United States Catholic Support for Overseas Residential Care

A Survey and Research Investigation of Catholic Organizations in the United States

July 2021

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Important Note: the photographs in this publication are used for illustrative purposes only; they do not imply any particular health, orphanhood or residential care status on the part of any person who appears in the photographs

Contents

LIST OF FIGURES

LIST OF TABLES

Acknowledgements

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This study has helped CTWWC to glean invaluable insights on U.S. Catholic Church support for children's residential care facilities outside of the U.S. This data provides a foundation for building effective engagement and messaging strategies, as well as informing CTWWC's future advocacy and influence work concerning support for family strengthening and care for vulnerable children by the U.S. Catholic community. CTWWC has hope that one day every child might achieve their God-given potential within a safe and nurturing family!

Acronyms

ACCU	Association of Catholic Colleges and Universities
BCN	Better Care Network
CCMA	Catholic Campus Ministry Association
CMSM	Conference of Major Superiors of Men
CMSWR	Council of Major Superiors of Women Religious
CRS	Catholic Relief Services
CTWWC	Changing the Way We Care
CVN	Catholic Volunteer Network
FOCUS	Fellowship of Catholic University Students
GDA	Global Development Alliance
GHR	Gerald and Henrietta Rauenhorst (Foundation)
LCWR	Leadership Conference of Women Religious
NFCYM	National Federation for Catholic Youth Ministry
NPH	Nuestros Pequeños Hermanos
PMS	Pontifical Mission Societies
U.S.	United States
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
USCMA	U.S. Catholic Mission Association

Glossary of Terms

Catholic Terms

Archbishop: the title given automatically to bishops who govern archdioceses. It is also given to certain other high-ranking church officials, notably Vatican ambassadors, the secretaries of Vatican congregations and the presidents of pontifical councils. Adjective—*archepiscopal*.

Archdiocese: the chief diocese of an ecclesiastical province. It is governed by an archbishop. Adjective—*archdiocesan*. See *diocese*.

Bishop: the highest order of ordained ministry In Catholic teaching. Most bishops are diocesan bishops, the chief priests in their respective dioceses. Diocesan bishops and their auxiliaries are responsible for the pastoral care of their dioceses. In addition to their diocesan responsibilities, all bishops have a responsibility to act in council with other bishops to guide the church. Adjective—*episcopal*.

Bishops' conference: a national body (or in a very few cases regional) body of bishops that meets periodically to collaborate on matters of common concern in their country or region such as moral, doctrinal, pastoral and liturgical questions; relations with other religious groups; and public policy issues. It also is called an episcopal conference. The United States conference is the United States Conference of Catholic Bishops (USCCB).

Brother: a man who has taken vows in a religious order but is not ordained or studying for the priesthood. Sometimes he is called a lay brother to distinguish him from clerical members of religious orders. See *lay*.

Clergy: a collective term referring to all those ordained—bishops, priests and deacons—who administer the rites of the church. Adjective—*clerical*.

Congregation: a multi-use term that may refer to 1) some Vatican departments that are responsible for important areas of church life such as worship/sacraments and the clergy/saints' causes; 2) the proper legal term for some institutes of men or women religious, all of whom are commonly called religious orders; or 3) any gathering of Christians for worship.

Dicastery: a church term for one of the major departments of the Roman Curia—including the Secretariat of State, Vatican congregations, tribunals, pontifical councils and a few other departments.

Diocese: a territorial division or district of the church which is headed by a bishop. The chief diocese of a group of dioceses is called an archdiocese. Adjective—*diocesan*.

Laity/lay: in canon law, anyone not ordained as a deacon, priest or bishop is a layperson. In this legal sense women religious (sisters) and non-ordained men religious (brothers) are laity. In the documents of the Second Vatican Council, however, the laity are those who are neither ordained nor members of a religious order. This latter Vatican II sense is the one usually intended in most discussions of laypeople and their role in the church.

Lay ecclesial ministry: a general theological description of the work of Catholics who are not ordained but are engaged in substantial public leadership positions in church ministry, collaborating closely with the ordained leadership and working under their authority.

Men's religious community: an order of priests and/or brothers. The community may be localized to one small region or may be a network of communities spanning across states, countries or continents, united under a charism (i.e., defining characteristics). Examples include Franciscans, Society of Jesus (Jesuits), etc.

Ministry: a broad term in Catholic usage for any activity conducive to the salvation of souls. It can include ordained ministry such as liturgical leadership and administration of the sacraments, or lay ministry such as instructing children in the faith, serving the poor, visiting the sick or being an altar server reader/music leader at Mass. See *lay ecclesial ministry*.

Nun: 1) strictly speaking, a member of a religious order of women with solemn vows; 2) in general, all women religious, even those in simple vows, who are more properly called sisters.

Parish: a specific community of the Christian faithful within a diocese, having its own church building, under the authority of a pastor who is responsible for providing ministerial service. Most parishes are formed on a geographic basis, but they may be formed along national or ethnic lines.

Pastor: a priest in charge of a Catholic parish or congregation. He is responsible for administering the sacraments, instructing the congregation in the doctrine of the church and providing other services to the people of the parish.

Priest *(religious priest/diocesan priest): religious priests* are professed members of a religious order or institute, live according to the rule of their respective orders, serve in pastoral ministry and are under the jurisdiction of their local bishop and the superiors of their order. *Diocesan* (or secular) *priests* are under the direction of their local bishop; most serve in the parishes of the diocese, but they also may be assigned to other diocesan posts and ministries or be released for service outside the diocese.

Sister: in popular speech, any woman religious. Strictly, the title applies to women religious of those institutes, mostly formed during or since the 19th century, whose members do not profess solemn vows. See *nun*.

