[36]			
[Child] likes school	2.00	0.00	61
[Child] is treated as well as the other students in the class	1.87	.39	60
[Child] has the materials he/she needs to do class work	1.33	.60	61
Health and safety			
I feel that [child] is growing as well as other kids their age	1.90	.35	68
I feel [child] is safe where we live	1.87	.38	68
Work or chores interferes with [child]'s sleep[37,38]	1.85	.44	61
[Child] has enough food to eat	1.10	.63	67
Psychosocial			
[Child] seems as happy as other children their age	1.84	.41	68
Community members treat [child] differently than other children[38]	1.81	.50	68
Our relatives (e.g., uncles, aunts, grandparents) support [child] the same as other children in the family	1.04	.86	67

[35] Due to an error, in Kenya data were not collected for the item, "Work or chores interferes with [child]'s school."
[36] These items were for children aged 5–10 enrolled in school
[37] This item was for children aged 5–10.
[38] These items were reverse coded so the scores were comparable with "positively-worded" items. (2=None of the time, 1=Some of the time, 0=All of the time.)

Child-informed well-being tool for children aged 11 and older

The following section presents data from the child self-report survey completed by children aged 11 and older.

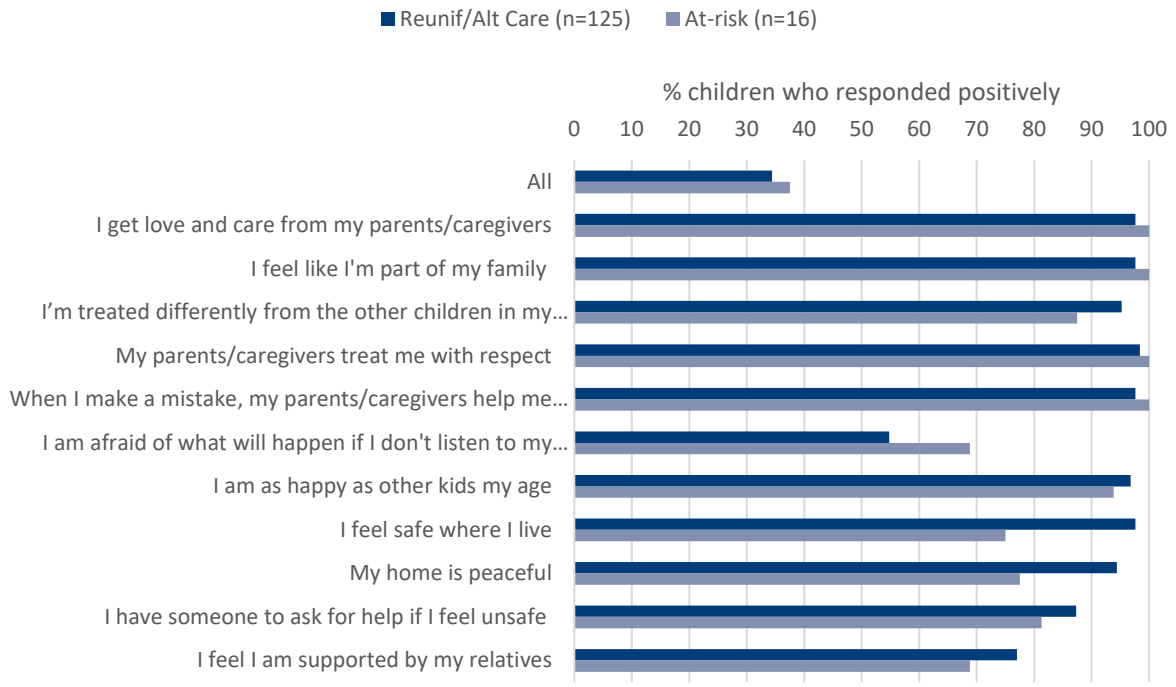
In Kenya, 38% of at-risk children and 34% of reintegrating children met the criteria set by CTWWC to be assessed as feeling safe and nurtured in their placement (Table 40).[39] This is a key outcome indicator in CTWWC's monitoring plan. It should be noted that the number of children in at-risk families aged 11 and older answering the questions used for this result is very small (n=16) and so the disaggregated results should be used with caution.

Table 40. Indicator table for CTWWC Outcomes 3 and 11: Sense of safety and nurture, Kenya

Percentage of children (aged 11 years and above) who feel safe and nurtured in the family	**N**	**%**
Outcome 3: Targeted children at risk of separation from their families	**16**	**38%**
Age: 11–14	12	42%
15–17	4	25%
18+	0	N/A
Sex: M	7	57%
F	9	22%
Disability: Disability	4	25%
No disability	11	45%
Outcome 11: Children who have been reunified, placed in family-based care, or in independent living	**130**	**34%**
Age: 11–14	77	36%
15–17	43	28%
18+	10	40%
Sex: M	76	29%
F	54	41%
Disability: Disability	18	11%
No disability	108	38%
Care type: Reintegration	128	34%
Alternative family-based care	2	50%
Supported independent living	0	N/A

[39] In order to be considered "feeling safe and nurtured" children must have a "none of the time" or "some of the time" response to the following statements: I am treated differently than the other children in my household; and I am afraid of what will happen if I don't listen to my parents/caregivers. They must also have an "all of the time" or "some of the time" response to: I feel I am supported by my relatives; I feel like I'm part of my family; I get love and care from my parents/caregivers; I am as happy as other kids my age; I feel safe where I live; My home is peaceful; I have someone to ask for help if I feel unsafe; When I make a mistake, my parents/caregivers help me improve; My parents/caregivers treat me with respect.

Figure 21. Composite results for indicator Outcome 3 and 11: Sense of safety and nurture, Kenya



Note: A positive response is a 1 or 2 response to each statement on a scale of 0 to 2, when 0 represented "none of the time," 1 was "some of the time," and 2 was "all of the time," unless the data were reverse coded. See table below.

Children aged 11–18 answered a child self-report survey if they were available. Table 41 shows the results from the contextualized child well-being tool, developed via focus group discussions with young people who have lived in residential care. Each item's responses could range from 0 to 2, where 0 represents the lowest well-being and 2 the highest. (Specifically, 0 was "none of the time," 1 was "some of the time," and 2 was "all of the time," unless the data were reverse coded, as noted in the footnotes.) Most of the items were positively scored on average, with areas of highest well-being including respect, love and care from parents; liking school teachers; feeling part of their family; and being as happy as other children. By contrast, three items received a score less than one, indicating lower well-being: children indicated they may not receive help from others if parents cannot help, that they were afraid of their parents if they did not listen to them, and that they had little choice about what and when to eat.

All of these items were averaged into an overall well-being score that could range from 0 to 2, with 2 representing the highest well-being. This allowed for comparisons to be made between groups of children. Importantly, these analyses reveal that amongst children aged 11 and above, children with disabilities reported lower well-being than children without disabilities (no disabilities=1.57, disabilities=1.29, p<.001). Equally important is that children who had lost one or both parents also had significantly higher well-being than children with two living parents (non-orphan=1.42, orphan=1.56, p<.01). There were not significant differences by child gender, at-risk vs reunified child, parental care status, or whether children lived with a non-relative adult. This score was also not correlated with child age.

Children also rated their OLS on a scale of 0–10, where 10 represented greatest satisfaction. The mean score was 7.53 in Kenya (SD: 2.25, min: 1, max: 10) (Table 42). Children with disabilities had significantly lower OLS than children without disabilities (no disability=7.71, disability=6.45, p<.05).

Children who lived with a non-relative adult had greater OLS than children who did not (live with non-relative=7.36, did not live with non-relative=8.39, p<.05). There were no differences by child gender, at-risk vs reunified child, parental care status, orphanhood status, or age.

Figure 22. Child-informed well-being tool, average scores clustered by domains, items ordered by highest well-being (2) to lowest well-being (0), Kenya

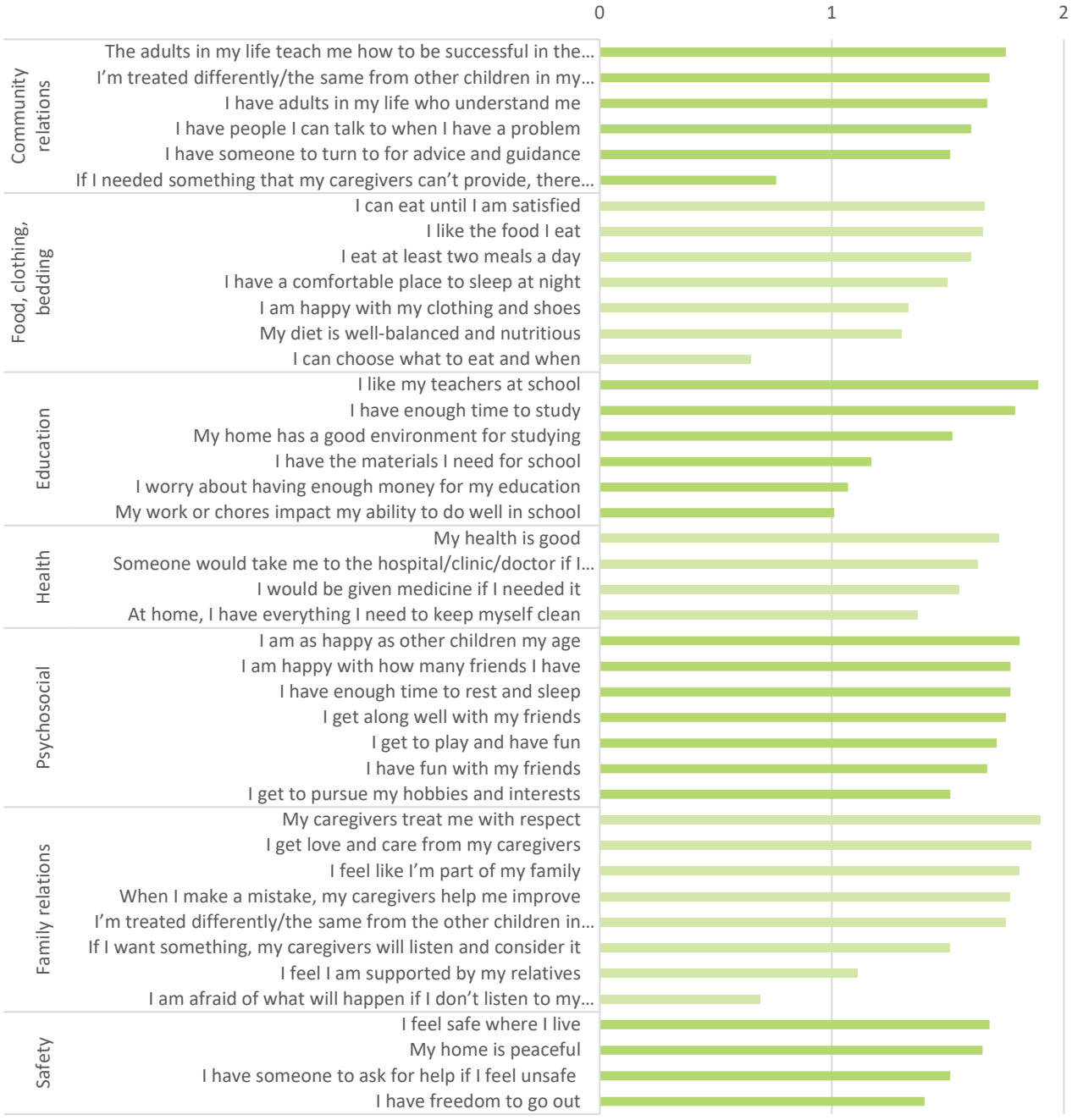


Table 41. Child-informed well-being tool, items ordered from highest well-being (2) to lowest well-being (0), Kenya[40]

	MEAN	*SD*	*N*
My parents/caregivers treat me with respect	1.90	0.34	141
I like my teachers at school[41]	1.89	0.31	138
I get love and care from my parents/caregivers	1.86	0.41	141
I feel like I'm part of my family	1.81	0.44	142
I am as happy as other kids my age	1.81	0.48	142
I have enough time to study	1.79	0.44	142
I am happy with how many friends I have	1.77	0.42	142
When I make a mistake, my parents/caregivers help me improve	1.77	0.47	142
I have enough time to rest and sleep	1.77	0.46	141
I'm treated differently from the other children in my household[42]	1.75	0.55	142
The adults in my life teach me how to be successful in the future	1.75	0.50	141
I get along well with my friends	1.75	0.47	142
My health is good	1.72	0.51	142
I get to play and have fun	1.71	0.49	138
I'm treated differently from other children in my village/neighborhood/compound/community[42]	1.68	0.59	142
I feel safe where I live	1.68	0.57	142
I have fun with my friends	1.67	0.54	141
I have adults in my life who understand me	1.67	0.57	142
I can eat until I am satisfied	1.66	0.50	142
I like the food I eat	1.65	0.54	142
My home is peaceful	1.65	0.60	141
Someone would take me to the hospital/clinic/doctor if I needed it	1.63	0.55	142
I have people I can talk to when I have a problem	1.60	0.65	142
I eat at least two meals a day	1.60	0.52	142
I would be given medicine if I needed it	1.55	0.54	142
My home has a good environment for studying[41]	1.52	0.68	138
I get to pursue my hobbies and interests	1.51	0.66	142
If I want something, my parents/caregivers will listen and consider it	1.51	0.60	142
I have someone to turn to for advice and guidance	1.51	0.73	142
I have someone to ask for help if I feel unsafe	1.51	0.72	142
I have a comfortable place to sleep at night	1.50	0.76	142
I have freedom to go out	1.40	0.73	141
At home, I have everything I need to keep myself clean	1.37	0.58	142
I am happy with my clothing and shoes	1.33	0.68	142
My diet is well-balanced and nutritious	1.30	0.65	142
I have the materials I need for school[41]	1.17	0.59	138
I feel I am supported by my relatives	1.11	0.76	142
I worry about having enough money for my education[41]	1.07	0.71	138
My work or chores impact my ability to do well in school[41]	1.01	0.88	138
If I needed something that my parents/caregivers can't provide, there are others who would help	0.76	0.72	142
I am afraid of what will happen if I don't listen to my parents/caregivers[42]	0.69	0.69	142
I can choose what to eat and when	0.65	0.69	142

[40] Due to an error, in Kenya, data were not collected for the item, "I'm happy with how much time I get to spend with my family."

[41] These items were only presented to children enrolled in school.

[42] These items were reverse coded so the scores were comparable with "positively-worded" items. (2=None of the time, 1=Some of the time, 0=All of the time.)

Table 42. Overall life satisfaction results for all children, Kenya (scale of 0-10, with 10 representing maximum satisfaction)

	KENYA			KISUMU			NYAMIRA			KILIFI		
	MEAN	***SD***	***N***	***MEAN***	***SD***	***N***	***MEAN***	***SD***	***N***	***MEAN***	***SD***	***N***
Overall life satisfaction – at time of survey	7.53	2.25	140	7.32	2.32	71	7.08	2.29	13	7.89	2.14	56

Well-being of reunified children

Some questions were asked specifically to children who had lived in residential care (126 children). These children were asked to think back to when they lived in residential care, which was, on average, about a year and a half prior, and rate their OLS at that time, using the same 10-point scale as above, where 10 represented greatest satisfaction. The mean score was 7.51 (SD: 2.45, min: 1, max: 10) (Figure 23, Table 43).

We calculated the difference between the OLS score at the time of the survey amongst reunified children and the OLS the same children recalled from their time in residential care. Children in Kenya were, on average, only 0.07 points more satisfied with life now, compared to when they lived in residential care, a negligible amount in the context of the 10-point scale.

The change in life satisfaction scores were significantly different between children with and without disabilities. On average, the life satisfaction of children with disabilities decreased, while it increased for children without disabilities (with disabilities=-1.81, without disabilities=0.39, $p<.05$). There was also a significant difference between orphaned children (those who had lost one or both parents) and non-orphaned children; non-orphaned children's OLS decreased, while orphaned children's increased (non-orphan=-1.26, orphan=0.59, $p<.01$). There were no significant differences by child gender, parental care status, or whether the child lived with any non-relative adult. Change in life satisfaction was also not correlated with child age, years in care, age at reunification, or age at entrance to care.

Reunified children also responded to a measure about family and community acceptance. The average family acceptance score in Kenya was 1.88 on a scale of 0–2 (with 2 representing higher acceptance), and the average community acceptance score was 1.63 (Table 44).

Orphaned children (single and double orphans) had greater community and family acceptance compared to non-orphans (non-orphan=1.74, orphan=1.92, $p<.01$). Community and family acceptance did not differ by child gender, disability status, parental status, or whether they lived with a non-relative adult. Community and family acceptance were also not correlated with child age, years in care, age at reunification, or age at entrance to care.

Community acceptance scores varied significantly by county; children in Kisumu had lower community acceptance scores than children in other counties (Kisumu=1.46, Nyamira=1.78, Kilifi=1.76, $p<.001$). Children in different counties had more or less the same family acceptance scores, however.