Superior: the head of a religious order or congregation. He or she may be the head of a province or of an individual house.

Women's religious community: an order of nuns and/or sisters. The community may be localized to one small region or may be a network of communities spanning across states, countries or continents, united under a charism (i.e., defining characteristics). Examples include the Missionaries of Charity, Order of St. Clare, etc.

Children's Care Terms

Adoption: the legal transfer of parental rights and responsibilities for a child which is permanent. *Domestic* (national) *adoption* involves adopters who live in the same country as the child. *International or intercountry adoption* involves adopters who live in a different country as the child.

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 at the initiative of the child, his/her parent(s) or primary caregivers, or spontaneously by a care provider in the absence of parents. Alternative care includes kinship care, foster care, adoption, kafala, supervised independent living and residential care.

Assessment: the process of building an understanding of the problems, needs and rights of a child and his/her family in the wider context of the community. It should cover the physical, intellectual, emotional/social needs and development of the child. There are various types of assessment, such as rapid, initial, risk and comprehensive, etc.

Attachment: the formation by a child of significant and stable emotional connections with the significant people in her/his life. This process begins in early infancy as the child bonds with one or more primary caregivers. A failure by a child to establish these types of important connections before the age of about 5 years may result in the child experiencing difficulties with a wide variety of social relationships for significant periods of time in her/his life.

Best interests of the child: in relation to children's care specifically, the *Guidelines for the Alternative Care of Children* articulate several factors that need to be taken into consideration in determining best interests—including 1) the importance of understanding and meeting

universal child rights (as articulated by the UNCRC) and the specific needs of individual children; 2) balancing children's immediate safety and well-being with their medium and longer-term care and development needs; 3) recognizing the problems associated with frequent placement changes, and the importance of achieving permanency in care relationships; 4) a consideration of children's attachments to family and communities—including the importance of keeping siblings together; and 5) the problems associated with care in large-scale institutions. In assessing best interests, it is important to consider the strengths and weaknesses of families, to ensure that maximum efforts are made to build upon strengths. This includes an assessment of relationships and not just a consideration of material needs.

Care leaver: a young person, typically over the age of 16 (18 in many countries), who is leaving or has left a formal alternative care placement. This typically refers to children who are leaving orphanages through reintegration, placement in an alternative family environment or independent living.

Care planning: the process of planning a program of alternative care for a child that has clear short- and long-term goals. A care plan is a written document that outlines how, when and who will meet the child's developmental needs.

Care reform: refers to 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, promote reintegration of children and ensure appropriate family-based alternative care options are available.

Case management: the process of identifying, registering, assessing (in reintegration cases this includes tracing activities), developing a case plan, implementing the case plan (delivering or referring to services, facilitating and overseeing the placement of the child into the family environment) and ongoing monitoring/documentation.

Child protection: measures and structures intended to prevent and respond to abuse, neglect, exploitation and violence affecting children.

Child protection system: a comprehensive system of laws, policies, procedures and practices designed to ensure the protection of children and to facilitate an effective response to allegations of child abuse, neglect, exploitation and violence.

Community-based support: a range of measures to ensure the support of children and families in the community.

Deinstitutionalization: the process of closing residential care institutions and providing alternative family-based care and prevention services within the community.

Do no harm: an approach that tries to avoid unintended negative impacts of development and other interventions.

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

Family support services: a range of measures to ensure the support of children and families. It is similar to community-based support but may be provided by external agents such as social workers and providing services such as counseling, parent education, day-care facilities, material support, etc.

Formal care: all care situations where the child's placement was made by order of a Competent Authority, as well as residential care, irrespective of the route by which the child entered.

Foster care: placement of a child with a person who is not the child's parent, relative or guardian and who is willing to undertake the care and maintenance of that child.

Gatekeeping: a recognized and systematic procedure to ensure that alternative care for children is used only when necessary. The gatekeeping process helps determine if a child should be separated from his or her family and, if so, what placement will best match his or her individual needs and interests. Placement should be preceded by some form of assessment of the child's physical, emotional, intellectual and social needs, matched to whether the placement can meet these needs based on its functions and objectives.

Inclusion: the process of taking necessary steps to ensure that every young person is given an equal opportunity to develop socially and to learn/enjoy community life. It is often associated with particular groups of young people—including: those with disabilities, from ethnic minority communities, people living with HIV, etc. It is also associated with certain regions, cities and neighborhoods.

Institution: a *large institution* is characterized by having 25 or more children living together in one building; a *small institution* (or children's home) refers to a building, housing 11 to 24 children.

Kafala: a form of family-based care used in Islamic societies that does not involve a change in kinship status, but does allow an unrelated child, or a child of unknown parentage, to receive care, legal protection and inheritance.

Kinship care: this can be either informal or formal.

- *informal*—a private arrangement within an extended family whereby a child is looked after on a temporary or long-term basis by his/her maternal or paternal extended family,

without it being ordered by an administrative or judicial authority. Family members include grandparents, aunts, uncles and older siblings.

- *formal*—an arrangement, ordered by an external administrative or judicial authority, whereby a child is looked after on a temporary or long-term basis by his/her maternal or paternal extended family. Family members include grandparents, aunts, uncles and older siblings.

Orphan: a child who has lost one or both parents. The loss of one parent classifies a child as a *single orphan* and the loss of both parents as a *double orphan*. In many cases an orphan may still live with primary or extended family.[1]

Orphanage: an institution that houses children long-term who have been separated from their parents due to parental death, child abuse and neglect at home, but more often due to a combination of socio-economic reasons. The terms *orphanage* and *institution* are often used interchangeably because orphanages tend to be characterized by a prevailing institutional culture where children are often isolated from the broader community and they or their parents do not have independent control over the children's lives and over decisions which affect them.

Parenting/parent management training: individual or group training on positive parenting practices led by a trained social or community worker. It typically includes information developing positive relationships with children, managing expectations, non-violent discipline, managing parental stress and communication skills.

Positive parenting: training typically led by a trained social or community worker and includes information on developing positive relationships with one's children, managing expectations, non-violent discipline, managing parental stress and communication skills.

Permanency: establishing family connections and placement options for a child in order to provide a lifetime of commitment, continuity of care, a sense of belonging and legal/social status that goes beyond the child's temporary foster care placement.

Prevention: a variety of approaches that support family life, strengthen caregivers and help to diminish the need for a child to be separated from her or his immediate or extended family or other caregiver and be placed in residential or alternative care.

Referral: the formal process of requesting a service for a child, young person or adult (e.g., psychosocial services, placement and education). The request is usually made in writing using a formal referral form.

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1 https://www.faithtoaction.org/wp-content/uploads/2014/03/Summary-of-Research4.pdf.

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 the community (usually of origin) in order to receive protection/care and to find a sense of belonging and purpose in all spheres of life.

Reunification: the physical reuniting of a separated child and 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.

Residential care facility: a home, institution, facility or village where multiple biologically unrelated children reside full-time and are cared for by one or more biologically unrelated caregivers, who are often paid to take care of the children. It may also misleadingly be called an orphanage. Most children in residential care facilities do not have two deceased parents.

Social and behavior change communication (SBBC): A comprehensive approach to influence individual, organizational, governmental or societal behaviors using a multitude of strategies to promote favorable knowledge, attitudes, skills and an enabling environment that impact the desired behavior change. Key strategies include, but are not limited to advocacy, interpersonal communications and mass media. These may be focused on changing individual behaviors and/or shifting societal norms.

Social service workforce: a variety of workers—both paid/unpaid and governmental/non-governmental—who staff the social service system and contribute to the care of vulnerable populations. The social service system is defined as the system of interventions, programs and benefits that are provided by governmental, civil society and community actors to ensure the welfare and protection of socially or economically disadvantaged individuals and families.

Social service worker: paid/unpaid or governmental/non-governmental professionals and para-professionals working to ensure the healthy development and well-being of children and families. The social service worker focuses on preventative, responsive and promotive programs that support families and children in communities by alleviating poverty; reducing discrimination; facilitating access to needed services; promoting social justice and preventing/responding to violence, abuse, exploitation, neglect and family separation.

Social services: services provided by public or private organizations aimed at addressing the needs and problems of the most vulnerable populations—including those stemming from violence, family breakdown, homelessness, substance abuse, immigration, disability and old age.

Supported independent living: occurs when a young person is supported in her/his own home, a group home, hostel or other form of accommodation, to become independent. Support/social workers are available as needed and at planned intervals to offer assistance and support but not to provide supervision. Assistance may include timekeeping, budgeting, cooking, job seeking, counseling, vocational training and parenting.

Vulnerable children: those whose rights to care and protection are being violated or who are at risk of those rights being violated. This includes children who are poor, abused, neglected, lack access to basic services, ill or living with disabilities and/or whose parents face similar circumstances or are living in institutions.

Definitions borrowed or adapted from:

Better Care Network. (n.d.) Better Care Network Toolkit Glossary. http://bettercarenetwork.org/sites/default/files/attachments/glossary.pdf.

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Bunkers, K., Cox, A., Gesiriech, S. and Olson, K. (2014). Children, orphanages and families: A summary of research to help guide faith-based action. Faith to Action. https://www.faithtoaction.org/children-orphanages-and-families/.

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Wedge, J., Krumholz, A. and Jones, L. (2013). Global learning on family reintegration in low and lower-middle income countries. The Interagency Group on Reintegration. http://bettercarenetwork.org/sites/default/files/attachments/Reaching%20for%20Home%20-%20Globaly%20Learning%20on%20Family%20Reintegration.pdf.

Executive Summary

Changing the Way We Care (CTWWC) is an initiative designed to promote safe and nurturing family care for children in institutions and children at risk of child-family separation. CTWWC is a consortium led by Catholic Relief Services (CRS) and Maestral International working with various partners globally. CTWWC implements within a context of growing global understanding that children fare far better in life in a family setting than in institutional care. The goal of CTWWC is to support current residential care facilities, often referred to as orphanages, in a transitioning process to become family-support organizations, in addition to preventing child-family separation before it happens.

The CTWWC regional and global strategy aims to shift commitments in international development practices and resource redirection (financial, human and material) toward promoting family care and reducing reliance on institutions in caring for children. People of faith tend to be both pro-family and deeply committed to aiding the most vulnerable; they are also likely to be among the largest private funders of institutions worldwide. This strategy, therefore, focuses on engaging faith-based networks in the United States (U.S.) and globally, especially the Catholic Church, with which CTWWC has very strong outreach capacity. As such, CTWWC plans to work with Catholic and other faith-based organizations to shift the way the faith community supports vulnerable children outside of the U.S., away from support for residential care facilities and toward support for family-based care. Specifically, the strategy targets faith-based networks and philanthropic bodies, beginning with "early adopter" influencers and leaders with the potential to become champions in care reform and to activate their large faith-based networks and constituencies to constructively redirect their financial and in-kind support, volunteers and mission/immersion trips.

These faith-based efforts complement a broad-based communications and awareness campaign, which is part of a larger CTWWC behavior-change strategy, seeking to create an enabling environment where attitudes and messaging about family-strengthening and family care for vulnerable children are widely accepted among faith-based and other targeted audiences. This strategy seeks to transform the knowledge, skills, practices and attitudes of targeted audiences through various means—including leadership engagement.