Figure 23. Overall life satisfaction results for reunified children, Kenya

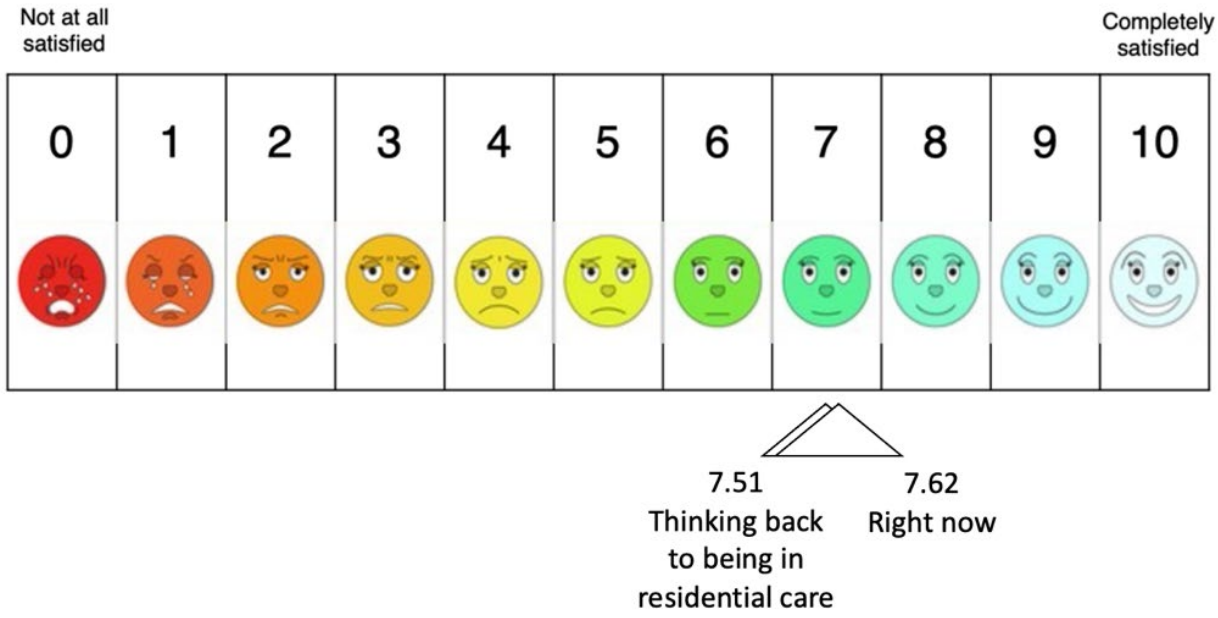


Table 43. Overall life satisfaction results for reunified children, Kenya

	KENYA			KISUMU			NYAMIRA			KILIFI		
	MEAN	*SD*	*N*	*MEAN*	*SD*	*N*	*MEAN*	*SD*	*N*	*MEAN*	*SD*	*N*
Overall life satisfaction – at time of survey	7.62	2.30	124	7.39	2.47	57	7.17	2.37	12	7.96	2.09	55
Overall life satisfaction – in residential care	7.51	2.45	124	7.75	2.44	55	6.17	2.79	12	7.56	2.35	57
Overall life satisfaction – change from care to now[43]	+0.07	3.15	122	-0.38	3.17	55	+1.00	3.91	12	+0.33	2.93	55

[43] Two children did not answer the question about OLS at the time of survey, and two other children did not answer the question about OLS in care. The mean change in OLS score only includes children who answered both questions. Thus, the mean change score is slightly different from the difference of the mean OLS at the time of survey minus the mean OLS in care.

Table 44. Family and community acceptance for reunified children, Kenya (scale of 0–2, with 2 representing greater acceptance)

	KENYA			KISUMU			NYAMIRA			KILIFI		
	MEAN	***SD***	***N***	***MEAN***	***SD***	***N***	***MEAN***	***SD***	***N***	***MEAN***	***SD***	***N***
Family acceptance score	1.88	0.28	124	1.87	0.32	54	1.89	0.27	12	1.87	0.24	57
Community acceptance score	1.63	0.44	124	1.46	0.46	54	1.78	0.30	12	1.76	0.39	57

Relationships between caregiver protective factors and child well-being

The following analyses examine the research question about whether caregiver protective factors were related to child well-being. Table 45 presents correlation coefficients between different variables, and statistically significant correlations are denoted by an asterisk.

Among all children aged 11 and above, overall well-being (the average on the child-informed well-being tool) was significantly correlated with almost every measure of protective factors. In addition, children's overall life satisfaction at the time of the survey was correlated with parental resilience, social and emotional competency of children, and positive parenting. Among reunified children aged 11 and above, some of the PAPF measures were correlated with a greater positive change in OLS from when they were living in residential care to the time of the survey. Positive parenting was also significantly correlated with higher family acceptance, and many of the PAPF scores were correlated with higher community acceptance. These findings reinforce the importance of looking at protective factors within family strengthening interventions.

Table 45. Pearson's r correlations between caregiver protective factors and child well-being measures for children 11 and above, Kenya

		ALL CHILDREN AGES 11+		REUNIFIED CHILDREN 11+		
		OVERALL WELL-BEING	***CURRENT OLS***	***CHANGE IN OLS***	***FAMILY ACCEPTANCE***	***COMMUNITY ACCEPTANCE***
Caregiving protective factors	Resilience	.39***	.20*	.18*	.17	.22*
	Social connections	.21*	.07	.19*	.07	.23**
	Concrete assistance	.13	.0009	-.003	.11	.04
	Social and emotional	.30***	.20*	.18*	.25**	.06
	Overall PFI	.29***	.12	.17	.17	.19*
Parenting practices	Positive parenting	.25**	.23**	.14	.25**	.03
	Parental involvement	.14	.09	.05	.10	-.12
Economic stability	Household Hunger Score	-.30***	-.14	-.006	-.04	-.06
	Ability to obtain funds in emergency	.21*	.15	.008	.003	.02
	Worried about money	.03	.03	.05	.05	.05

*Note: Correlations significant at the level of *p<.05, **p<.01, ***p<.001.*

Results: Guatemala

Participant characteristics

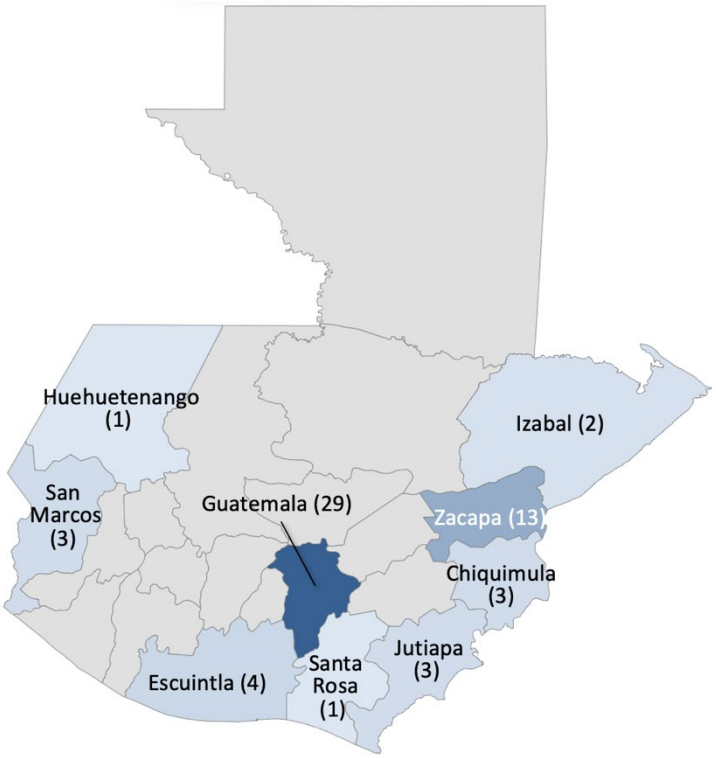
Regions

There were 59 households that participated in the survey. In Guatemala, about half of the households were in the department of Guatemala and a further 22% in the demonstration area of Zacapa (Table 46).

Table 46. Number of participating households per department, Guatemala

Department	*N*	*%*
Guatemala	29	49.2%
Zacapa	13	22.0%
Escuintla	4	6.8%
Chiquimula	3	5.1%
Jutiapa	3	5.1%
San Marcos	3	5.1%
Izabal	2	3.4%
Huehuetenango	1	1.7%
Santa Rosa	1	1.7%
Total	**59**	**100%**

Figure 24. Map of department locations and numbers of participating households, Guatemala



Household characteristics

In the Guatemala sample, 88% of the 59 households included a child who was reintegrating from residential care, while the other 12% were receiving services to prevent family separation. Within the sample, 57.6% of households were urban and 42.4% were rural.

The mean number of children per household in Guatemala was 3.4 (SD: 1.5, min: 1, max: 6) (Figure 25) and the mean number of adults was 2.7 (SD: 1.3, min: 1, max: 8) It was most common for households to have two adults (42.3%) (Figure 26).

Figure 25. No. of children per household, Guatemala

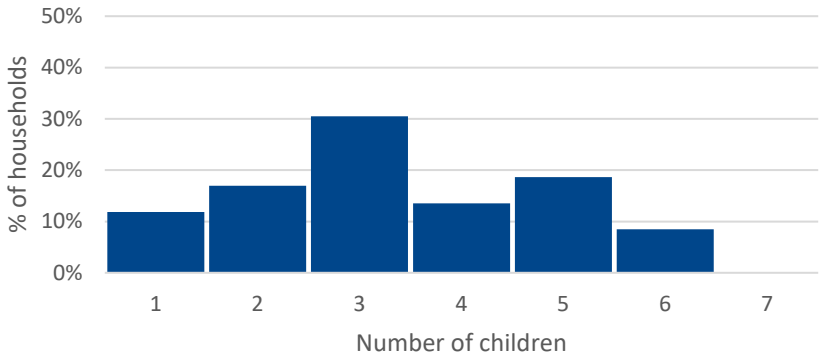
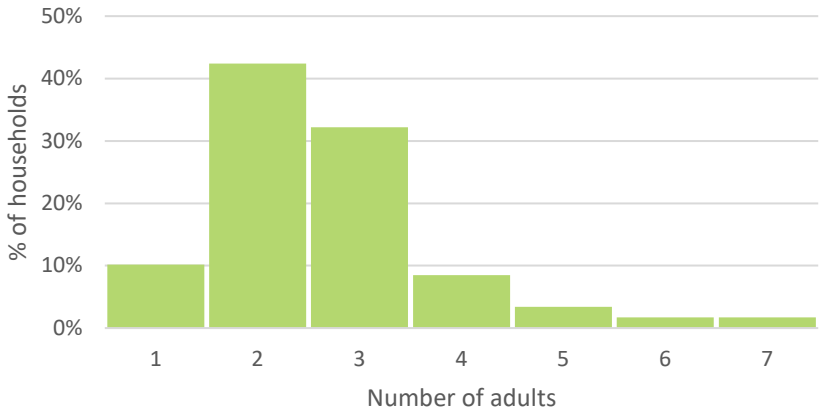


Figure 26. No. of adults per household, Guatemala



Caregiver demographics

Almost all (90%) of the 59 caregiver respondents in Guatemala were female. The mean age of the caregiver respondent was 40.9 years (SD: 11.3, min: 22, max: 78) (Figure 27). It was most common for the primary caregiver to be married (67.8%) (Table 47). Most caregivers (66.1%) had less than a primary education (Table 48).

In Guatemala, 15.2% of caregivers had a disability (Table 49). The difficulties they had were most commonly in cognition (5 caregivers), followed by vision (3), mobility (3), hearing (1), and communication (1), while none had functional difficulties with self-care. (Caregivers could have difficulties in more than one domain.)

Figure 27. Caregiver age, Guatemala (n=59)

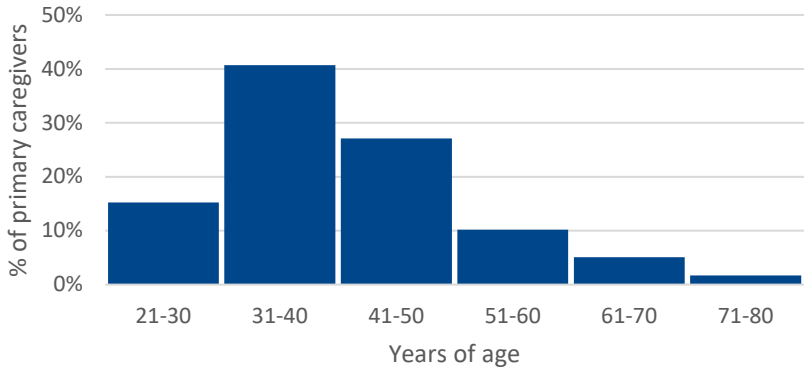


Table 47. Primary caregiver marital status, Guatemala

	N	*%*
Married/living together as if married	40	67.8%
Single/never married	8	13.6%
Widowed	7	11.9%
Divorced/separated	4	6.8%
Total	**59**	**100%**

Table 48. Primary caregiver education level, Guatemala

	N	*%*
Less than primary	39	66.1%
Primary	15	25.4%
Secondary	4	6.8%
Higher than secondary	1	1.7%
Total	**59**	**100%**

Table 49. Primary caregiver disability status, Guatemala

	N	*%*
Disability	9	15.2%
No disability	50	84.8%
Total	**59**	**100%**

Child demographics

The survey collected information about all of the children identified as receiving case management with support from CTWWC (n=107 children). The information in this section was provided by the primary caregiver. In Guatemala, 77 (72.0%) children had been reunified after living in residential care, while 30 (28.0%) children were receiving services to prevent family separation. About half (51.4%) of the children were female and the mean age of children was 10.7 years (SD: 5.3, min: 1, max: 18) (Figure 28). According to their caregivers' answers on the WG/UNICEF CFM, about 17.6% of children in Guatemala had a disability (Table 50). In Guatemala, the most common domains in which children had functional difficulties were behavior (8 children), followed by learning (5), anxiety (5), remembering

(4), making friends (4), depression (4), and finally, concentrating (3), accepting change (3), and communication (3). (It was possible for children to have difficulties in more than one domain.)

Figure 28. Child age, Guatemala (n=107 children)

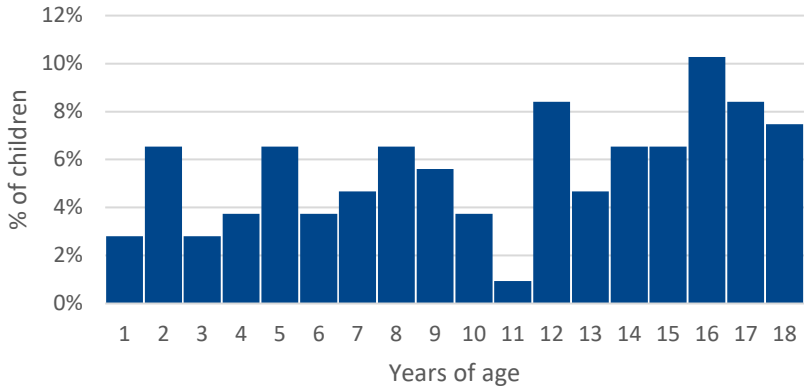


Table 50. Child disability status, Guatemala

	N	***%***
Disability	18	17.6%
No disability	84	82.4%
Total	**102**	**100%**

Note: For seven children, caregivers skipped one or more disability questions.

Child's relationship to the household

The primary caregiver (who was responding to the survey) was most frequently the child's biological mother (true of 75.7% of children) (Table 51). About 40% of children lived with only their mother, while about a third (37.4%) of the children were living with both of their biological parents (Figure 29). While it was common for children to live with at least one biological sibling (74.8%), many also lived with other children (Table 52). In Guatemala, 25.2% of children were living with a half-sibling, and 10.3% lived with a cousin. In addition, 21 (19.6%) children were living with an adult who was not related to them by blood. These often included a step-parent or caregiver's romantic partner—true of 15.0% of children. Most children (82.5%) were not orphaned, while 17.5% of children were a single orphan (Figure 30). However, not all of the children's orphanhood status was known because in some cases the respondent did not know whether or not a child's parents were alive. The father's status was unknown for four children in Guatemala.

If a child's parent was alive, but they did not live with them, the respondent was asked about the child's frequency of contact with the parent. In Guatemala, 16 children did not live with their living biological mother; in six cases (37.5%) they never had contact with their mother, and in three cases (18.8%) they talked to her almost every day or every day. There were 44 children not living with their living father; 25 (56.8%) of these children never had contact with him, and five (11.4%) talked to him every day or almost every day.

Table 51. Relationship between child and their primary caregiver, Guatemala

	N	*%*
Biological mother	81	75.7%
Biological father	4	3.7%
Grandparent	7	6.5%
Aunt/Uncle	9	8.4%
Sibling	2	1.9%
Other relative	4	3.7%
Non-relative foster parent	0	0%
Step-parent/romantic partner of biological parent	0	0%
Other non-relative	0	0%
Total	**107**	**100%**

Figure 29. Child's parental care status, Guatemala

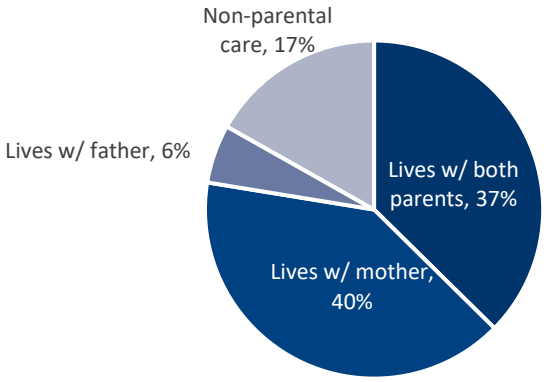
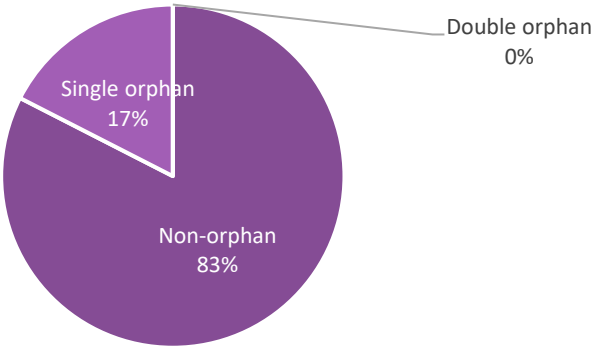


Table 52. Frequency of living with different types of children in their household, Guatemala

	N	*%*
Biological sibling (same parents)	80	74.8%
Half-sibling (one parent the same)	27	25.2%
Cousin (children of a relative)	11	10.3%
Other relative child	13	12.1%
Unrelated children	3	2.8%
Total	**107**	

Note: Children could live with more than one type of adult.

Figure 30. Child's orphanhood status, if it was known whether or not parents were living, Guatemala



Care histories of reunified children

For children who were reunified after living in residential care (n=77 children), the primary caregiver also gave information about their care histories. The caregiver was asked how old the child was the first time they entered the residential care institution, as well as how old they were when they most recently came to live with them permanently. The mean age at which children entered care was 9.5 years old (SD: 5.3, min: 0, max: 17) (Figure 31), and the mean age of reunification was 10.5 years old (SD: 5.3, min: 0, max: 18) (Figure 32). There is a noticeable number of 16-year-olds amongst the children in the sample. This is likely due to referrals during COVID-19 from SBS to CTWWC of several adolescent cases where CTWWC undertook the family assessment and case plan preparation with SBS providing follow-up support. Taking the difference of these two ages, roughly speaking, children in Guatemala spent 1.0 years in care, on average, with 55% spending less than one year in care, although one child spent 11 years in care (SD: 2.1, min: 0, max: 11) (Figure 33).