Rationale for Research

While over 80 years of research clearly demonstrates the importance of family-based care in children's long-term well-being and the harmful impacts of institutional care on children's cognitive, physical and social development, limited evidence-based research exists on funding and material support for children in institutional care globally. To this end, CTWWC conducted this study to provide data regarding U.S. Catholic Church support for children's residential care facilities (sometimes misleadingly called orphanages, as most children

in residential care do not have two deceased parents)[2] outside of the U.S. Through this study, CTWWC aimed to identify funding and volunteering practices linking Global North funding streams to in-country recipient institutions. The data from this study will serve as a foundation for designing strategy and messaging for engaging and raising awareness among U.S. Catholic audiences. Through increased knowledge about the benefits of family-based care, CTWWC seeks to influence U.S. Catholic audiences to transition its financial and resource support to family-based care options for vulnerable children.

Questions that remain to be answered include:

- How many children are living in institutions and where?
- Who is privately funding these institutions and for how much?
- Which mission networks are most involved?
- How many people are volunteering in institutions and from what groups?

According to CRS' internal CTWWC Annual Workplan for Year One (December 2018), "globally, millions of children live in institutions." However, there is no definitive, accurate estimation of the number of children (separated from their families and communities) placed in institutions. Estimates range from eight million[3] to more than 2.7 million children according to a recent United Nations Children's Fund (UNICEF) study[4] (although this figure was qualified as the "tip of the iceberg").[5] The Workplan further elaborates that "contrary to common beliefs, institutional facilities are not cost effective. Studies show that funds spent on institutions could support reintegration of up to ten times as many children into their own or other safe, nurturing families and achieve better outcomes. Despite this evidence, institutional care persists and in some parts of the world, the phenomenon is on the rise."

CRS has conducted some relevant research in recent years, including looking at 1) the state of Catholic residential care in Zambia with an in-depth review of 39 of the 40 Catholic-affiliated residential care facilities in the country and the characteristics of children who lived in these facilities[6] and 2) the specifics of financial support of residential care in Haiti by Catholics in the U.S. through a funding stream analysis of 68 U.S.-based Catholic entities that supported 57 residential care facilities in Haiti.[7] In addition, CTWWC also is researching and identifying alternate models for mission and immersion trips, global service-learning and volunteer programs, in order to refer Catholic groups to alternative programs.

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2 Csáky, C. (2009). Keeping children out of harmful institutions: Why we should be investing in family-based care. Save the Children. https://resourcecentre.savethechildren.net/library/keeping-children-out-harmful-institutions-why-we-should-be-investing-family-based-care.

3 Cited in: Pinheiro, P., World Report on Violence against Children, UNICEF, New York, 2006.

4 https://www.sciencedirect.com/science/article/pii/S0145213416302873.

5 https://www.unicef.org.uk/press-releases/data-gaps-children-residential-care-leave-vulnerable-unaccounted-unicef/.

6 Januario, K., Hembling, J., Rytter Kline, A. and Roby, J. (2015). *Factors Related to the Placement into and Reintegration of Children from Catholic-affiliated Residential Care Facilities in Zambia*. Catholic Relief Services. https://www.crs.org/our-work-overseas/research-publications/factors-related-placement-and-reintegration-children.

7 Lamberty, K. and Collins, N. (2017). *Final Report: Children's Residential Care Project in Haiti: Funding Stream Analysis: Survey of U.S. Catholic Partners*. Catholic Relief Services.

There is a growing body of research[8] on the potential risks of "voluntourism," and the importance of ensuring mission/immersion trips, global service learning and volunteer programs that do no harm and support the work they visit in a meaningful and safe manner.

However, a particular lack of evidence exists concerning residential care support around the world by Catholics. While Protestant-based coalitions in the U.S. have made significant strides to mobilize and educate churches, faith-based organizations and individual Christians to engage in care that upholds the vital importance of family in a child's life,[9] such efforts largely would be new and exploratory within the Catholic Church. This evidence-based research is essential in better understanding the Catholic-involved residential care landscape and achieving major shifts in global and regional support toward family-based care. Therefore, CTWWC is helping address this evidence gap regarding funding flows, the number and location of children who are institutionalized and the number and type of volunteers.

To this end, CTWWC conducted this study to provide data regarding U.S. Catholic Church support for children's residential care facilities (sometimes misleadingly called orphanages, as most children in residential care do not have two deceased parents[10]) outside of the United States. Through this study, CTWWC aimed to identify funding and volunteering practices linking Global North funding streams to in-country recipient institutions. The data from this study will serve as a foundation for designing strategy and messaging for engaging and educating the U.S. Catholic Church on the issues and influencing it to use its resources to support family-based care for vulnerable children.

CTWWC carried out this research via 1) designing and sending out a survey to Catholic leaders representing organizations and constituencies and 2) engaging in supplemental internet and phone research on specific Catholic organizations. CTWWC initially reached out to:

- CRS' diocesan partners
- CRS' university and high school partners
- Catholic Volunteer Network member organizations
- lay-led mission groups—including Maryknoll Lay Missioners, Franciscan Mission Service, Lay Mission Helpers, etc.
- large Catholic non-governmental organizations (NGOs) supporting children's residential care facilities overseas
- national Catholic organizations and coalitions—including Leadership Council of Women Religious (LCWR), Council of Major Superiors of Women Religious (CMSWR), Conference of Major Superiors of Men (CMSM), National Federation for Catholic Youth Ministry (NFCYM), Association of Catholic Colleges and Universities (ACCU), Fellowship of Catholic University Students (FOCUS) and U.S. Catholic Mission Association (USCMA)

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8 https://www.worldvision.ca/stories/voluntourism-the-good-and-the-bad.
9 https://www.faithtoaction.org/.
10 Csáky, C. (2009). *Keeping children out of harmful institutions: Why we should be investing in family-based care*. Save the Children. https://resourcecentre.savethechildren.net/library/keeping-children-out-harmful-institutions-why-we-should-be-investing-family-based-care.