Among reunified children, 40.3% lived with someone other than their current primary caregiver before they entered residential care. Children lived in a variety of settings before entering residential care, including with their biological parents (77.9% of reunified children) and other relatives' homes (18.2%) (Table 53). Of the reunified children, 40.3% lived with a sibling in residential care. Out of these, 28 (90.3%) were reintegrated along with a sibling.

When asked if the child was in contact from anyone from their residential care institution, most caregivers in Guatemala (70.3%) said the child was not. For those remaining children who were in touch with someone, it was most often a social worker/case worker (Table 54).

Finally, we sought to determine whether children moved in and out of care during the period of time they were in residential care. The caregiver was presented with the following question:

"Think back to the whole period of time [child] lived in the residential care institution (between ages [age of entrance] to [age of reunification]). Did [child] ever leave the residential care institution to live with you or another family member, but then return to the residential care institution again?"

Almost all (91.9%) of respondents in Guatemala said no (Table 55). As a follow up, the respondents who reported any movement in and out of care were asked if this movement happened due to the COVID-19 pandemic. All six said no.

Figure 31. Reunified children's age at entrance to care, Guatemala (n=77)

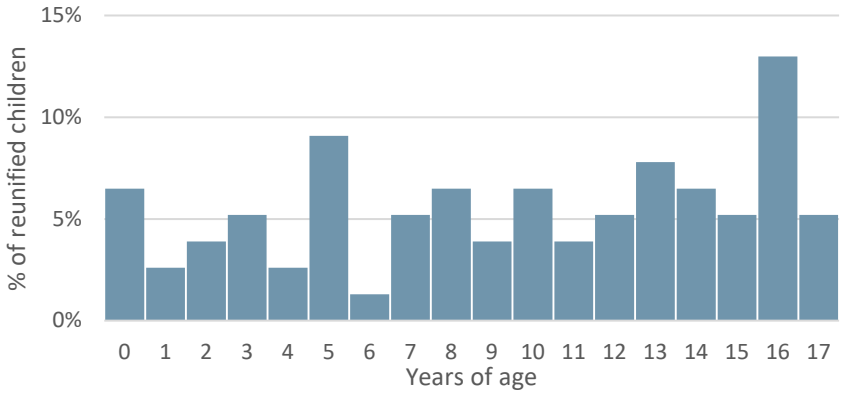


Figure 32. Reunified children's age at reunification, Guatemala (n=77)

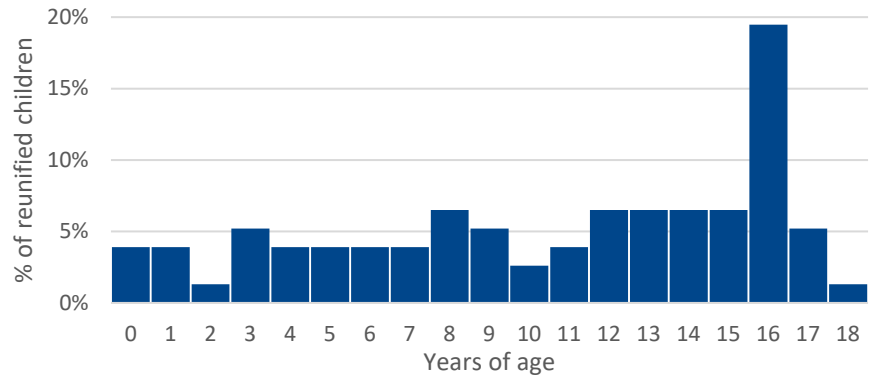


Figure 33. Reunified children's approximate years in care, Guatemala (n=77)

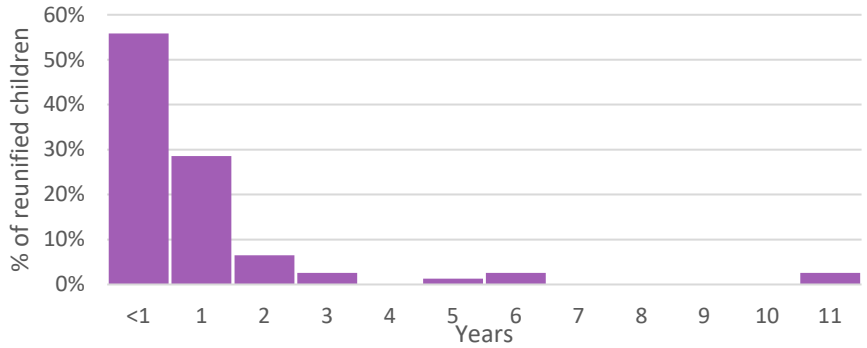


Table 53. Who reunified children lived with prior to entering residential care, Guatemala

	N	***%***
Biological parents' home	60	77.9%
Other relatives' home	14	18.2%
Non-relatives' home	3	3.9%
Another institution	5	6.5%
Other	4	5.2%
Denominator	**77**	

Note: Children could live in more than one type of place.

Table 54. Children's current contact with individuals from their residential care institution, Guatemala

	N	*%*
Not in contact with individuals from residential care institution	52	71.2%
In contact with houseparent/social worker/case worker	19	26.0%
In contact with other children	2	2.7%
In contact with director	1	1.4%
In contact with volunteer	0	0%
In contact with supporter	0	0%
In contact with other individual	0	0%
Denominator	**73**	

Note: Children could be in contact with more than one type of individual. Four respondents in Guatemala did not know.

Table 55. How often children moved between residential care and family/current placement, Guatemala

	N	*%*
Never	68	91.9%
Once a month or more	0	0.0%
A few times per year	1	1.4%
About once a year	2	2.7%
Less than once a year	3	4.1%
Total	**74**	**100%**

Note: Three respondents in Guatemala did not know.

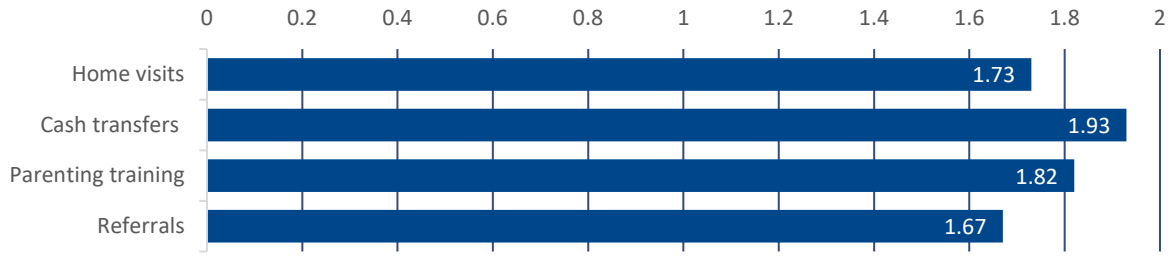
Family strengthening support

All caregivers (n=59) were asked if they received any of the following family strengthening support from CTWWC. If the caregiver reported that they received a service, they were also asked to rate how helpful the service was for taking care of their children. A score of 0 corresponded to "didn't help at all," 1 meant "helped a little," and 2 meant "helped a lot." Over 80% of caregivers reported receiving home visits, and two-thirds reported receiving cash transfers and parenting training (Table 56). Only 1 in 10 reported receiving referrals to other services. It is possible that the question about whether caregivers had received certain services from CTWWC was confusing since CTWWC worked very closely with SBS on some cases. Caregivers rated all services as helpful (Figure 34), with cash transfers seen as the most helpful service and parenting training as the second most helpful.

Table 56. Caregivers' reported receipt of family strengthening support services, Guatemala

	N	*%*
Home visit from a case worker, involvement in case planning to set goals for the family/child, counselling and guidance	48	81.4%
Cash transfers	40	67.8%
Parenting training, either within home visits or as part of a group	39	66.1%
Referrals to other services providers (such health care, microfinance, disability support, etc.)	6	10.2%

Figure 34. Caregivers' average rating of the helpfulness of family strengthening support, Guatemala (scale 0-2, with 2 representing most helpful)



Caregiver protective factors

Protective factors examined in the household survey included caregiving protective factors, parenting practices, and economic stability.

Figure 35. PAPF definitions

Parental resilience: Managing stress and functioning well when faced with challenges, adversity, and trauma.

Social support and connections: Positive relationships that provide emotional, informational, instrumental, and spiritual support.

Access to concrete support in times of need: Access to concrete support and services that address a family's needs and help minimize stress caused by challenges.

Social and emotional competence of children: Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships.

Caregiver protective factors

The mean scores in Guatemala on the PAPF measure are presented in Table 57. Although there are no set cut offs that indicate whether a score should be considered high, medium, or low, higher scores indicate more protective factors as a baseline to measure changes over time in future surveys. These results should only be interpreted in relation to other variables (e.g., looking at differences in PAPF scores between groups). The text of each of the survey questions that make up these scales are included in the appendix on page 106.

In Guatemala, female caregivers had statistically significantly higher scores on all parental protective factor subscales than male caregivers, including on parental resilience (female=3.69, male=2.94, p<.001), social connections (female=3.43, male=2.61, p<.01), concrete assistance in times of need (female=3.52, male=2.87, p<.01), social and emotional competency of children (female=3.51, male=2.80, p<.01), and the overall PFI (female=3.54, male=2.81, p<.01).

There were no significant differences on these scores between groups by caregiver disability status, widow status, urban/rural household, and whether the household had reunified or at-risk children. There were no significant correlations between PAPF scores and caregiver age, education level, number of adults in the household, or number of children in the household.

Table 57. PAPF scores (scale of 0–4 with 4 representing greater protective factors)

	MEAN	*SD*	*N*
Parental resilience	3.61	0.52	59
Social connections	3.34	0.71	59
Concrete assistance in times of need	3.45	0.57	59
Social and emotional competency of children	3.44	0.65	56
Overall Protective Factors Index (PFI)	3.47	0.54	59

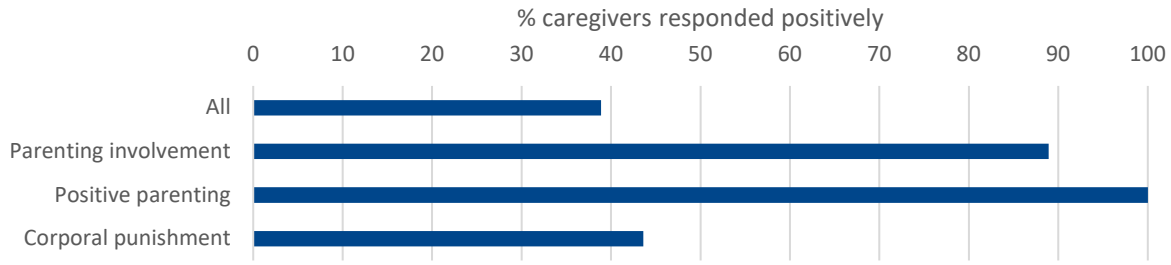
Parenting practices

In Guatemala, 39% of caregivers met the criteria for "practicing positive parenting."[44] This is a key outcome indicator in CTWWC's monitoring plan. Since the parenting training was a relatively new and still evolving intervention in Guatemala at the time of the survey, this result can be seen as baseline against which future measures can be compared.

Table 58. Indicator table for CTWWC Outcome 8: Positive parenting, Guatemala

Percentage of caregivers who completed training in positive parenting who are subsequently assessed as practicing positive parenting skills	N	%
Guatemala	36	39%
Household type: At-risk	5	40%
Reintegrating	31	39%
Sex: Male	5	20%
Female	31	42%

Figure 36. Composite results for indicator Outcome 8: Positive parenting, Guatemala



Note: Positive responses to all questions asked in subscales (e.g., always or often for parental involvement and positive parenting subscales, and never for slap or hit, never or almost never for spank for corporal punishment questions).

The average scores on the parental involvement and positive parenting subscales of the APQ are presented in Table 59 below as a baseline, though they should only be interpreted in relation to other variables (e.g., looking at differences in scores between groups or changes over time for future surveys). Although there are no set cut offs that indicate whether a score should be considered high, medium, or low, higher scores represented more parental involvement and more positive parenting. The items these scales consist of are included in the appendix on page 107.

The more adults that lived in the household, the higher the caregivers' positive parenting scores (r=.29, p<.05), but there was no correlation with parental involvement. There were no correlations between parental involvement or positive parenting and caregiver age, education level, and number of children in the household. Widows also had better parental involvement scores than non-widows (non-widows=20.0, widows=13.0, p<.01), but they did not differ on positive parenting. There were no

[44] In order to be assessed as "practicing positive parenting," a caregiver needed a score of 15+ on Positive Parenting; a score of 15+ on Parental Involvement, if they were eligible for those questions; a "never/almost never" answer on spanking; a "never" answer on slapping the face; and a "never" answer on hitting with object.

differences in APQ scores between caregivers by gender, disability status, urban/rural household status, or whether the household had reunified or at-risk children.

Caregivers were asked how often they used various methods of corporal punishment with their children. The distribution of caregiver answers to these APQ corporal punishment questions are presented in Table 60 and Figure 37 below. The majority of caregivers reported that they never or almost never use corporal punishment. This is likely to be an under-report due to the sensitive nature of this topic.

For these questions, "never" was coded as 0 and "always" as 4, allowing them to be used in bivariate analyses. Correlational analyses showed that the older the caregiver, the less they hit children with an object ($r=-.32$, $p<.05$). There were no correlations between caregiver age, education level, number of adults in the household, or number of children in the household with other corporal punishment variables. Male caregivers hit children with objects more frequently than female caregivers (female=0.36, male=1.50, $p<.01$), but females and males did not differ on the other corporal punishment types. There were no differences in corporal punishment frequency between caregivers by disability status, widow status, urban/rural household status, and whether the household had reunified or at-risk children.

Taken together, these results indicate that caregivers may need continued support in parenting education, especially younger caregivers and male caregivers.

Table 59. APQ parental involvement and positive parenting scores, Guatemala (possible range: 0–24)

	MEAN	*SD*	*N*
Parental involvement	19.57	3.89	49
Positive parenting	21.73	2.13	59

Figure 37. APQ corporal punishment results, Guatemala (possible options: never, almost never, sometimes, always)

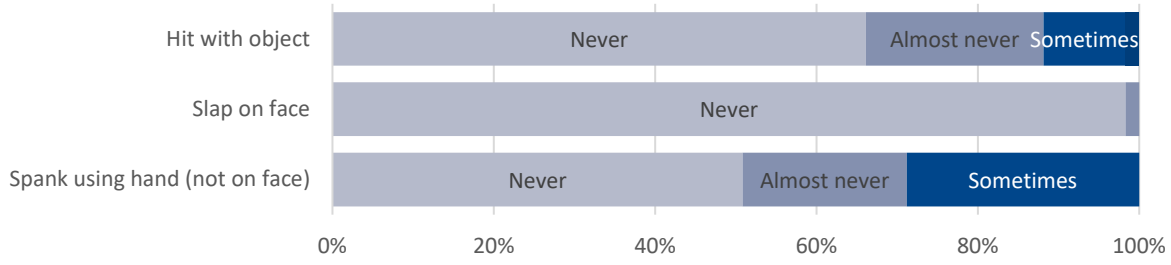


Table 60. APQ corporal punishment results, Guatemala

		N	*%*
Spank children on body with hand	Never	30	50.9%
	Almost never	12	20.3%
	Sometimes	17	28.8%
	Often	0	0%
	Always	0	0%
Slap children on face with hand	Never	58	98.3%
	Almost never	1	1.7%
	Sometimes	0	0%
	Often	0	0%
	Always	0	0%
Hit children with object	Never	39	66.1%
	Almost never	13	22.0%
	Sometimes	6	10.2%
	Often	1	1.7%
	Always	0	0%
	Total	**59**	

Household economic stability

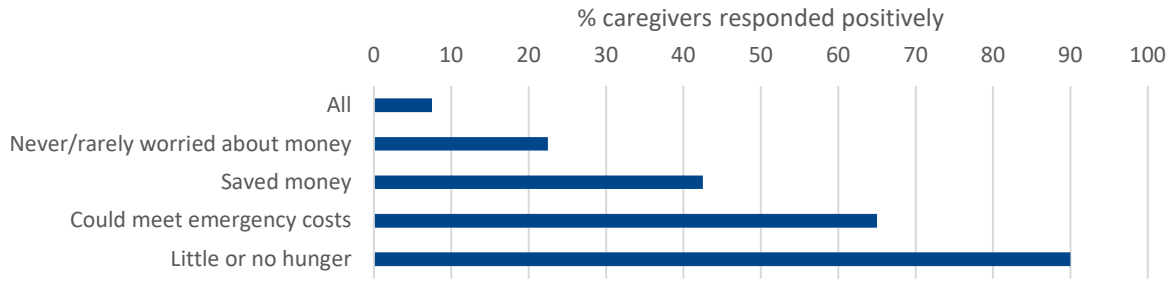
Caregivers were asked a variety of questions to assess their household economic stability. In Guatemala, 8% met the criteria set by CTWWC for being considered economically stable (Table 61).[45] This is a key outcome indicator in CTWWC's monitoring plan. Although this is a low level of economic stability amongst the households being supported, it should be remembered that the main economic strengthening approach was an emergency cash transfer provided to households when COVID-19 protocols first began. It is clear from the above results on family strengthening interventions (page 53) that caregivers found this to be a helpful intervention, likely to have helped them meet the immediate needs of changes in circumstances. These results will provide a useful baseline against which future measurements can be compared as further support is provided to families to build economic stability.

Table 61. Indicator table for Outcome 7: Economic stability

Percentage of caregivers who received economic support who are subsequently assessed as being economically stable	**N**	**%**
Guatemala	40	8%
Household type: At-risk	7	0%
Reintegrating	33	9%
Sex: Male	4	25%
Female	36	6%

[45] In order to be assessed as "economically stable," a caregiver needed: a "never"/"rarely" response on "worried about money"; a "yes" response on "did you save any money"; a "hard"/"easy" response on "If you were facing an emergency"; and a "little to no hunger" score on the HHS.