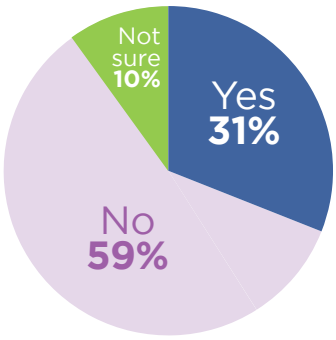
All responses provided were based on the institution's work and not the perspective of the individual leader completing the survey. To reach as many respondents as possible, CTWWC asked all respondents to recommend other Catholic institutions to contact who are involved in residential care. CTWWC then contacted these organizations to complement the original respondents' inputs. The survey collected 273 responses in total (103 women's religious communities, 41 archdioceses and dioceses, 32 universities/colleges, 32 men's religious communities, 25 non-profit organizations, 14 parishes, 8 high schools, 8 non-profit volunteer programs, 5 non-profit orphan care ministries, 4 organizations categorized as "other," and one individual donor).

Survey Results

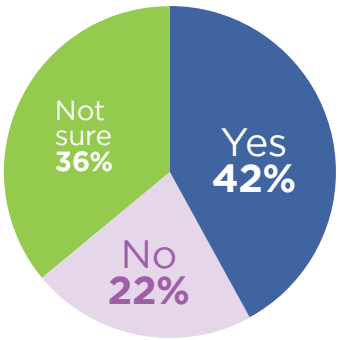
For the survey, CTWWC targeted respondents with residential care facilities in countries where CTWWC works or plans to work. This report—which only represents those who completed the survey—used 273 responses for the final analysis. Over one-third of respondents answered on behalf of women's religious communities. The next most common category was archdioceses/dioceses and non-profits, making up 14 percent of the responses each, universities/colleges (13 percent), and men's religious communities (12 percent).

86 respondents (31 percent) said that they supported one or more residential care facilities in 2018, 161 (59 percent) said they did not and 26 (10 percent) were not sure. The survey asked respondents to give details about the residential care facilities they supported in 2018.

Figure 1. Whether Respondents' Organizations Supported Residential Care in 2018



Whether respondents' organizations supported residential care in 2018 (n=273 respondents; 0 missing)



Whether the facility supported children with disabilities (n=81 facilities; 8 missing)

The top 10 countries in which respondents supported residential care were India, Haiti, the Philippines, Uganda, Jamaica, Kenya, Mexico, Guatemala, Honduras and Ghana.

Less than half of these facilities (42 percent) supported children with disabilities, while under a quarter (22 percent) did not. For 36 percent of facilities, the respondent was unsure if the facility supported children with disabilities (n=81 facilities; 8 missing).

The facilities were small on average, with a plurality of facilities housing between 15 and 30 children.

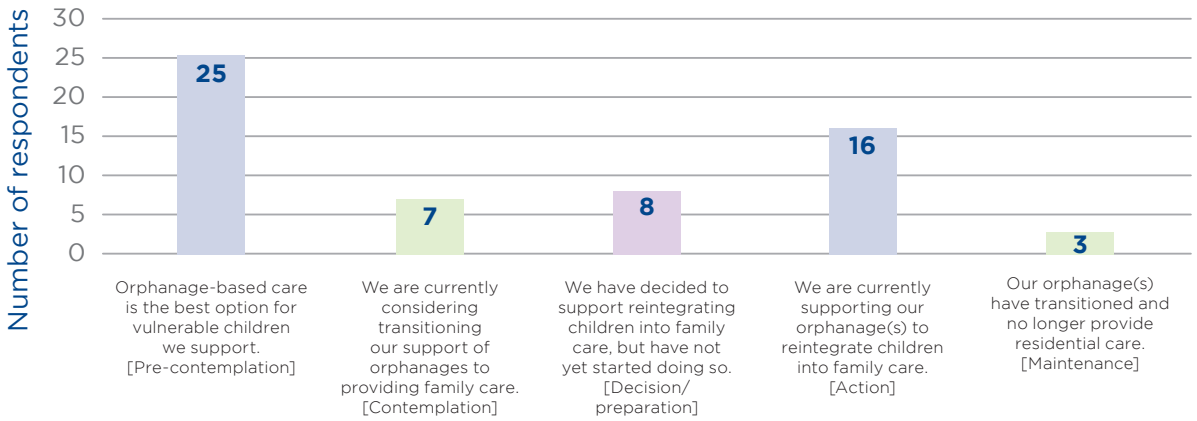
Most survey respondents provided between $1,000 and $6,000 to each facility in 2018. Some organizations, however, provided over $150,000, especially non-profit organizations and religious communities. Most groups provided financial support through individual and community fundraising, rather than more formalized methods like grant writing and child sponsorship.

At least half of our respondents sent volunteers to the residential care facilities they support. Most sent short-term trips of 1 to 50 people, while 10 respondents sent longer-term volunteers who served for over a month. Respondents spent significant financial resources on sending these volunteers, with short-term mission trips costing $20,000 on average.

The survey also gauged knowledge and attitudes of respondents, whether or not they supported any residential care facilities in 2018.

The CTWWC behavior-change theory places individuals and organizations on a continuum regarding how far along they are in changing their behavior away from supporting residential care and toward supporting family-based care. Generally, respondents were not very far along on this continuum, and were not reconsidering their support for residential care.

Figure 2. Responses to "Stages of Change" Question (respondents who supported residential care facilities)



Note: n=59; 27 missing

The survey posed various knowledge and attitudes statements to respondents, and respondents rated to what extent they agreed with each statement. Respondents agreed the most with the statement: *"In general, my organization thinks reintegrating children from orphanages to family-based care is important."* Agreement levels did not vary much depending on the type of respondent (e.g., women's religious, parish or non-profit).

Table 1. Mean Agreement Scores and Standard Deviations for Knowledge and Attitude Questions

Statement	Mean agreement score	Standard Deviation	Question posed to
In general, my organization thinks reintegrating children from orphanages to family-based care is important.	3.4	0.9	Residential care supporters
A primary goal for organizations that support orphanages should be to reunite children with their families.	3.2	0.9	All
There are some situations where residential institutions will always be necessary—such as for unaccompanied refugee children or children with complex care needs in low-income countries.	3.1	0.9	All
Given the choice, money should be given to families living in poverty conditions to keep children at home rather than in orphanages.	3.0	0.9	All
Everyone in my organization is on board about wanting to reintegrate children into family-based care.	2.7	0.9	Residential care supporters
My organization has sufficient knowledge/ skills to reintegrate children into family-based care.	1.8	1.4	Residential care supporters
Most children are in orphanages because neither of their parents are living.	1.5	1.1	All
Babies in orphanages can receive the same nurturing care and stimulation as babies raised in family care.	1.0	1.1	All

Note: 4=highest agreement; 0=lowest agreement

Conclusions

The research confirmed that the types of institutions CTWWC reached out to were supporting residential care for children overseas, as expected. Key findings:

- A common funding mechanism for men and women religious involves creating a small foundation as a means by which to raise money for their ministries, both domestic and overseas. In many cases they are sending money to support the work of their own sisters, brothers or priests; in other cases, they are supporting the work of other local men and women religious.
- Most dioceses, parishes, and universities supporting residential care for children are sending small amounts of money but larger numbers of volunteers, both short- or long-term. These volunteers are most likely to be supporting the work of women or men religious. Women and men religious are widely respected within the Church, and these volunteers are most likely to be supporting their work, whatever it might be.
- The larger Catholic NGOs tend to support the work of women and men religious overseas. These organizations are receiving funding from individual Catholics as well as foundations. In some cases, the volunteer groups coming from dioceses, parishes, universities or schools are also funneled through these larger organizations. This is not the case in every instance, but it is the trend. In some cases, they are supporting the work of a local diocese or parish residential care facility which may or may not be operated by women or men religious.

The survey and research included questions designed to understand what kind of interventions (e.g., messaging, communication, educations materials) would be needed to support an outreach/influencing strategy. Through the behavior-change questions, the survey addressed where respondents fell on the Stages of Change continuum, and what kinds of interventions would be needed to facilitate movement from one stage to the next. Key findings:

- The data indicate that Catholic constituencies tend to fall into the earlier stages, meaning that either they have no intention of changing their behavior, or they recognize that there is a problem but have no plans to take any action. The exception is men religious, with 44 percent of respondents in those communities falling into the "action" stage. On the other hand, women's religious communities and archdioceses/dioceses are slightly more likely to be in the "pre-contemplation" phase than other types of respondents.
- Although most respondents believe that there will always be instances where residential care is necessary, they overwhelmingly agree that family care should be prioritized.
- The majority of respondents who currently support residential care facilities do not believe they have the knowledge or skills needed to transition to family-based care.
- Answers to the knowledge and attitudes questions did not vary significantly across audience segments.

There were statistically significant (though relatively weak) relationships between stage of change and the five knowledge and attitude items. The majority of respondents who are in the "earlier" three stages will benefit from interventions that address knowledge and attitudes.

Introduction

Changing The Way We Care[SM] (CTWWC) is an initiative designed to promote safe, nurturing family care for children reintegrating from residential care and children at risk of child-family separation. This includes strengthening families and reforming national systems of care for children, including family reunification and reintegration, development of alternative family-based care (in keeping with the United Nations Guidelines for the Alternative Care of Children). CTWWC has been designed around three levels of work: 1) communities, families, and children; 2) national and local governments; and 3) regional and global stakeholders.

Founding members of the CTWWC consortium (Catholic Relief Services [CRS], Lumos Foundation [no longer a member] and Maestral International) were joined—through a Global Development Alliance (GDA)—by three donors (McArthur Foundation, USAID and GHR Foundation), key partner Better Care Network (BCN) and individuals. CTWWC operates in the context of an increased interest in care reform and a global understanding that institutional care of children is a significant problem. It is apparent that the problem will be best addressed through collaboration, learning and influence between/with national, regional and global stakeholders to develop care and protection systems supportive of family care.

In October 2018, CTWWC launched in three demonstration countries: Guatemala, Kenya and Moldova. Future demonstration countries will include India, Haiti, Indonesia, and Lebanon.

Grounded in the work of demonstration countries, as well as regional and global engagement, CTWWC intends to help advance government and non-government care systems, civil society initiatives and public attitudes/behaviors that focus on keeping children in safe and nurturing families. CTWWC does this by:

- strengthening families so that they can provide and care for children under their care
- working with communities to support families and family care for vulnerable children
- reforming national systems to support family care for children
- shifting policy and funding commitments nationally, regionally and globally
- influencing faith-based actors and organizations so they shift support away from residential care for children and toward the support of family care

Through this work, CTWWC is building foundations and models for how to transition from residential care to family care for children, as well as broader reforms for how national governments care for vulnerable children and their families.