Figure 38. Composite results for indicator Outcome 7: Economic stability, Guatemala



Note: Positive responses are: "Never" or "rarely" responses to "In the past four weeks how often were you worried about money?"; "Yes" to "Have you managed to save some money within the past month?" (Response Y/N); "It would be hard but we could" or "It would be easy" to "If you were facing an emergency, how difficult would it be for your family to get 7,500 Kenyan shilling?"; and "little to no hunger" score on HHS.

In Guatemala, most households (88.1%) were facing little to no hunger (Table 62). Households with reunified children had less hunger than prevention-only households (at-risk only=1.00, reunified children=0.23, $p<.05$). There were no differences in household hunger scores when comparing caregivers by gender, disability status, widow status, or urban/rural households. Household hunger scores did not correlate significantly with caregiver age, education level, or the number of adults or children in the household.

Only about a quarter (22.0%) of caregivers reported never having worried about money in the last four weeks, while about 70% worried about money sometimes or often (Table 63). Caregivers with a disability worried about money more than caregivers without a disability (disability=2.56, no disability=1.60, $p<.05$). There were no differences on how much they worried about money when comparing caregivers by gender, widow status, urban/rural households, or households with reunified vs. at-risk children. Frequency of worrying about money did not correlate significantly with caregiver age, education level, or the number of adults or children in the household.

Sixty-one percent of caregivers had not managed to save any money in the past month (Table 64). This percentage did not significantly vary by caregivers' gender, disability status, widow status, urban/rural households, households with reunified vs. at-risk children, number of children or adults per household, caregiver education level, or caregiver age.

When asked how difficult it would be to obtain about $70 USD[46] in an emergency, about one third (32.2%) of caregivers said it would be impossible, while half stated that it would be hard, but they could do it (Table 65). Caregivers' answers to this question did not differ significantly when comparing caregivers by gender, disability status, widow status, urban/rural households, or households with reunified vs. at-risk children. Their responses did not correlate significantly with caregiver age, education level, or the number of adults or children in the household.

Caregivers who had at least one child in school were also asked about their ability to pay for expenses related to education, including transport, uniforms, and other fees. Of the caregivers who reported having any education expenses, 86.7% were able to pay them in full, 10.0% were not able to pay but

[46] This survey question was adapted from a question used in South Africa in the Parenting for Lifelong Health evaluation. Since in South Africa the question asked about the equivalent of $70 USD, we used this amount (550 quetzales) in our study as well.

this did not cause children to miss school, and only 3.8% had children who had missed school due to inability to pay (Table 66).

Caregivers were also asked if any of their children had needed health care services and if they were able to pay for them. Out of the 20 caregivers who said their children needed health care, 70.0% were able to pay for it, 15.0% were not able to pay for it, and 15.0% did not seek health care even though their children needed it (Table 67).

Finally, caregivers were asked about unexpected household expenses that were not related to health care and education. Of the 16 who had such an expense, 56.3% were able to afford it (Table 68).

Overall, the findings on economic stability suggest that many caregivers are struggling economically, although they do not face much acute hunger. Most caregivers worry about their economic situation and in some instances, are not seeking health care when children need it. This situation may be worse for caregivers with disabilities, who tended to worry more about money than those without disabilities.

Table 62. Household Hunger Score (HHS), Guatemala

	N	***%***
Little to no hunger	52	88.1%
Moderate hunger	4	6.8%
Severe hunger	1	1.7%
Total	**59**	**100%**

Table 63. How often caregivers worried about money in the past four weeks, Guatemala

	N	***%***
Never	13	22.0%
Rarely	5	8.5%
Sometimes	25	42.4%
Often	16	27.1%
Total	**59**	**100%**

Table 64. Caregivers who had saved any money in the last month, Guatemala

	N	***%***
No	36	61.0%
Yes	23	39.0%
Total	**59**	**100%**

Table 65. Ability to obtain 550 Q ($70 USD) in an emergency, Guatemala

	N	***%***
It would be impossible	19	32.2%
It would be hard but we could	30	50.9%
It would be easy	10	17.0%
Total	**59**	**100%**

Figure 39. Ability to pay for children's education expenses in the past three months, Guatemala

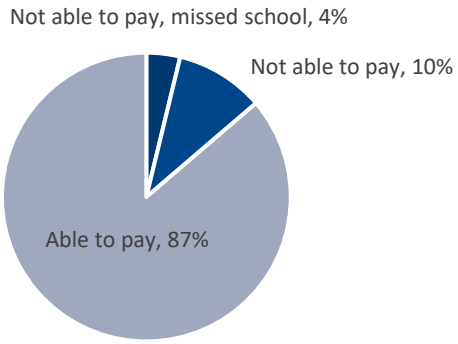


Table 66. Ability to pay for children's education expenses in the past three months, Guatemala

	N	% of total	% of those with an expense to pay
Not able to pay in full, causing children to miss school	1	1.9%	3.8%
Not able to pay in full, but children did not miss school	3	5.6%	10.0%
Expenses fully paid	26	48.2%	86.7%
N/A, no expenses associated with education	24	44.4%	--
Total	**54**	**100%**	**100%**

Note: Five caregivers didn't have children of school age and so were not asked this question.

Figure 40. Ability to pay for children's health care services in the past three months, Guatemala

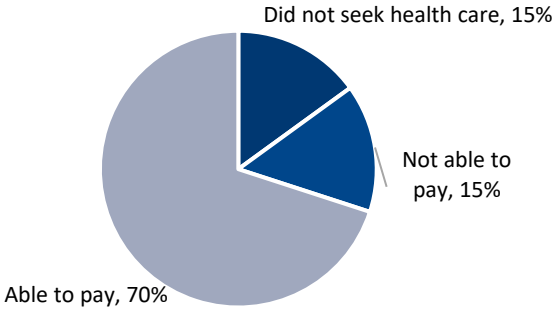


Table 67. Ability to pay for children's health care services in the past three months, Guatemala

	N	% of total	% of those with children who needed healthcare
Children needed health care but did not seek it	3	5.1%	15.0%
Not able to pay	3	5.1%	15.0%
Able to pay	14	23.7%	70.0%
N/A, no children needed health care	39	66.1%	--
Total	**59**	**100%**	**100%**

Figure 41. Ability to pay for unexpected household expenses in the last three months (other than children's health and education), Guatemala

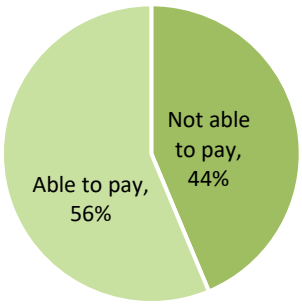


Table 68. Ability to pay for unexpected household expenses in the last three months (other than children's health and education), Guatemala

	N	%	% of those with any unexpected expenses
Not able to pay	7	12.1%	43.7%
Able to pay	9	15.5%	56.3%
N/A, did not have any unexpected household expenses	42	72.4%	--
Total	**58**	**100%**	

Note: One respondent did not know if their unexpected expenses were paid for.

Child well-being

Early childhood education

For children (in case management) aged 2–4, caregivers asked if they were enrolled in any sort of ECE program. Four out of 14 (28.6%) were enrolled in Guatemala.

Caregivers of children aged 2–4 were also asked if anyone over age 15 had engaged in ECE stimulation activities with the child in the past three days. These activities included reading books or looking at picture books, telling stories, singing songs or lullabies, taking the child outside, playing with the child, and naming/counting/drawing things with the child. All of the children in Guatemala had received at least two of these stimulation activities.

Education for children aged 5 and older

Caregivers were asked about school enrollment for children aged 5 and older, and in Guatemala, 80.9% of children were enrolled (17 were not enrolled). The reasons for not being enrolled are listed in Table 69.

For children enrolled in school, caregivers were also asked if the child had been absent for four or more days in the last month. This was true of 12.9% of children in Guatemala (Table 70).

Table 69. Reasons children aged 5+ were not enrolled in school, Guatemala

	N
Child is too young/old[47]	6
Missed registration period	3
Child does not like school	1
No money for school fees, materials, transport	1
School was not in session (for example, due to COVID-19)	1
Problems with documents/identification	1
Parenting	1
Psychological issue	1
Lack of device *(dispositivo)*	1
No nearby kindergarten *(párvulo)*	1
Total	**17**

Table 70. Reasons children missed four or more days of school, Guatemala

	N
Child does not like school	3
No money for school fees, materials, transport	2
Child is too sick to attend school	1
Child needs to care for sick household	1
Is doing classes via correspondence	1
Tired from work	1
Total	**9**

Caregiver-reported well-being for children aged 2–10

In Guatemala, there were 47 children aged 2–10 in case management about whom data was collected. Caregivers were asked to rate children's overall health on a scale of 0 (poor) to 4 (excellent). The average was 2.91 (SD: 1.18, min: 0, max: 4).

Children with functional difficulties had significantly poorer caregiver-rated overall health compared to children without difficulties (no difficulties=3.15, with difficulties=1.33, $p<.001$). At-risk children also had poorer health than reunified children (at-risk=2.26, reunified=3.36, $p<.01$). Children's health did not differ by child gender, parental care status, orphanhood, or whether they lived with a non-relative adult. It was also not correlated with child age, years in care, age at reunification, or age at entrance to care.

Caregivers also answered 11 questions about various domains of their children's well-being (Table 71). These questions were on a scale of 0 to 2, where 2 represents greater well-being. (Specifically, 0 was "none of the time," 1 was "some of the time," and 2 was "all of the time," unless the data were reverse coded, as noted in the footnotes.) Caregivers felt their children were not involved in work or chores in a way that interfered with school or sleep, were treated well at school, were safe and happy, and

[47] Caregivers of all children aged 5–18 were asked if children were enrolled in school. In some cases, parents reported that the child had finished secondary school or were too young to start school.

growing well. There were slightly lower scores around treatment by family and community members and having the material needs to complete school work.

These 11 items were averaged to create an overall well-being score for children aged 2–10, in order to allow comparisons by child characteristics. Children without functional difficulties were rated as having higher well-being than children with functional difficulties (no difficulties=2.07, difficulties=1.56, p<.001). Children's well-being scores did not differ by child gender, parental care status, placement type (at-risk vs. reunified), orphanhood, or whether they lived with a non-relative adult. It was also not correlated with child age, years in care, age at reunification, or age at entrance to care.

Table 71. Well-being questions for children aged 2–10, Guatemala (scale 0–2, with 2 representing greatest well-being)

	MEAN	*SD*	*N*
School[48]			
[Child] likes school	1.78	.52	23
[Child] is treated as well as the other students in the class	1.96	.21	23
[Child] has the materials he/she needs to do class work	1.74	.54	23
Health and safety			
[Child] has enough food to eat	1.93	.25	44
I feel that [child] is growing as well as other kids their age	1.95	.30	44
Work or chores interfere with [child]'s sleep[49,50]	2.00	0	31
Work or chores interfere with [child]'s school[48,49]	2.00	0	23
I feel [child] is safe where we live	1.95	.30	44
Psychosocial			
[Child] seems as happy as other children their age	1.93	.33	44
Our relatives (like uncles, aunts, grandparents) support [child] the same as other children in the family	1.77	.60	44
Community members treat [child] differently than other children[49]	1.70	.70	44

Child-informed child well-being tool for children 11 and older

The following section presents data from the child self-report survey completed by children aged 11 and older.

In Guatemala, 30% of at-risk children and 53% of reintegrated children met the criteria set by CTWWC to be assessed as feeling safe and nurtured in their placement (Table 72).[51] This is a key outcome indicator in CTWWC's monitoring plan. It should be noted that the number of children in families at

[48] These items were for children aged 5–10 enrolled in school.

[49] These items were reverse coded so the scores were comparable with "positively-worded" items. (2=None of the time, 1=Some of the time, 0=All of the time.)

[50] This item was for children aged 5–10.

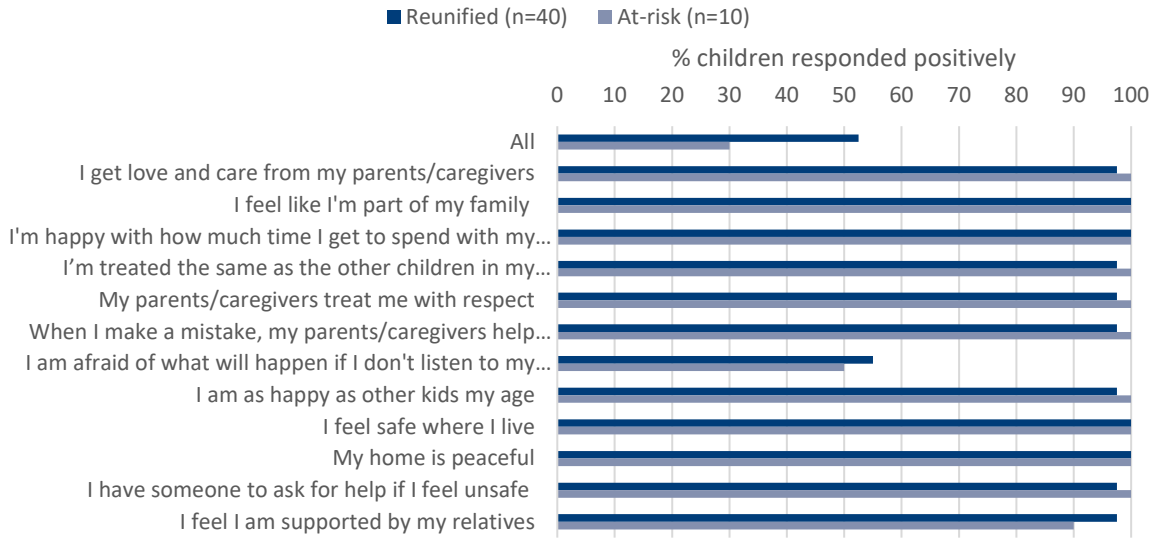
[51] In order to be considered "feeling safe and nurtured" children must have a "none of the time" or "some of the time" response to the statement "I am afraid of what will happen if I don't listen to my parents/caregivers." They must also have an "all of the time" or "some of the time" response to: I feel I am supported by my relatives; I feel like I'm part of my family; I get love and care from my parents/caregivers; I am as happy as other kids my age; I feel safe where I live; My home is peaceful; I have someone to ask for help if I feel unsafe; When I make a mistake, my parents/caregivers help me improve; My parents/caregivers treat me with respect; I am happy with how much time I get to spend with my family; I am treated the same as the other children in my household.

risk of separation aged 11 and older answering the questions used for this result is very small (n=10) and so the disaggregated results should be used with caution.

Table 72. Indicator table for CTWWC Outcomes 3 and 11: Sense of safety and nurture, Guatemala

Percentage of children (aged 11 years and above) who feel safe and nurtured in the family	N	%
Outcome 3: Targeted children at risk of separation from their families	**10**	**30%**
Age: 11–14	5	60%
15–17	4	0%
18+	1	0%
Sex: M	7	29%
F	3	33%
Disability: Disability	3	100%
Not Disability	7	0%
Outcome 11: Children who have been reunified, placed in family-based care, or in independent living	**40**	**53%**
Age: 11–14	15	60%
15–17	20	50%
18+	5	40%
Sex: M	18	61%
F	22	45%
Disability: Disability	5	40%
Not Disability	34	56%

Figure 42. Composite results for indicator Outcome 3 and 11: Sense of safety and nurture, Guatemala



Note: Positive response is a 1 or 2 to each statement on scale of 0 to 2, when 0 represented "none of the time, 1 was "some of the time," and 2 was "all of the time," unless the data were reverse coded. See table below.

Children aged 11–18 answered a child self-report survey, if they were available. Table 73 below shows the results from the contextualized child well-being tool, developed via focus group discussions with young people who have lived in residential care. These questions were on a scale of 0 to 2, where 2

represents greater well-being. (Specifically, 0 was “none of the time,” 1 was “some of the time,” and 2 was “all of the time,” unless the data were reverse coded, as noted in the footnotes.) Most of the items were rated highly, including living conditions (e.g., food, place to sleep, studying environment), being treated with respect, feeling safe, and family relationships (e.g., having time, receiving love and care) and friendships. The only item to score less than 1 on average was “I am afraid of what will happen if I don’t listen to my parents/caregivers” (average score of 0.72).

All of the items in Table 73 were averaged into an overall well-being score, allowing comparisons by child characteristics. However, it was not significantly correlated with child age, and there were no significant group differences (i.e., looking at child gender, disability status, placement type, parental care status, orphanhood status, and whether they lived with a non-relative adult).

Children also rated their OLS on a scale of 0-10, where 10 represented greatest satisfaction. The mean score was 9.22 in Guatemala (SD: 1.68, min: 2, max: 10). Amongst these children aged 11–18, the older the child, the lower was their OLS ($r=-.28$, $p<.05$). There were no significant group differences on this measure (i.e., looking at child gender, disability status, placement type, parental care status, orphanhood status, and whether they lived with a non-relative adult).

Figure 43. Child-informed well-being tool, average scores clustered by domains, items ordered by highest well-being (2) to lowest well-being (0), Guatemala

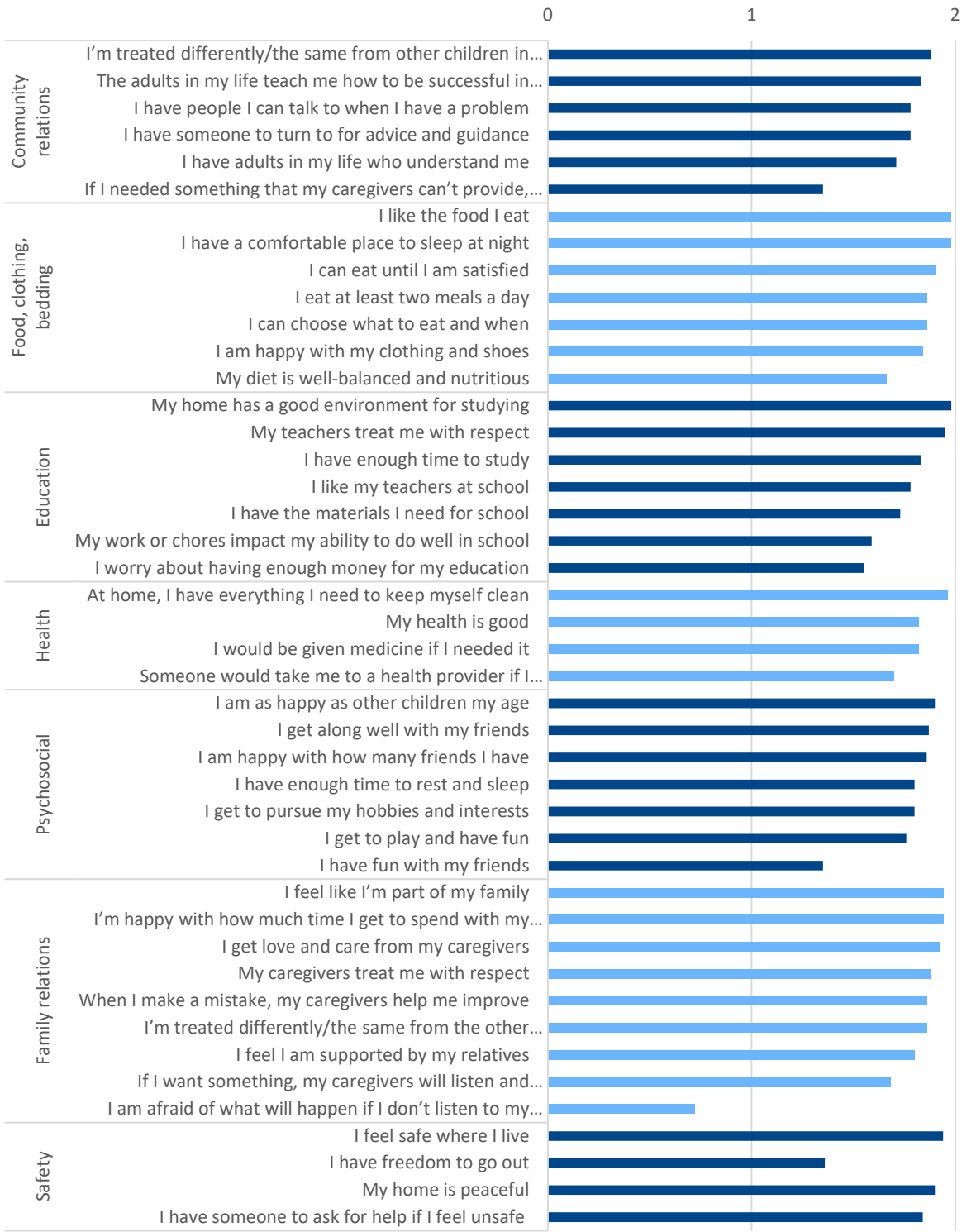


Table 73. Child-informed well-being tool, items ordered from highest well-being (2) to lowest well-being (0), Guatemala

	MEAN	*SD*	*N*
I like the food I eat	1.98	0.14	50
I have a comfortable place to sleep at night	1.98	0.14	50
My home has a good environment for studying[52]	1.98	0.16	41
At home, I have everything I need to keep myself clean	1.96	0.20	50
My teachers treat me with respect[51]	1.95	0.22	41
I feel safe where I live	1.94	0.24	50
I'm happy with how much time I get to spend with my family	1.94	0.24	49
I feel like I'm part of my family	1.94	0.24	49
I get love and care from my parents/caregivers	1.92	0.34	50
I can eat until I am satisfied	1.90	0.30	50
I am as happy as other kids my age	1.90	0.36	50
My home is peaceful	1.90	0.30	50
My parents/caregivers treat me with respect	1.88	0.39	50
I'm treated the same as other children in my neighborhood/community	1.88	0.39	49
I get along well with my friends	1.87	0.40	46
I eat at least two meals a day	1.86	0.40	50
I can choose what to eat and when	1.86	0.35	50
I'm treated the same as the other children in my household[53]	1.86	0.45	50
When I make a mistake, my parents/caregivers help me improve	1.86	0.40	50
I am happy with how many friends I have	1.86	0.35	49
I am happy with my clothing and shoes	1.84	0.37	50
I have someone to ask for help if I feel unsafe	1.84	0.47	50
The adults in my life teach me how to be successful in the future	1.83	0.48	48
I have enough time to study	1.83	0.38	40
My health is good	1.82	0.39	50
I would be given medicine if I needed it	1.82	0.39	50
I have enough time to rest and sleep	1.80	0.45	50
I get to pursue my hobbies and interests	1.80	0.45	50
I feel I am supported by my relatives	1.80	0.49	50
I like my teachers at school[51]	1.78	0.52	41
I have someone to turn to for advice and guidance	1.78	0.58	50
I have people I can talk to when I have a problem	1.78	0.59	49
I get to play and have fun	1.76	0.52	50
I have the materials I need for school[51]	1.73	0.50	41
I have adults in my life who understand me	1.71	0.61	49
Someone would take me to the hospital/clinic/doctor if I needed it	1.70	0.61	50
If I want something, my parents/caregivers will listen and consider it	1.68	0.55	50
My diet is well-balanced and nutritious	1.66	0.60	47
My work or chores impact my ability to do well in school[51,54]	1.59	0.63	41
I worry about having enough money for my education[51,53]	1.55	0.71	42
I have freedom to go out	1.36	0.66	50
I have fun with my friends	1.35	0.73	48
If I needed something that my parents/caregivers can't provide, there are others who would help	1.35	0.80	49
I am afraid of what will happen if I don't listen to my parents/caregivers[53]	0.72	0.76	50

[52] These items were for children enrolled in school.

[53] Although these items were originally written as "I am treated differently from the other children in my household," and used this way in Kenya, Guatemalan research consultants suggested that the negative wording (i.e., "differently") sounded confusing in Spanish, so the item was changed to "I'm treated the same as other children in my household" for Guatemala.

[54] These items were reverse coded so the scores were comparable with "positively-worded" items. (2=None of the time, 1=Some of the time, 0=All of the time.)

Well-being of reunified children

Some questions were specific to children who had lived in residential care. These children were asked to think back to when they lived in residential care and rate their OLS at that time. The difference between the current OLS scores and the OLS in residential care scores are also presented below. Children in Guatemala were, on average, 5.5 points more satisfied with life at the time of the survey, compared to when they lived in residential care, rating life in residential care at only 3.70 on average (Table 74).

This change in life satisfaction score was not significantly correlated with child age, years in care, age at reunification, or age at entrance to care. It also did not differ by child gender, disability status, parental care status, orphanhood status, or whether they lived with a non-relative adult.

Figure 44. OLS results for reunified children, Guatemala (scale of 0–10, with 10 representing maximum satisfaction)

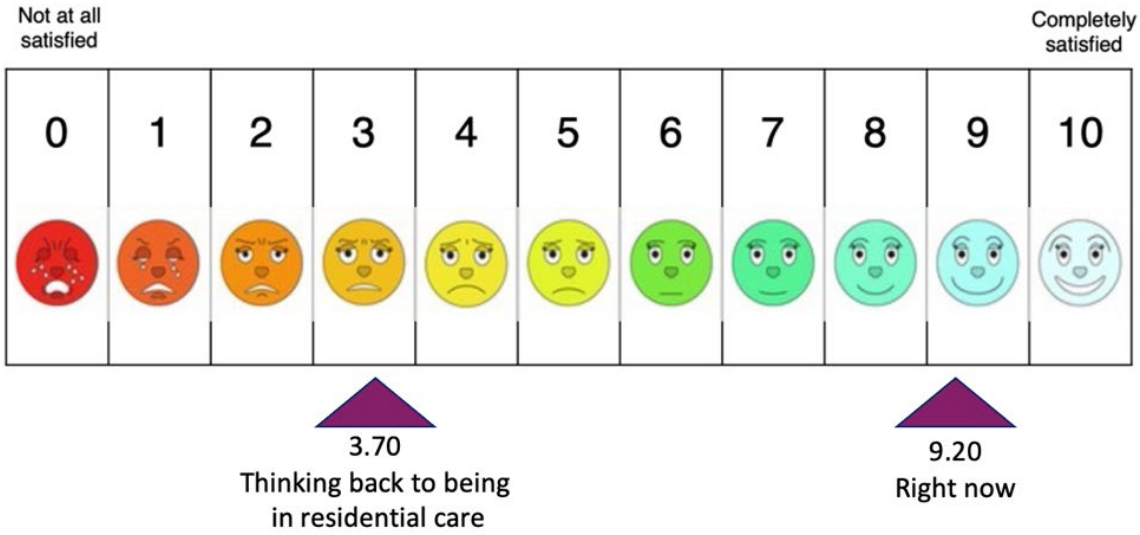


Table 74. OLS results for reunified children, Guatemala (scale of 0–10, with 10 representing maximum satisfaction)

	MEAN	*SD*	*N*
Overall life satisfaction – at time of survey	9.20	1.73	40
Overall life satisfaction – in residential care	3.70	3.22	40
Overall life satisfaction – change from care to time of survey	5.50	3.90	40

Children were also asked questions about family and community acceptance (see question text in the appendix). As a baseline, the average family acceptance score was 1.95, and the average community acceptance score 1.72, on a scale of 0 to 2, where 2 represented greater acceptance (Table 75).

The younger the age at which the child entered into care, the lower their family acceptance score ($r=-.36$, $p<.05$). Relatedly, the more years a child spent in care, the lower their family acceptance score ($r=.33$, $p<.05$). However, these did not correlate with their community acceptance scores. There were no other correlations between family and community acceptance and child age, years in care, age at reunification, and age at entrance to care. In addition, family and community acceptance scores did

not significantly differ by child gender, disability status, placement type, parental care status, orphanhood status, or whether they lived with a non-relative adult.

Table 75. Family and community acceptance for reunified children, Guatemala (scale of 0–2, with 2 representing greater acceptance)

	MEAN	*SD*	*N*
Family acceptance score	1.95	0.17	39
Community acceptance score	1.72	0.39	40

Relationships between caregiver protective factors and child well-being

The following analyses examined the research question about whether caregiver protective factors were related to child well-being. This table presents correlation coefficients between different variables. Statistically significant correlations would be denoted by an asterisk, however, there were no statistically significant correlations, likely due to the sample size being too small to detect relationships between variables if they were not especially strong. As such, we did not draw any conclusions related to these data.

Table 76. Pearson's r correlations between caregiver protective factors and child well-being measures for children aged 11 and above, Guatemala

		ALL CHILDREN AGES 11+		REUNIFIED CHILDREN 11+		
		OVERALL WELL-BEING	*CURRENT OLS*	*CHANGE IN OLS*	*FAMILY ACCEPTANCE*	*COMMUNITY ACCEPTANCE*
Caregiving protective factors	Resilience	.07	.05	.03	-.04	.08
	Social connections	.10	.08	-.0005	-.04	.16
	Concrete assistance	.15	.17	.07	-.14	.19
	Social/emotional	.08	.04	.06	-.02	.10
	Overall PFI	.11	.09	.04	-.06	.14
Parenting practices	Positive parenting	.04	.15	-.03	.10	.06
	Parental involvement	-.08	-.06	.28	.06	-.03
Economic stability	Household Hunger Score	-.05	-.15	-.07	.12	.11
	Ability to obtain funds in emergency	.18	.08	.35	.11	.16
	Worried about money	-.26	-.19	-.23	-.30	-.27

*Note: Correlations significant at the level of *p<.05, **p<.01, ***p<.001.*

Conclusion

This conclusion section presents a summary of the findings for each of the research questions as well as a summary of the characteristics of the caregivers and children who participated.

Participant characteristics

Primary caregivers

The vast majority of **primary caregivers** (the person taking a leading role in caring for children in a family and the contact point for CTWWC's support) are women in both Guatemala and Kenya. In Kenya, around half of these women are the mother of children in their care, another 30% are a grandmother or aunt. Half of the women are also widowed or single and often the only adult in their household. Around a third of caregivers are over 50 years and 18% have a disability. In Guatemala, most caregivers are the mother of the children in their care, are married, and aged between 30 and 50 years. Over 15% of caregivers have a disability. Having predominately female primary caregivers is an important factor to consider when designing approaches for family strengthening. Gender norms—within both families and communities—will affect these caregivers' capacities to provide adequate care.

Children

In Guatemala, the **children** covered by the survey are of all ages, with almost 18% having a disability. Most children have two living biological parents and live in the care of one or both of those parents, 40% with just their mother. It should be noted that 15% of children are living with a non-biological stepparent or romantic partner of their caregiver. In Kenya, children are mostly school-going age, 15% have a disability, and many have lost one or both biological parents. It is important to note that within the Muslim communities in Kenya, the loss of a father is considered to be an orphanhood. Less than 10% of children live with both parents, with over 40% living with just their mother and another 40% living in the care of people who are not their parents. Just over half of reunified children in Guatemala had spent less than a year in residential care, whilst in Kenya the average amount of time in care was 4.5 years.

The characteristics of reunified children who are supported by CTWWC reflects the different nature of the care systems in the two countries as well as the way children are returned to family care. Poverty and the cost of education are push factors for children entering residential care in Kenya. Institutions report providing food, clothing, and shelter, and either provide education directly or cover the costs and provide additional scholastic support.[55] This means children are more likely to enter institutions when they are of school-going age and stay for many years to attend school. In Kenya, tens of thousands of children left residential care rapidly due to a government directive in early 2020 aimed at curbing COVID-19 by closing boarding schools and residential care facilities. Many children returned to residential care when schools opened again a year later. In Guatemala, children enter residential care when they have been removed from their families by court decisions due to concerns about maltreatment and violence.[56] Removal often happens before any intervention or support can be provided to families to address the concerns and prevent the separation, and the systems can lack

[55] Kenya Ministry of Labor and Social Protection, State Department for Social Protection, Department of Children's Services (2020). *Situational Analysis Report for Children's Institutions in Five Counties: Kiambu, Kilifi, Kisumu, Murang'a and Nyamira Summary Report*. Available at: https://bettercarenetwork.org/library/the-continuum-of-care/residential-care/situational-analysis-report-for-childrens-institutions-in-five-counties-kiambu-kilif-i-kisumu-murang

[56] Guatemala Oganismo Judicial and PGN (2019). *Informe Censo de Niños, Niñas y Adolescentes albergados en Hogares Privados de Protección y Abrigo autorizados o en proceso de autorización, realizado en Febrero y Marzo de 2019 a nivel Nacional*.

the capacity and resources to strengthen families and return children. During 2019-2020, CTWWC Guatemala identified children in care where it was possible to address the families' needs and planned and then supported these children to return to family care with government approval.

Family strengthening support

Caregivers participating in the survey, most of whom had been receiving support for one to two years, were asked to consider all types of support they received from CTWWC, and to report how helpful they were as they care for their children. All types of support were rated as being helpful in both countries.

Cash transfers were rated as most useful, followed by parenting training and home visits. In both countries, cash transfers were provided during the COVID-19 pandemic to cover household costs during the initial uncertainty. In Guatemala, the amount per monthly cash transfer, as well as the total number of months per family, was determined by the Economic Opportunities Plan that was developed with each family. Each transfer was made for $67, and each family received approximately six transfers, on average. In Kenya, three installments of $35 were provided, totaling $105; this was done in collaboration with the government of Kenya and UNICEF after large numbers of children suddenly returned to families as described above. In both countries, children had been in their respective families for less than two years. Whilst cash transfers may always be appreciated by families and there are likely to be times, such as these, when cash transfers are appropriate, it is clear from the findings in the next section that on their own, cash transfers are insufficient to address long-term economic stability.

Referrals to other services were positively rated, but not as highly as other support types, and far fewer caregivers report receiving a referral. In Guatemala, examples of referral services are: psychological support, parenting school, health services in cases of malnutrition, and birth certificate access to register in schools, among others. Whilst in Kenya, examples of referrals services include accessing support through the National Hospital Insurance Fund, birth registration, treatment at local health facilities, and registration with the National Council for Persons with Disabilities (this registration is the first step to accessing an array of services tailored to people with disabilities). As is shown in the following sections, community connections and concrete support are important in strengthening families[57] and referrals should play a role in building these connections and supporting caregivers to overcome any barriers they face.

Caregiver Protective factors

In both countries, caregivers reported the presence of **protective factors** in their lives: resilience, social connections, concrete support, and social and emotional competence of children. The relatively large sample size in Kenya allowed further analysis to show that caregivers with a disability reported lower levels of these protective factors than those without disabilities, as did caregivers in urban areas versus those in rural areas, those with less education, and those who are widowed. It is likely that caregivers with a disability face stigma, need specialized services, and have to overcome more barriers in building up these protective factors. Caregivers with less education, those in urban areas, and/orthose who are widows may also find themselves more isolated, facing additional challenges, stigma, or with fewer community support structures around them. For instance, other projects have found that caregivers in urban areas in Kenya and Uganda have struggled with community connections

[57] CTWWC Protective factors framework

due to work commitments, less stability in their living arrangements, and less deeply rooted neighborhood ties than in rural villages where solid familial ties tend to be the norm.[58]

The majority of caregivers report using **positive parenting** practices such as asking their child about their day, helping with homework, praising them, and rewarding good behavior. However, many also still report using some form of corporal punishment. It is likely that the use of corporal punishment is under-reported because of the sensitivity of this topic, with mixed opinions of its appropriateness. Recent work in Kenya on a national parenting curriculum found that faith beliefs may play a role in continued acceptance of corporal punishment. Results from Kenya showed that older caregivers report being less involved with the children they care for and are less likely to use corporal punishment. This needs further exploration but could be linked to a tendency for grandparents to spoil or pamper children and the economic stress faced by younger caregivers (see below). In Guatemala, male caregivers were more likely than female caregivers to use corporal punishment, perhaps linked to gender norms.[59]

The majority of caregivers in both countries were found to lack **economically stability**. In Guatemala, most families do not struggle with the costs of food, education, or health care, however most are still unable to save money or easily meet emergency costs, creating high levels of worry about their financial situation. A small number of caregivers did report struggling economically and need additional immediate support. In Kenya, the combined inability in most households to meet regular or emergency costs and to save is impacting food, education, and health care for a significant number of families.