Objectives of this Study

Included in the CTWWC strategy is a plan to work with Catholic and other faith-based partners in the U.S. and globally to shift the way the faith community supports vulnerable children abroad, i.e., away from support for residential care facilities and toward support for family-based care.

The purpose of this study is to provide data regarding U.S. Catholic Church support for children's residential care facilities (sometimes misleadingly called orphanages; most children in residential care do not have two deceased parents)[11] outside of the U.S. This data will serve as a foundation for designing strategy and messaging for engaging and educating the U.S. Catholic Church on key issues and influencing it to use its resources to support family-based care for vulnerable children. Data was gathered via a survey, key informant interviews and online sources, then analyzed to assess U.S. Catholic funding and support for children's residential care facilities outside the U.S. Methods used for data gathering also surfaced U.S. Catholic attitudes (among some select groups) toward transitioning care and reuniting children (who are currently in residential care facilities) with their families, in order to help CTWWC to target our messaging and support.

The research aimed to reveal knowledge, attitudes and practices—including faith-based funding practices and trends—among Catholic networks and inform future advocacy messaging to and strategies for engaging with U.S. Catholics who currently fund residential care facilities.

The research objectives were as follows:

1. Identify U.S. Catholic organizations giving to or working with children's residential care facilities in some capacity, recognizing trends and key groups.
2. Identify, profile, and map Catholic children's residential care facilities in CTWWC Demonstration Countries that use U.S. Catholic funding and support.
3. Surface attitudes toward transitioning care among prioritized Catholic organizations.
4. Create a prioritized short-list of possible national Catholic organizations as conversation partners for the CTWWC project that are working in some or all the CTWWC Demonstration Countries.
5. Create a contact list of Catholic organizations in the U.S. giving to residential care facilities.

11 Csáky, C. (2009). Keeping children out of harmful institutions: Why we should be investing in family-based care. Save the Children. https://resourcecentre.savethechildren.net/library/keeping-children-out-harmful-institutions-why-we-should-be-investing-family-based-care.

Methodology

Survey of Catholic Institutions in the United States

Utilizing the network of partnerships and relationships that CRS maintains with Catholic institutions and leaders in the U.S., CTWWC designed and sent out a survey to Catholic leaders representing organizations and constituencies, asking them to fill out the survey and to send the survey out to their constituencies and/or membership.

Although it was not possible to document every instance of Catholic support, the research identifies trends and key organizations to target. The research also identifies knowledge and attitudes among Catholic supporters, which will provide the data needed to design a program of engagement and influence.

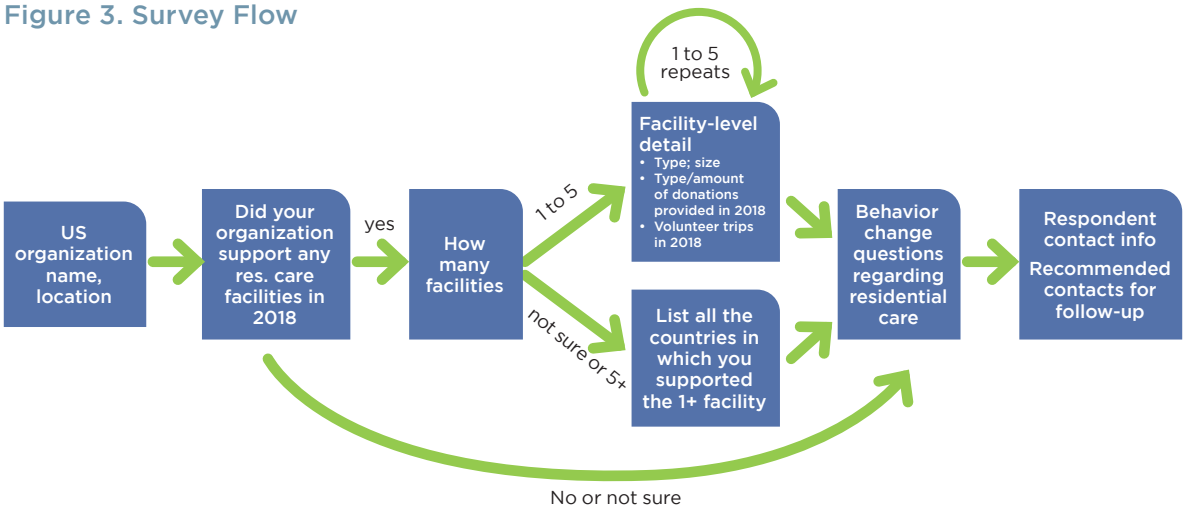
The survey was not designed to identify individual donors, although a few surfaced. Rather, it was designed to identify institutional support such as a diocese, a parish, an order of women religious or a Catholic non-profit.

Survey design

The survey was designed to collect 1) information about U.S. Catholic institutional **relationships with overseas residential care facilities** and 2) information that can influence **behavior change** of such actors, specifically U.S. Catholic knowledge and attitudes toward residential care, regardless of whether they support any facilities.

The graphic below illustrates the sections and flow of the survey. To avoid respondent fatigue, facility-level detail of respondents who supported more than five facilities was not gathered, instead opting to follow up with these respondents via phone. The text of the full survey is included in the annex.

Figure 3. Survey Flow



Survey recruitment and distribution

Since various partners assisted in distributing the survey, unique links were created that tracked the origin of each survey response. In this way, the approximate number of responses of each group or individual could be assessed of those who helped distribute the survey. The Table 2 identifies the CRS Catholic partners and organizations that received the survey, as well as the actions taken with each group.