Given that most families had received a cash transfer from CTWWC, it is clear that on their own, such unconditional cash transfers were insufficient to address economic stability. Cash transfers are designed to help struggling households meet immediate needs and, when provided with conditions, can also address non-economic barriers to improving children's well-being in the short-term.[60] There is evidence that cash transfers in combination with savings and loans groups and financial literacy education can bring about such stability, especially amongst extremely poor households. For instance, the ASPIRES project in Uganda, which addresses similar issues to CTWWC's work in Kenya, found that cash transfers, membership in village savings and loans associations, and training, motivation, and encouragement helped households stabilize and increase income and their ability to meet basic needs.[61] The ASPIRES research however noted that reintegrating households made less improvement than those considered to be at risk of separation, and that the poorest at-risk households still struggled with education costs. Increasing recognition of the importance of "cash plus care" emphasizes the importance of combining cash transfers with one or more types of complementary support, either as an integral element of the cash transfer intervention, such as providing cash alongside additional benefits (e.g., parenting interventions), in-kind transfers (e.g., educational equipment or farming resources), information or social and behavior change communication, or psychosocial support,

[58] Namey, E. & Laumann, L. (2019). ASPIRES Family Care Summary Research Report, available at https://bettercarenetwork.org/library/strengthening-family-care/household-economic-strengthening/aspires-family-care-summary-research-report

[59] See for instance: Lokot, M., Bhatia, A., Kenny, L., Cislaghi, B. (2020). Corporal punishment, discipline and social norms: A systematic review in low- and middle-income countries, *Aggression and Violent Behavior,* 55, https://doi.org/10.1016/j.avb.2020.101507

[60] Roelen, K., Devereux, S., Abdulai, A-G., Martorano, B., Palermo, T., Ragno, L.P. (2017). How to Make 'Cash Plus' Work: Linking Cash Transfers to Services and Sectors, *Innocenti Working Papers* no. 2017-10. Available at: https://www.unicef-irc.org/publications/915-how-to-make-cash-plus-work-linking-cash-transfers-to-services-and-sectors.html/

[61] Namey, E. & Laumann, L. (2019) op cit

and/or as referrals to services provided by other sectors, such as through direct provision of access to services or facilitating linkages to services.[62]

The survey results in both countries showed that caregivers with disabilities face heightened economic instability. These caregivers are likely to be facing more challenges in earning an income and providing for their families. In Kenya, families who are supported by CTWWC because they are at risk of separation and families with more children are more food insecure. Interestingly, in Kenya, older caregivers reported being less worried about money and better prepared for emergencies. This needs to be explored further; it could reflect a greater resilience or a sense of "making do with what they have" that comes with age, or it could link to older caregivers being supported by remittances from other family members working or receiving government case transfers, meaning that the pressure of finding money is not felt in the same way.

Child well-being

Overall, both caregiver- and child-reported child well-being and life satisfaction is positive. Caregivers reported positive well-being of children aged 2–10. In Kenya, relative to other well-being indicators, children in this age group had lower food security and rates of receiving support from others. Young children aged 2–4 years in Kenya, although few in number, are all accessing early childhood education and stimulation, however in Guatemala, only four out of 14 young children are in early childhood education.

Children aged 11 and older, on average, reported their **OLS** to be positive at 7.5 in Kenya and 9.2 in Guatemala, on a scale from 0–10 with 10 being completely satisfied. Importantly, it should be noted that results from Kenya showed that children with disabilities reported lower life satisfaction of 6.5 on the same scale, compared to 7.7 for children without a disability.

Responses to 44 questions, designed with children and asked of children aged 11 and older, were mostly positive across a **range of well-being** areas covering safety, love, family nurture, psychosocial, education, health, community relations, food, and bedding. Notably, in both Guatemala and Kenya, around 50% of children said they were afraid of what will happen if they do not listen to their caregivers. In Kenya, some of the lower rated indicators were on whether they had other people to help them, had a choice of foods, and whether they had education materials. Children also reported household chores impacted their studies.

A composite well-being score based on children's self-reports allowed for deeper bivariate analysis which showed that, in Kenya, children with a disability reported lower well-being than children without a disability and children who had lost one or both parents reported higher well-being than those with two living parents.

Children's perspectives on life in residential care and their acceptance at home

Children (aged 11 years and above) who had returned from residential care were additionally asked to rate their **life satisfaction when they were in care**. In Guatemala, there was a large difference between children's views of their life in care and at home: from 3.7 in care to 9.2 at home (on a scale from 0–10 with 10 being completely satisfied). However, in Kenya there was very little difference in the two results: 7.5 in care and 7.6 at home. In addition, children with a disability showed a negative change (-1.8 on the same scale) between care and home. These results need to be better understood through engagement with the children themselves. However, it is possible that this difference in

[62] Roelen, K., Palermo, T., Prencipe, L. (2018). 'Cash Plus': Linking Cash Transfers to Services and Sectors, *Innocenti Research Briefs* no. 2018-19. Available at: https://www.unicef-irc.org/publications/976-cash-plus-linking-cash-transfers-to-services-and-sectors.html

responses again reflects the difference in the care system and the push factors as mentioned above. In Guatemala, children had, on average, spent less time in care and their reunification was planned and supported, whilst in Kenya, children had often been in residential care to access education and other services and had suddenly returned home during the pandemic, missing out on a year of education. It is also clear that the families in Kenya are facing great struggles financially and in the provision of food.

The same children who had returned to family care were also asked about their sense of **family acceptance and community belonging**. Both factors are known to be important in helping children thrive as they reintegrate.[63] Both were ranked positively, however in both countries, community belonging was ranked lower than family acceptance, on average. In Guatemala, family acceptance was lower for children taken into care at a younger age and those who stayed longer in care. This reflects the findings of other similar studies.[64]

Correlations between protective factors and child wellbeing

The larger sample size in Kenya allowed analysis to flag significant **correlations between protective factors and child well-being**. The results showed that self-reported child well-being is higher when caregivers report higher resilience (e.g., feeling confident they can achieve their goals), greater social connections (e.g., having someone to turn to for support), more positive parenting practices (e.g., praising child when they do something well), and a greater ability to obtain funds in an emergency. This is an important finding that reflects the importance of CTWWC's family strengthening approach which aims to promote protective factors in families in order to keep children safe and in family care.

[63] For example: Betancourt, T.S., Borisova, I.I., Williams, T.P., Brennan, R.T. et al (2010) Sierra Leone's Former Child Soldiers: A Follow-Up Study of Psychosocial Adjustment and Community Reintegration, *Child Development* https://doi.org/10.1111/j.1467-8624.2010.01455.x

[64] van IJzendoorn MH, Bakermans-Kranenburg MJ, Duschinsky R, et al. (2020) Institutionalisation and deinstitutionalisation of children 1: a systematic and integrative review of evidence regarding effects on Development, *Lancet Psychiatry* https://doi.org/10.1016/S2215-0366(19)30399-2

Recommendations

The recommendations presented here are the result of discussions across research teams and with those involved in implementing the household survey and ongoing CTWWC interventions. Firstly, they reflect recommendations for CTWWC's ongoing efforts, which will likely also be useful for all those working on care reform with Guatemala and Kenya and potentially beyond. They are focused on practice; however, they are also relevant for policy makers, donors, and program managers. Secondly, we present recommendations for future household surveys and further research on the topics raised in this report. These are relevant for CTWWC, its implementing agencies and partners, and other actors undertaking learning and research with children and families involved in care reform efforts.

Family strengthening and reintegration practice

Recommendation 1: CTWWC and partners should share the key findings and key messages from caregivers and children with those involved in providing and supporting children's care and family strengthening, such as governments, non-governmental organizations, faith-based supporters, and donors.

These messages include the following, but should be nuanced and contextualized to the audience:

- CTWWC's support to families has been highly appreciated by caregivers in helping them care for their children.
- Approaches, strategies, and interventions that aim to strengthen families should focus on protective factors (e.g., parenting skills, concrete support, and community connection), as this is shown to be positively linked to child well-being, including those aspects identified as important by children themselves, like love and a sense of belonging.
- Reintegration of children in Guatemala should be prioritized, promoted, and supported given the finding that overwhelmingly, children rate their lives in families considerably better than their lives in residential care facilities.
- Although children in Kenya did not rate their life satisfaction very differently between residential and family care, this must be understood within the context of their return home during the COVID-19 pandemic and the push factor of access to education. Children's perspectives must be better understood in order to advocate for their needs.
- Caregivers with disabilities and children with disabilities tend to have weaker protective factors and more vulnerability, as well as face isolation and stigma. We need to do more to prioritize support for them.
- Most primary caregivers are women; many are widowed or single mothers. Support for reunifying children and strengthening families must consider gender norms and dynamics.
- There are a significant number of older caregivers (over 50 years of age) caring for children. Support must consider the strengths and challenges of children's care within an aging caregiver population.
- There is an important opportunity for organizations that have residential care facilities, and who want to reunify children with families and focus on family strengthening, to respond to the CTWWC findings by transitioning to providing new services for families with a focus on children with disabilities, targeted family strengthening, education programs, and early childhood services, which have been shown to be areas of particular need.

Recommendation 2: CTWWC and other care reform actors should consider adaptations to interventions to better support the different groups of caregivers whose particular needs were highlighted in the findings of the survey. These include women, widows, male caregivers, older caregivers, and caregivers with disabilities.

The specific recommendations for these groups are:

- Further support must be provided to **caregivers with disabilities,** considering the individual strengths and needs of these caregivers, children, and their wider families, and including a range of community awareness and behavior change approaches that address the social norms that lead to stigma, exclusion/isolation, and discrimination.
- Program approaches should consider particular challenges of parenting and economic stability facing single **women with children** by connecting family strengthening interventions with access to daycare, early childhood programs, family-friendly work place policies, etc. Here, residential care facilities transitioning to community services should be encouraged to consider transforming to family centers with daycare and other working-parent supports.
- Attention should be paid to the role of **male caregivers**, even if they are not primary caregivers. Activities could include building male champions, parenting programs for male caregivers, etc.
- **Widows and older caregivers** face particular challenges of economic stability, generational divides, and lack of natural family supports. Given the high numbers of old caregivers, widowed or not, program approaches must seek to better understand this population and adapt parenting programs, household economic strengthening and referrals to better address the needs. Case planning may need to include long-term permanency for children.

Recommendation 3: CTWWC and other care reform actors should consider adaptations to interventions in order to not leave any child behind, especially younger children and those with disabilities, when reunifying, developing family-based alternative care, or working to prevent separation.

The recommendations are:

- **Children with disabilities** and their families should be provided with additional resources to ensure that their well-being does not suffer disproportionately compared to other children. This should be combined with community social norms interventions that address issues of disability-related stigma and discrimination, particularly in the context of care reform.
- In Guatemala, **younger children** continue to enter residential care facilities. Early childhood programs, early education, daycare, and early supports and services for families of young children are critically important and should be given focus. At the same time, family-based alternative care such as foster care must continue to be strengthened for those children who cannot remain with their families.
- In Kenya, further investigation should explore why children did not rate their life satisfaction very differently between residential care and family. Likely, rapid reunifications during the COVID-19 pandemic and the push factor of access to education impacted this finding, however, **children's perspectives** must be better understood in order to provide aligned and informed programming.

Recommendation 4: CTWWC and other care reform actors must look at how home-based support, often as part of case management, is serving as a key intervention for families going through a reintegration process (before and after reunification) and those assessed to be at risk of separation and take up constant quality improvement to those services.

Specific recommendations are:

- Caseworkers need to be acutely aware of **children's concerns** about what will happen if they do not listen to their parent/caregiver. These concerns should be included in their planning and monitoring plans, and safe spaces to address these concerns should be created. Fears could be reduced through supporting caregivers and children to develop the skills and language to talk through these issues and find agreed-upon strategies to address their concerns.
- Cash transfers have been helpful, especially during the pandemic. We now need to go further with additional **economic strengthening activities** which promote resilience amongst families at risk of separation and those with a child from residential care. Short-term support (cash transfers and food bundles) should be targeted to those household most likely to struggle to meet their immediate needs (larger households, at-risk households, and those with individuals with disabilities).
- Findings suggest that families continue to struggle to connect to basic and specialized services where they exist. Case management processes must improve around **referrals** so that they lead to access to appropriate concrete support and services for different families (e.g., older caregivers). Increasing case worker and local community awareness of services and how to access them should also be a part of this work.
- **Communities** should be made further aware of the issues children and families are facing and should be encouraged to provide support that can help families remain together. For instance, this could be through community-level awareness raising activities or the use of champions, such as religious leaders, who prompt action within their social groups. A special focus should be given to families in urban areas in Kenya where social structures may be more fluid, and to caregivers with less education, who are widowed, and/or have disabilities, who may find it harder to connect and be supported.
- Children, youth, care leavers, and caregivers must be at the heart of driving **service improvements** and care reform more broadly. This household survey and its findings should be an opportunity to bring light to their voices and experiences.

Future learning and research

Recommendation 5: CTWWC and other care reform actors should implement learning agendas which engage children, young people, and caregivers in participatory and meaningful ways, ideally as co-producers of learning. These efforts should dig further into areas of family strengthening and child and caregiver well-being to learn more about the reasons behind the

Some areas for further learning include:

- There are specific strengths and challenges faced by older caregivers, and across context, there is a lot to learn about the role older kinship caregivers are playing and what family strengthening services are needed, as well as what social behavior change activities best address some of the stigma and isolation facing this population.

- Education plays a significant role in driving children's residential care and their well-being in Kenya. Accessing education is a cost for families that puts them under additional stress, even while they carry high aspirations for their children. This push factor needs to be better understood and specific policy and practice implications outlined for both advocacy and service provision.
- While the court system plays a significant role in children entering residential care in Guatemala, we need to learn more about if and how addressing family breakdown, child abuse, and neglect can reduce court involvement and separation. Research should examine the roles that awareness building, capacity building, and new alternative care models play within this legal system.
- In Kenya, children with disabilities and children who having living parents showed lower life satisfaction after leaving residential care. This finding needs to be better understood in order to inform the type of services and supports that might be needed to support improvements in well-being and a more solid reintegration over time. Case workers, community volunteers, neighbors, and others who interact directly with the families must understand how to help children and closely monitor for well-being declines.

Recommendation 6: CTWWC should repeat this survey in Year 5 of the initiative to enable the analysis of changes in results over time and incorporate adjustments to address weaknesses identified in this initial implementation.

In the next round of the survey, CTWWC should:

- Pay particular attention to the interpretation of measures like the PAPF (caregiving protective factors measures) and APQ (parenting practices), which are not easily interpretable without analyzing them in conjunction with other variables because they do not have cutoffs or benchmarks to suggest which scores are sufficiently high. These scores will become more meaningful when examining trends over time.
- Adjustments to the survey tool could include allowing triangulation of caregiver responses on services received, corporal punishment, and other parenting practices with children's responses on the same topics.

Recommendation 7: Future research studies seeking to understand the well-being of children with experience of care should make further use of the child-informed well-being tool to examine how it performs in other contexts.

In these future efforts, it will also be important to:

- Undertake more focus groups in different settings to continue revising the child-informed well-being tool and strengthening its cross-cultural applicability.
- Use factor analysis to determine the factor structure of the child-informed well-being tool, as the measure currently does not have subscales that can be used in analysis. Having subscales will allow researchers to understand if children have different levels of well-being in different domains of well-being (such as provision of basic needs, support from relatives and peers, stigma and belonging, etc.).
- Use confirmatory factor analysis to see how the PAPF performs in these contexts. To our knowledge, this was the first time the PAPF instrument has been used outside the U.S., so confirmatory factor analysis could lend additional insight to how well the tool functions in a setting like Kenya.

Appendix 1: Bivariate statistics tables

Table 77. Pearson's r correlations coefficients for caregiver protective factors and caregiver/household characteristics – Kenya

	PARENTAL RESILIENCE	SOCIAL CONNECTIONS	CONCRETE ASSISTANCE	SOCIAL/EMOTIONAL	OVERALL PFI
Caregiver age	.02	.04	-.05	.04	.01
Caregiver education	.10	.16*	.23***	-.02	.16**
No. of adults in household	.07	.10	.04	.04	.08
No. of children in household	-.03	-.03	-.03	.02	-.03

Correlations statistically significant at *p<.05, **p<.01, ***p<.001.

Table 78. T-tests comparing caregiver protective factor mean scores by caregiver groups – Kenya

	PARENTAL RESILIENCE	SOCIAL CONNECTIONS	CONCRETE ASSISTANCE	SOCIAL/EMOTIONAL	OVERALL PFI
Caregiver gender					
Female	3.07	2.07	2.52	3.12	2.70
Male	3.23	2.31	2.67	3.21	2.86
Caregiver disability status					
Disability	2.96*	2.01	2.46	3.03	2.62
No disability	3.13*	2.13	2.56	3.16	2.75
Caregiver widow stats					
Non-widows	3.12	2.21*	2.58	3.12	2.76
Widows	3.07	1.98*	2.51	3.15	2.68
Household locale					
Rural	3.10	2.15	2.55	3.18*	2.74
Urban	3.09	2.02	2.55	3.03*	2.67
Household placement type					
Has at-risk children only	3.12	2.13	2.45	3.18	2.68
Has reunified children	3.02	2.05	2.57	3.13	2.74

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.

Table 79. Pearson's r correlations coefficients for parenting practices and caregiver/household characteristics – Kenya

	PARENTAL INVOLVEMENT	POSITIVE PARENTING	FREQ. OF SPANKING	FREQ. OF SLAPPING	FREQ. OF HITTING WITH OBJECT
Caregiver age	-.17**	.01	-.12*	-.16*	-.24***
Caregiver education	.17**	.09	.17**	.17**	.14*
No. of adults in household	-.08	-.03	-.02	-.05	-.02
No. of children in household	-.03	-.02	.11	-.005	.06

Correlations statistically significant at *p<.05, **p<.01, ***p<.001.

Table 80. T-tests comparing parenting practices by caregiver groups – Kenya

	PARENTAL INVOLVEMENT	POSITIVE PARENTING	FREQ. OF SPANKING	FREQ. OF SLAPPING	FREQ. OF HITTING WITH OBJECT
Caregiver gender					
Female	15.5	15.8	0.76	0.42	0.77
Male	15.3	16.1	0.63	0.33	0.76
Caregiver disability status					
Disability	15.0	15.4	0.65	0.31	0.79
No disability	15.6	16.0	0.75	0.42	0.77
Caregiver widow stats					
Non-widows	15.7	16.0	0.68	0.38	0.75
Widows	15.3	15.7	0.81	0.43	0.80
Household locale					
Rural	15.4	15.9	0.69	0.40	0.74
Urban	15.9	15.9	0.84	0.42	0.86
Household placement type					
Has at-risk children only	16.4	15.1	0.74	0.42	0.98
Has reunified children	15.3	16.0	0.73	0.40	0.73

*Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.*

Table 81. Pearson's r correlations coefficients for economic stability outcomes and caregiver/household characteristics – Kenya

	HOUSEHOLD HUNGER SCORE	DEGREE OF WORRY ABOUT MONEY	ABILITY TO OBTAIN FUNDS IN EMERGENCY
Caregiver age	-.08	-.12*	-.14*
Caregiver education	-.07	-.02	.09
No. of adults in household	-.04	-.02	.07
No. of children in household	.15*	-.02	.05

*Correlations statistically significant at *p<.05, **p<.01, ***p<.001.*

Table 82. T-tests comparing economic stability outcomes by caregiver groups – Kenya

	HOUSEHOLD HUNGER SCORE	DEGREE OF WORRY ABOUT MONEY	ABILITY TO OBTAIN FUNDS IN EMERGENCY
Caregiver gender			
Female	1.20	2.38	0.39
Male	0.98	2.43	0.39
Caregiver disability status			
Disability	1.56*	2.48	0.26
No disability	1.07*	2.37	0.42
Caregiver widow stats			
Non-widows	1.10	2.41	0.46*
Widows	1.23	2.37	0.31*
Household locale			
Rural	1.23	2.40	0.39
Urban	0.99	2.37	0.41
Household placement type			
Has at-risk children only	1.81***	2.58	0.28
Has reunified children	1.04***	2.35	0.42

*Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.*

Table 83. Chi-squared tests of significance for distributions of caregivers who had been able to save any money – Kenya

	% WHO SAVED	% WHO DID NOT SAVE
Caregiver gender		
Female	38.7%	61.3%
Male	28.3%	71.7%
Caregiver disability status		
Disability	27.1%	72.9%
No disability	39.1%	60.9%
Caregiver widow status		
Non-widows	42.6%*	57.4%*
Widows	29.6%*	70.4%*
Household locale		
Rural	36.9%	63.1%
Urban	36.8%	63.2%
Household placement type		
Has at-risk children only	18.6%***	81.4%***
Has reunified children	39.8%***	60.2%***

*Chi-squared test statistically significant at *p<.05, **p<.01, ***p<.001.*

Table 84. Chi-squared tests of significance for distributions of caregivers who had been able to save any money – Kenya

	MEAN AMONGST THOSE WHO SAVED	MEAN AMONGST THOSE WHO DID NOT SAVE
Caregiver age	44.02	45.05
Caregiver education^	1.02	0.85
No. of adults in household	2.79	2.58
No. of children in household	3.46	3.87

*Differences between means statistically significant at statistically significant at *p<.05, **p<.01, ***p<.001.*
^ Where 0=Less than primary school completed, 1=Primary school completed, 2=Secondary school completed, 3=higher than secondary school completed.

Table 85. Pearson's r correlations coefficients for child well-being measures and child characteristics – children aged 2–10, Kenya

	OVERALL WELL-BEING	OVERALL HEALTH
Child age (all children)	.14	.02
Years in care (reunified children)	.11	-.14
Age at reunification (reunified children)	.29*	.14
Age at entrance to care (reunified children)	.18	.19

*Correlations statistically significant at *p<.05, **p<.01, ***p<.001.*

Table 86. T-tests comparing child well-being measures by child groups – children aged 2–10, Kenya

	OVERALL WELL-BEING	OVERALL HEALTH
Child gender		
Female	1.77	2.50
Male	1.75	2.72
Child disability status		
No difficulties	1.75	2.67
With functional difficulties	1.66	2.13
Child placement type		
At-risk child	1.68	2.27
Reunified child	1.76	2.73
Child parental care status		
In non-parental care	1.73	2.50
In parental care	1.76	2.73
Child orphanhood status		
Non-orphan	1.73	2.45
Orphan	1.75	2.73
Living with non-relative adult		
Does not live with non-relative adult	1.77	2.67
Lives with non-relative adult	1.63	2.42

*Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.*

Table 87. Pearson's r correlations coefficients for child well-being measures and child characteristics – children aged 11–18, Kenya

	OVERALL WELL-BEING	OVERALL LIFE SATISFACTION AT SURVEY
Child age	-.008	.07

*Correlations statistically significant at *p<.05, **p<.01, ***p<.001.*

Table 88. T-tests comparing child well-being measures by child groups – children aged 11–18, Kenya

	OVERALL WELL-BEING	OVERALL LIFE SATISFACTION AT SURVEY
Child gender		
Female	1.53	7.30
Male	1.54	7.70
Child disability status		
No difficulties	1.57***	7.71*
With functional difficulties	1.29***	6.45*
Child placement type		
At-risk child	1.46	6.81
Reunified child	1.54	7.62
Child parental care status		
In non-parental care	1.53	7.67
In parental care	1.53	7.43
Child orphanhood status		
Non-orphan	1.42**	6.94
Orphan	1.56**	7.74
Living with non-relative adult		
Does not live with non-relative adult	1.53	7.36*
Lives with non-relative adult	1.53	8.39*

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.

Table 89. Pearson's r correlations coefficients for child well-being measures and child characteristics – reunified children aged 11–18, Kenya

	OVERALL WELL-BEING	OVERALL LIFE SATISFACTION AT SURVEY	CHANGE IN LIFE SATISFACTION	COMMUNITY ACCEPTANCE	FAMILY ACCEPTANCE
Child age	-.06	.04	.0002	-.03	-.07
Years in care	-.06	-.002	.04	-.03	.006
Age at reunification	.02	.04	.04	-.04	-.05
Age at entrance to care	.05	.03	-.02	-.02	-.02

Correlations statistically significant at *p<.05, **p<.01, ***p<.001.

Table 90. T-tests comparing child well-being measures by child groups – reunified children aged 11–18, Kenya

	OVERALL WELL-BEING	OVERALL LIFE SATISFACTION AT SURVEY	CHANGE IN LIFE SATISFACTION	COMMUNITY ACCEPTANCE	FAMILY ACCEPTANCE
Child gender					
Female	1.55	7.41	-0.48	1.66	1.86
Male	1.53	7.73	0.46	1.61	1.88
Child disability status					
No difficulties	1.57***	7.73	0.39*	1.64	1.88
With functional difficulties	1.29***	6.56	-1.81*	1.48	1.78
Child parental care status					
In non-parental care	1.55	7.86	0.47	1.62	1.86
In parental care	1.53	7.42	-0.19	1.64	1.88
Child orphanhood status					
Non-orphan	1.40**	6.94	-1.26**	1.50*	1.74**
Orphan	1.58**	7.84	0.59**	1.68*	1.92**
Living with non-relative adult					
Does not live with non-relative adult	1.54	7.44	-0.09	1.62	1.87
Lives with non-relative adult	1.52	8.40	0.90	1.70	1.91

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.

Table 91. Pearson's r correlations coefficients for caregiver protective factors and caregiver/household characteristics – Guatemala

	PARENTAL RESILIENCE	SOCIAL CONNECTIONS	CONCRETE ASSISTANCE	SOCIAL/EMOTIONAL	OVERALL PFI
Caregiver age	-.003	.08	.06	.10	.06
Caregiver education	-.06	.05	-.03	-.10	-.04
No. of adults in household	.14	.19	.19	.21	.21
No. of children in household	-.08	-.10	-.10	-.21	-.13

Correlations statistically significant at *p<.05, **p<.01, ***p<.001.

Table 92. T-tests comparing caregiver protective factor mean scores by caregiver groups – Guatemala

	PARENTAL RESILIENCE	SOCIAL CONNECTIONS	CONCRETE ASSISTANCE	SOCIAL/EMOTIONAL	OVERALL PFI
Caregiver gender					
Female	3.69***	3.43**	3.52**	3.51**	3.54**
Male	2.94***	2.61**	2.87**	2.80**	2.81**
Caregiver disability status					
Disability	3.57	3.16	3.33	3.31	3.34
No disability	3.62	3.38	3.48	3.46	3.49
Caregiver widow stats					
Non-widows	3.59	3.35	3.43	3.39	3.45
Widows	3.78	3.30	3.62	3.76	3.62
Household locale					
Rural	3.67	3.28	3.47	3.51	3.48
Urban	3.57	3.39	3.45	3.39	3.45
Household placement type					
Has at-risk children only	3.63	3.52	3.56	3.22	3.51
Has reunified children	3.61	3.32	3.44	3.46	3.46

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.

Table 93. Pearson's r correlations coefficients for parenting practices and caregiver/household characteristics – Guatemala

	PARENTAL INVOLVEMENT	POSITIVE PARENTING	FREQ. OF SPANKING	FREQ. OF SLAPPING	FREQ. OF HITTING WITH OBJECT
Caregiver age	-.04	.04	-.17	-.17	-.32*
Caregiver education	.001	-.13	.13	-.08	.02
No. of adults in household	.02	.29*	.04	-.07	.0003
No. of children in household	.27	.13	-.02	.14	.14

Correlations statistically significant at *p<.05, **p<.01, ***p<.001.

Table 94. T-tests comparing parenting practices by caregiver groups – Guatemala

	PARENTAL INVOLVEMENT	POSITIVE PARENTING	FREQ. OF SPANKING	FREQ. OF SLAPPING	FREQ. OF HITTING WITH OBJECT
Caregiver gender					
Female	19.6	21.68	0.77	0.02	0.36**
Male	19.7	22.17	0.83	0.0	1.50**
Caregiver disability status					
Disability	18.14	21.22	0.78	0.0	0.44
No disability	19.81	21.82	0.78	0.02	0.48
Caregiver widow stats					
Non-widows	20.0**	21.85	0.81	0.02	0.52
Widows	13.0**	20.86	0.57	0.0	0.14
Household locale					
Rural	18.8	22.1	0.56	0.04	0.44
Urban	20.1	21.4	0.94	0.0	0.50
Household placement type					
Has at-risk children only	20.67	21.14	1.29	0.0	0.43
Has reunified children	19.42	21.81	0.71	0.02	0.48

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.

Table 95. Pearson's r correlations coefficients for economic stability outcomes and caregiver/household characteristics – Guatemala

	HOUSEHOLD HUNGER SCORE	DEGREE OF WORRY ABOUT MONEY	ABILITY TO OBTAIN FUNDS IN EMERGENCY
Caregiver age	-.08	-.11	-.18
Caregiver education	-.04	.06	.11
No. of adults in household	-.03	-.05	-.04
No. of children in household	.06	.04	.02

Correlations statistically significant at *p<.05, **p<.01, ***p<.001.

Table 96. T-tests comparing economic stability outcomes by caregiver groups – Guatemala

	HOUSEHOLD HUNGER SCORE	DEGREE OF WORRY ABOUT MONEY	ABILITY TO OBTAIN FUNDS IN EMERGENCY
Caregiver gender			
Female	0.34	1.70	0.91
Male	0.17	2.17	0.33
Caregiver disability status			
Disability	0.78	2.56*	0.56
No disability	0.24	1.60*	0.90
Caregiver widow status			
Non-widows	0.31	1.69	0.81
Widows	0.43	2.14	1.14
Household locale			
Rural	0.48	1.84	0.76
Urban	0.21	1.68	0.91
Household placement type			
Has at-risk children only	1.00*	2.14	1.00
Has reunified children	0.23*	1.69	0.83

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.

Table 97. Chi-squared tests of significance for distributions of caregivers who had been able to save any money – Guatemala

	% WHO SAVED	% WHO DID NOT SAVE
Caregiver gender		
Female	41.5%	58.5%
Male	16.7%	83.3%
Caregiver disability status		
Disability	11.1%	88.9%
No disability	44.0%	56.0%
Caregiver widow stats		
Non-widows	40.4%	59.6%
Widows	28.6%	71.4%
Household locale		
Rural	40.0%	60.0%
Urban	38.2%	61.8%
Household placement type		
Has at-risk children only	28.6%	71.4%
Has reunified children	40.4%	59.6%

Chi-squared test statistically significant at *p<.05, **p<.01, ***p<.001.

Table 98. Chi-squared tests of significance for distributions of caregivers who had been able to save any money – Guatemala

	MEAN OF THOSE WHO SAVED	MEAN OF THOSE WHO DID NOT SAVE
Caregiver age	42.30	40.06
Caregiver education^	0.30	0.53
No. of adults in household	2.61	2.72
No. of children in household	3.30	3.39

Differences between means statistically significant at statistically significant at *p<.05, **p<.01, ***p<.001.
^ Where 0=Less than primary school completed, 1=Primary school completed, 2=Secondary school completed, 3=higher than secondary school completed.

Table 99. Pearson's r correlations coefficients for child well-being measures and child characteristics – children aged 2–10, Guatemala

	OVERALL WELL-BEING	OVERALL HEALTH
Child age	-.10	.02
Years in care	-.19	-.06
Age at reunification	-.23	.17
Age at entrance to care	-.15	.20

Correlations statistically significant at *p<.05, **p<.01, ***p<.001.

Table 100. T-tests comparing child well-being measures by child groups – children aged 2–10, Guatemala

	OVERALL WELL-BEING	OVERALL HEALTH
Child gender		
Female	2.00	2.92
Male	2.06	2.91
Child disability status		
No difficulties	2.07***	3.15***
With functional difficulties	1.56***	1.33***
Child placement type		
At-risk child	1.96	2.26**
Reunified child	2.08	3.36**
Child parental care status		
In non-parental care	1.84	3.00
In parental care	2.06	2.90
Child orphanhood status		
Non-orphan	2.02	2.83
Orphan	2.19	3.13
Living with non-relative adult		
Does not live with non-relative adult	2.02	2.81
Lives with non-relative adult	2.04	3.27

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.

Table 101. Pearson's r correlations coefficients for child well-being measures and child characteristics – children aged 11–18, Guatemala

	OVERALL WELL-BEING	OVERALL LIFE SATISFACTION AT SURVEY
Child age	-.06	-.28*

Correlations statistically significant at *p<.05, **p<.01, ***p<.001.

Table 102. T-tests comparing child well-being measures by child groups – children aged 11–18, Guatemala

	OVERALL WELL-BEING	OVERALL LIFE SATISFACTION AT SURVEY
Child gender		
Female	1.78	9.40
Male	1.76	9.04
Child disability status		
No difficulties	1.78	9.37
With functional difficulties	1.85	9.38
Child placement type		
At-risk child	1.75	9.30
Reunified child	1.77	9.20
Child parental care status		
In non-parental care	1.79	8.89
In parental care	1.76	9.29
Child orphanhood status		
Non-orphan	1.76	9.24
Orphan	1.78	9.63
Living with non-relative adult		
Does not live with non-relative adult	1.75	9.12
Lives with non-relative adult	1.84	9.75

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.

Table 103. Pearson's r correlations coefficients for child well-being measures and child characteristics – reunified children aged 11–18, Guatemala

	OVERALL WELL-BEING	OVERALL LIFE SATISFACTION AT SURVEY	CHANGE IN LIFE SATISFACTION	COMMUNITY ACCEPTANCE	FAMILY ACCEPTANCE
Child age	-.13	-.33*	-.22	-.27	-.06
Years in care	-.14	.06	-.14	.05	-.36*
Age at reunification	-.03	-.25	-.16	-.24	.09
Age at entrance to care	.08	-.23	-.006	-.22	.34*

Correlations statistically significant at *p<.05, **p<.01, ***p<.001.

Table 104. T-tests comparing child well-being measures by child groups – reunified children aged 11–18, Guatemala

	OVERALL WELL-BEING	OVERALL LIFE SATISFACTION AT SURVEY	CHANGE IN LIFE SATISFACTION	COMMUNITY ACCEPTANCE	FAMILY ACCEPTANCE
Child gender					
Female	1.79	9.36	5.27	1.76	1.97
Male	1.75	9.00	5.78	1.69	1.93
Child disability status					
No difficulties	1.80	9.41	5.88	1.79	1.96
With functional difficulties	1.84	9.20	4.80	1.53	1.90
Child parental care status					
In non-parental care	1.79	8.89	4.67	1.67	1.93
In parental care	1.77	9.29	5.74	1.74	1.96
Child orphanhood status					
Non-orphan	1.78	9.25	5.72	1.71	1.96
Orphan	1.76	9.57	6.00	1.88	1.90
Living with non-relative adult					
Does not live with non-relative adult	1.76	9.09	5.55	1.75	1.94
Lives with non-relative adult	1.85	9.71	5.29	1.62	2.00

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001.

Appendix 2: Household Survey Instrument

Caregiver survey

Caregiver and household demographics questions

What is your marital status?

(0) Single/never married
(1) Married/living together as if married
(2) Widowed
(3) Divorced/separated

What is the highest level of education you have completed?

(0) Less than primary
(1) Primary
(2) Secondary
(3) Higher than secondary

Throughout this questionnaire we will ask some questions about your household. A "household" is a group of people who normally live together and cook their meals together. A household can be related or unrelated people, including nuclear or extended family.

If the participant has questions about the definition of "household," please consider:

- *A household lives together in the same "unit" or space or homestead.*
- *A household shares the same housekeeping arrangements, caregiving practices, and day-to-day provisions.*

How many adults (18+) live in this household, including yourself?

How many children (0-17) live in this household?

Washington Group Short Set on Functioning (WG-SS)

The next questions ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM.

- Do you have difficulty seeing, even if wearing glasses?
- Do you have difficulty hearing, even if using a hearing aid(s)?
- Do you have difficulty walking or climbing steps?
- Do you have difficulty remembering or concentrating?
- Do you have difficulty with self-care, such as washing all over or dressing?
- Using your usual language, do you have difficulty communicating, for example understanding or being understood?

Response options:

(0) No difficulty
(1) Some difficulty
(2) A lot of difficulty
(3) Cannot do at all

Services from CTWWC

Which of the follow supports have you received from Changing the Way We Care?

- Home visit from a case worker, involvement in case planning to set goals for the family/child, counselling and guidance.
- Referrals to other services providers (such health care, microfinance, disability support etc.).
- Parenting training, either within home visits or as part of a group.
- Cash transfers.
- Food bundles.
- Kitchen garden training.
- Membership of a savings and loans group.

How much do you think the [insert service received] have helped you to take care of your children?

(0) Did not help at all
(1) Helped a little bit
(2) Helped a lot

Household economic stability questions

[The following three questions come from the *Parenting for Lifelong Health* evaluation.[65]]

In the past four weeks how often were you worried about money?

(0) Never
(1) Rarely
(2) Sometimes
(3) Often

Have you managed to save some money within the past month?

If you were facing an emergency, how difficult would it be for your family to get 7,500 Kenyan shillings/550 quetzales? (You could get it by using savings, borrowing money, selling belongings, reducing spending, or any other way you can think of.)

(0) It would be impossible
(1) It would be hard but we could
(2) It would be easy

Are any of the children living in this household enrolled in school?

[From here to end of section, questions come from CRS COFE/SILC evaluation.[66]]

In the past three months, did you or someone in your household pay for all of the school fees required for the children to stay in school? This includes all costs needed to attend school, including the cost of transport, uniforms, tuition, etc.

In the past three months, how much of the required school fees and costs did your household pay?

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[65] Shenderovich, Y., Ward, C.L., Lachman, J.M. *et al.* Evaluating the dissemination and scale-up of two evidence-based parenting interventions to reduce violence against children: study protocol. *Implement Sci Commun* 1**,** 109 (2020). https://doi.org/10.1186/s43058-020-00086-6

[66] Kim, E.T., Zhour, Y., Mugenyi, L., et al. (2022). Impact of the Child-Optimized Financial Education (COFE) curriculum among savings group participants in Uganda: A cluster randomized controlled trial. Journal of Development Effectiveness (forthcoming).

(3) More than half of the required school fees
(2) About half of the required school fees
(1) Less than half of the required school fees
(0) None of the required school fees

In the last three months, did any children in this household have to miss any school days because you or someone in your household only paid some of the required costs, or paid them late?

In the past three months, did any children in this household have any sickness or any need for health services at all (including prevention, testing, screening, and wellness visits)?

Did you seek any health services in the past three months for any children in this household?

How many times did you seek health services for children in the past three months?

Were you able to pay for all the children's healthcare expenses in the past three months?

In the past three months, were there any unexpected household expenses, such as a house repair, bike repair, motorcycle repair, car repair, funeral, or urgent medical treatment (do not include any education expenses or children's health visits for this)?

Were these unexpected household expenses paid for in the past three months?

Household Hunger Scale (HHS)

In the past 30 days, was there ever no food to eat of any kind in your house because of lack of resources to get food?

How often did this happen in the past 30 days?
(0) Rarely (1-2 times)
(1) Sometimes (3-10 times)
(2) Often (more than 10 times)

In the past 30 days, did you or any household member go to sleep at night hungry because there was not enough food?

How often did this happen in the past 30 days?
(0) Rarely (1-2 times)
(1) Sometimes (3-10 times)
(2) Often (more than 10 times)

In the past 30 days, did you or any household member go a whole day and night without eating anything at all because there was not enough food?

How often did this happen in the past 30 days?
(0) Rarely (1-2 times)
(1) Sometimes (3-10 times)
(2) Often (more than 10 times)

Parents' Assessment of Protective Factors (PAPF)

Next, we are going to ask you some questions about taking care of your child or children. In responding to the statements, please think about the past three months.

Response options:

(0) This is NOT AT ALL LIKE me
(1) This is NOT MUCH LIKE me
(2) This is A LITTLE LIKE me
(3) This is LIKE me
(4) This is VERY MUCH LIKE me

Resilience subscale

- I feel positive about being a parent/caregiver.
- I take good care of my child even when I am sad.
- I find ways to handle problems related to my child.
- I take good care of my child even when I have personal problems.
- I manage the daily responsibilities of being a parent/caregiver.
- I have the strength within myself to solve problems that happen in my life.
- I am confident I can achieve my goals.
- I take care of my daily responsibilities even if problems make me sad.
- I believe that my life will get better even when bad things happen.

Social connections subscale

- I have someone who will help me get through tough times.
- I have someone who helps me calm down when I get upset.
- I have someone who can help me calm down if I get frustrated with my child.
- I have someone who will encourage me when I need it.
- I have someone I can ask for help when I need it.
- I have someone who will tell me in a caring way if I need to be a better parent/caregiver.
- I have someone who helps me feel good about myself.
- I am willing to ask for help from my family.
- I have someone to talk to about important things.

Concrete assistance in times of need subscale

- I don't give up when I run into problems trying to get the services I need.
- I make an effort to learn about the resources in my community that might be helpful for me.
- When I cannot get help right away, I don't give up until I get the help I need.
- I know where to go if my child needs help.
- I am willing to ask for help from government/community/NGO programs or institutions.
- I know where I can get helpful information about parenting and taking care of children.
- Asking for help for my child is easy for me to do.
- I know where to get help if I have trouble taking care of emergencies.
- I try to get help for myself when I need it.

Social and emotional competency of children subscale

- I maintain self-control when my child misbehaves or doesn't listen.
- I help my child learn to manage frustration.
- I stay patient when my child cries or gets upset.
- I play or have a conversation with my child when we are together.

- I can control myself when I get angry with my child.
- I make sure my child gets the attention he or she needs even when my life is stressful.
- I stay calm when my child misbehaves or doesn't listen.
- I help my child calm down when he or she is upset.
- I am happy when I am with my child.

Alabama Parenting Questionnaire (APQ)

The following are a number of statements about your family. Please rate each item as to how often it TYPICALLY occurs in your home.

If the respondent asks "which child?", please explain that the questions ask how often they do these things with any of their children.

Response options:

(0) Never
(1) Almost never
(2) Sometimes
(3) Often
(4) Always

Positive parenting scale

- How often do you let your child(ren) know when he/she is doing a good job with something?
- How often do you reward or give something extra to your child(ren) for obeying you or behaving well?
- How often do you compliment your child(ren) when he/she does something well?
- How often do you praise your child(ren) if he/she behaves well?
- How often do you hug or kiss your child(ren) when he/she has done something well?
- How often do you tell your child(ren) that you like it when he/she helps around the house?

Parental involvement scale (only presented if caregiver has a child between ages of 5–17)

- How often do you have a friendly talk with your child(ren)?
- How often do you participate in special activities that your child(ren) is involved in (such as sports, clubs, church youth groups)?
- How often do you play games or do other fun things with your child(ren)?
- How often do you ask your child(ren) about his/her day in school?
- How often do you help your child(ren) with his/her homework (work that comes from school)?
- How often do you talk to your child(ren) about his/her friends?

Corporal punishment questions

- How often do you spank your child(ren) with your hand, on a part of their body that isn't their face, when he/she has done something wrong?
- How often do you slap your child(ren) on the face when he/she has done something wrong?
- How often do you hit your child(ren) with a cane, belt, switch, or other object when he/she has done something wrong?

Caregiver report on the child

Child demographics and household structure

How are you related to [child name]?

(0) Biological mother
(1) Biological father
(2) Grandparent
(3) Aunt/Uncle
(4) Sibling
(5) Other relative
(6) Step-parent / romantic partner of biological parent
(7) Non-relative foster parent
(8) Other non-relative

[The next five questions come from *Measure Evaluation OVC Surveys*]

[Children 2–4] Does [child name] attend any organized or early childhood education program, such as a private or government facility, including kindergarten or community child care or pre-primary school?

[Children 5+] Is [child name] currently enrolled in school?

Why isn't [child name] enrolled in school? [Do not read the responses out loud. Choose one primary response.]

(0) No money for school fees, materials, transport
(1) Child is too sick to attend school
(2) School is too far away or there is no school
(3) Child has to work to help the family
(4) Child needs to care for sick household members
(5) Child does not like school
(6) School was not in session (for example, due to COVID)
(7) Child is too young/old
(8) Other

In the last school month, did [child name] miss four or more days of school for any reason?

Why did [child name] miss school days during the last school month? [Do not read the responses out loud. Choose one primary response.]

(0) No money for school fees, materials, transport
(1) Child is too sick to attend school
(2) School is too far away or there is no school
(3) Child has to work to help the family
(4) Child needs to care for sick household members
(5) Child does not like school
(6) School was not in session (for example due to COVID)
(7) Other

Is [child name]'s biological mother alive? (That is, the woman who gave birth to him/her.)

Is [child name] living with his/her biological mother?

In the past three months, how often has [child name] been in contact with his/her biological mother?

(4) Every day or almost every day
(3) At least once a week
(2) At least once a month
(1) Less than once a month
(0) Never

Is [child name]'s biological father alive? (That is, the man related by birth/genetically to him/her.)

Is [child name] living with his/her biological father?

In the past three months, how often has [child name] been in contact with his/her biological father?

(4) Every day or almost every day
(3) At least once a week
(2) At least once a month
(1) Less than once a month
(0) Never

Think about all the children under 18 years who live in this household right now. Is [child name] the only child, the oldest, the youngest, or somewhere in the middle?

(0) Only child
(1) Oldest child
(2) Middle child
(3) Youngest child

How are the other children related to [child name]? (Check all that apply)

(0) Biological sibling (same parents)
(1) Biological half sibling (one parent the same)
(2) Biological cousins (children of a relative)
(3) Not related
(4) Other type of relative

Are there any adults living in this household who are not biologically related to [child name]?

Is one of these adults your romantic partner (spouse, girlfriend, boyfriend)?

Children's care history (for reunified children)

Before [child name] came to live with you, what residential care institution were they living in?

How old was [child name] the first time they entered [residential care institution]?

When did [child name] most recently come to live with you permanently?

How old was [child name] when they most recently came to live with you permanently?

Before they entered [residential care institution] the first time, were they living with you or with someone else?

What places did [child name] live in before they entered [residential care institution]? [Check all that

apply]

(0) Another institution
(1) Biological parents' home
(2) Other relatives' home
(3) Non-relatives' home
(4) Other: ___

Think back to the whole period of time [child name] lived in [residential care institution] (between ages [age of entrance] to [reunification age]). Did [child name] ever leave [residential care institution] to live with you or another family member, but then return to [residential care institution] again?

How often did that usually happen?

(0) Once a month or more
(1) A few times per year
(2) About once a year
(3) Less than once a year

Did [child name] leave [residential care institution] and then go back to live in [residential care institution] because of the COVID-19 pandemic?

Did [child name] live in [residential care institution] with any siblings?

When [child name] came to live with you, did any of their siblings come to live with you as well?

Since [child name] left [residential care institution] and came to live with you, do they communicate with or see anyone from [residential care institution]?

Who do they communicate with? [Check all that apply]

(0) Other children
(1) Houseparents/social workers/case worker
(2) Director
(3) Volunteer
(4) Supporter/donor
(5) Other: ___

Washington Group UNICEF Child Functioning Module (CFM)

To view the CFM for children aged 2–4, visit:

https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/Washington_Group_Questionnaire__4_-_WG-UNICEF_Child_Functioning_Module__ages_2-4_.pdf

To view the CFM for children aged 5+, visit:

https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/Washington_Group_Questionnaire__5_-_WG-UNICEF_Child_Functioning_Module__ages_5-17_.pdf

Caregiver report on child well-being (ages 2–10)

Would you say that in general [child name]'s health is……?

(4) Excellent
(3) Very good
(2) Good
(1) Fair
(0) Poor

[Question from *Measure Evaluation OVC Surveys*]

[For children 2–4] In the past three days, did you or any household member over 15 years of age engage in any of the following activities with [child name]? [Read response options]

(0) Read books to or looked at picture books with [child name]?
(1) Told stories to [child name]?
(2) Sang songs to or with [child name], including lullabies?
(3) Took [child name] outside the home, compound, yard, or enclosure?
(4) Played with [child name]?
(5) Named, counted, or drew things to or with [child name]?

[Question from *Measure Evaluation OVC Surveys*]

I am now going to read you some statements. I would like you to please tell me how often each statement is true for [child name], to the best of your knowledge. You can say none of the time, some of the time, or all of the time.

[Questions adapted from *CRS OVC Well-being Tool*]

Response options:

(0) None of the time
(1) Some of the time
(2) All of the time

- [child name] has enough food to eat.
- I feel [child name] is safe where we live.
- Community members treat [child name] differently than other children.
- [Child name] seems as happy as other children their age.
- Our relatives (like uncles, aunts, grandparents) support [child name] the same as other children in the family.
- I feel that [child name] is growing as well as other kids their age.
- Work or chores interferes with [child name]'s sleep.
- Work or chores interferes with [child name]'s school.*
- [Child name] has the materials he/she needs to do class work.*
- [Child name] is treated as well as the other students in the class.*
- [Child name] likes school.*

*Displayed for children aged 5–10 enrolled in school.

Child self-report survey on well-being

Contextualized well-being tool developed through focus group discussions

Response options:

(0) None of the time
(1) Some of the time
(2) All of the time

I am now going to read you some statements. I would like you to please tell me how often each statement is true for you: None of the time, some of the time, or all of the time. If you would like me to repeat the statements at any time, please stop me and ask me to repeat. Do you understand? (See if child has any questions.) May I begin?

- At home, I have everything I need to keep myself clean.
- I am happy with my clothing and shoes.
- I have the materials I need for school.*
- I like my teachers at school.*
- My teachers treat me with respect.*
- My work or chores impact my ability to do well in school.*
- I worry about having enough money for my education.*
- I eat at least two meals a day.
- I like the food I eat.
- I can eat until I am satisfied.
- My diet is well-balanced and nutritious.
- My health is good.
- I would be given medicine if I needed it.
- Someone would take me to the hospital/clinic/doctor if I needed it.
- If I needed something that my parents/caregivers can't provide, there are others who would help.
- I get to play and have fun.
- I have enough time to study.*
- I have enough time to rest and sleep.
- I get to pursue my hobbies and interests.
- I have freedom to go out.
- I have fun with my friends.
- If I want something, my parents/caregivers will listen and consider it.
- I can choose what to eat and when.
- I am happy with how many friends I have.
- I get along well with my friends.
- I have someone to turn to for advice and guidance.
- I have people I can talk to when I have a problem.
- I have adults in my life who understand me.
- The adults in my life teach me how to be successful in the future.
- I feel I am supported by my relatives.
- I'm happy with how much time I get to spend with my family.
- I feel like I'm part of my family.
- I get love and care from my parents/caregivers.
- I'm treated differently from the other children in my household.
- I'm treated differently from other children in my village/neighborhood/compound/community.

- I am as happy as other kids my age.
- I have a comfortable place to sleep at night.
- My home has a good environment for studying.*

- I feel safe where I live.
- My home is peaceful.
- I have someone to ask for help if I feel unsafe.
- When I make a mistake, my parents/caregivers help me improve.
- I am afraid of what will happen if I don't listen to my parents/caregivers.
- My parents/caregivers treat me with respect.

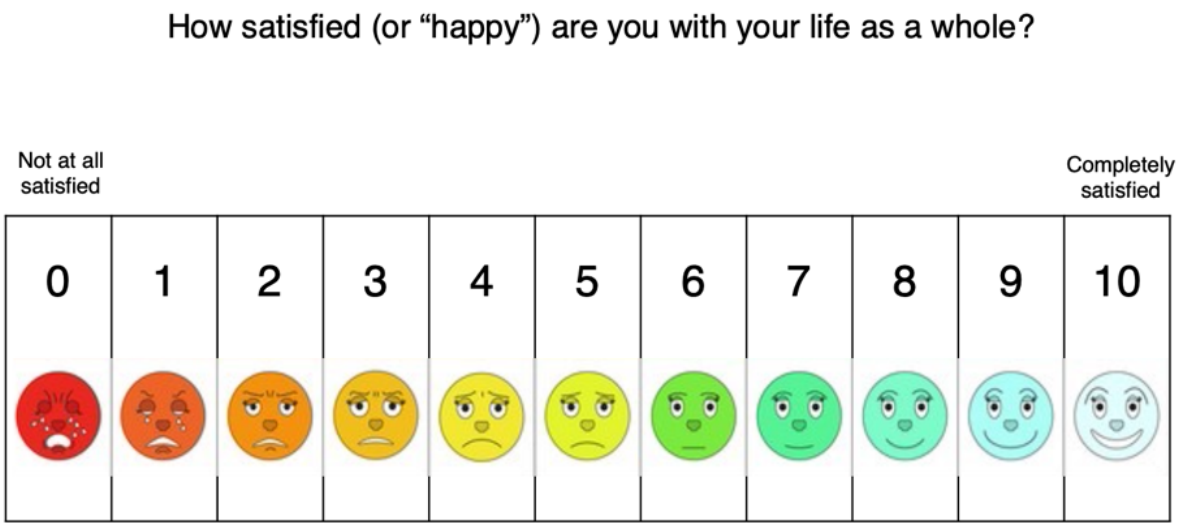
*Displayed for children enrolled in school.

Overall Life Satisfaction (OLS)

Using the following scale (give the scale to the person), if 0 is not at all satisfied and 10 is completely, satisfied, can you tell me: Right now, how satisfied (or “happy”) are you with your life as a whole?

Think back to when you were living in the children’s home. At that time, how happy were you with your life as a whole?

Figure 45. Visual aid for OLS



Family and community acceptance

I'm going to read you 12 more statements. Please tell me how often each statement is true for you. You can say not true, sometimes or somewhat true, or very true.

Response options:

(0) Not true
(1) Sometimes/somewhat true
(2) Very true

Community acceptance

- Since leaving the children’s home, you feel you have been welcomed back into the community

where you live.
- You trust the people in this community.
- Adults in the community like you.
- People in this community want you to do better.
- Since leaving the children's home, people in this community have been good to you.
- Old and young people in this community like you.

Family acceptance
- Since leaving the children's home, you feel you are welcome in the family with whom you live.
- Your parent(s)/caregiver(s) treat you as well as the other children in the family/household.
- You have the same opportunities and responsibilities as other children in the family/household.
- Your parent(s)/caregiver(s) like you just as much as the other children in the family/household.
- You are treated well in your family.
- You feel loved and cared for in your family.

Need to know more? Contact *Changing the Way We Care* at info@ctwwc.org or visit changingthewaywecare.org.

To provide feedback on this resource, scan the QR code.

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