Table 2. Survey Distributors and Response Numbers

Survey Distributor	Outreach Description	Responses
Leadership Conference of Women Religious (LCWR)	LCWR sent the survey twice by email to the provincials of their member congregations with the request signed by the LCWR executive director.	104
U.S. Roman Catholic Dioceses	CRS sent the survey to diocesan staff (primarily mission office directors and some CRS diocesan directors) representing 151 dioceses in the US. In turn, several dioceses sent the survey to their parishes, schools, Catholic Charities offices and other Catholic groups/institutions.	50
Conference of Major Superiors of Men (CMSM)	CMSM sent the survey to the 228 superiors on their mailing list.	34
CRS universities	CRS sent the survey to faculty/staff representing 104 CRS university partners.	29
Catholic Volunteer Network (CVN)	CVN sent the survey link to the 600 people on their mailing list, representing 185 member organizations. The request was sent as part of a monthly newsletter and not an individual request. Due to limited response, a follow-up was conducted via email and phone to all the CVN member organizations listed on their website whose profiles indicated they worked outside the U.S.	26
Organizations/ parishes working in CTWWC demonstration countries	CRS sent the survey directly to specific U.S. Catholic organizations and parishes believed to be working with residential care facilities in the CTWWC demonstration countries: Guatemala, Haiti, India, Indonesia, Kenya, Lebanon and Moldova.	10
National Federation for Catholic Youth Ministry (NFCYM)	NFCYM sent the survey to the 700 people on their mailing list. The request was sent out as part of their monthly newsletter and not an individual request. Due to limited response, a follow-up was conducted by sending the request directly to individual dioceses.	7
CRS Global High Schools	CRS sent the survey to CRS representatives at 25 platinum-level CRS global high school partners.	7
Catholic Campus Ministry Association (CCMA)	CCMA sent the survey twice: first, to the 700 people on their mailing list as part of their monthly newsletter and next, directly to CRS University contacts. They also did individual outreach/online research.	4
Other	The Coordinator for the U.S. Hispanic Women Religious Association shared the survey with her association contacts.	1
Total Responses		273

Note: n=273 respondents; 0 missing

In the survey, respondents were asked if they knew of other individuals who they recommended to also take the survey. Those persons were contacted as well as respondents who started but did not complete surveys.

In all, 319 responses of varying quality were received. 47 responses were deleted and not included in analysis for the following reasons: 38 were duplicate responses from the same organization, one was from a non-Catholic organization, one was from a Canadian organization, five appeared to be tests of the survey with invalid responses, and two provided no organization name or contact information.

In the final analysis, 273 responses were used. About one-fifth (21 percent) of these surveys were partially incomplete but were retained in the analysis regardless, being close to complete (93 percent of the 273 responses were 93–100 percent complete). Since respondents were not required to answer every question, and because some respondents exited the survey before completing, responses for a few questions were missing. The number of responses and number missing is provided for every data point reported.

Survey limitations

The methodology of this survey had some limitations. All efforts were made to limit the effects of these as much as possible. The following list outlines the limitations and measures taken to limit their effects.

- *There is limited information about how many people received the request to fill out the survey.* An initial response rate calculation was discarded once it became clear an accurate estimate was improbable, given the various ways the survey was distributed (via organizational newsletters; specific emails from organizations to their membership; and directly from CRS to specific partners in dioceses, universities, high schools and parishes). Often more than one person per organization was contacted, and some of these partners also shared the survey with their own membership (e.g., diocesan schools offices sharing with their schools).
- *This study is a non-probability sample since a random sample of respondents/ organizations was not practical nor reasonable.* Therefore, the study/analysis can only refer to actual respondents and not confidentially generalize the findings to all similar (eligible) organizations.
- *The sample was not random and there was intention to reach out to many organizations that had previously demonstrated affiliation or support of residential care.* This was done purposefully to ensure as much information could be collected about institutions actively supporting residential care.
- *Not everyone answered the survey, and those who chose to answer may have been either more or less likely to support residential care.* When looking at duplicate responses from the same organization, two responses may have had different answers to this question, indicating that many respondents were unsure about their organization's support for residential care, or unsure whether the facility they support should be defined as residential care, despite the fact that the survey provided definitions.

- *Although respondents were asked to respond on behalf of their organizations, not all organizations had policies or stances on residential care.* Therefore, respondents may have been unsure how to respond or responded based on their own opinions. They may also have responded on behalf of only a portion of their organization (e.g., rather than their whole university, responding only as a representative of the department in which they worked).
- *Due to the limitations mentioned previously, there is caution against comparing the percentages of organizations who support residential care facilities across respondent categories.* Further engagement with respondents and complementary research could support conclusions across respondent categories.

Supplemental Internet and Phone Research

In some cases, recruiting survey responses worked very well and in others no response or an incomplete response was received. In the cases where there was an insufficient response to the initial survey request, a follow-up was conducted via phone or email outreach.

Phone or email was also used to survey respondents who stated they supported five or more facilities, as these respondents were not asked to provide facility-level detail in the survey.

When key organizations did not respond to the request to complete a survey or for more information about their survey answers, internet research about them was conducted. Some of these key organizations were identified via the survey; for others, CRS staff had previous knowledge or had identified them via online research.

Survey Results: U.S. Catholic Support for Overseas Residential Care

Responding Organizations' Demographics

Respondents were asked to select the category to which their organization belonged. Over a third of respondents answered on behalf of women's religious communities. The next most common category was archdioceses/dioceses and non-profits, making up 14 percent of the responses each, universities/colleges (13 percent), and men's religious communities (12 percent).

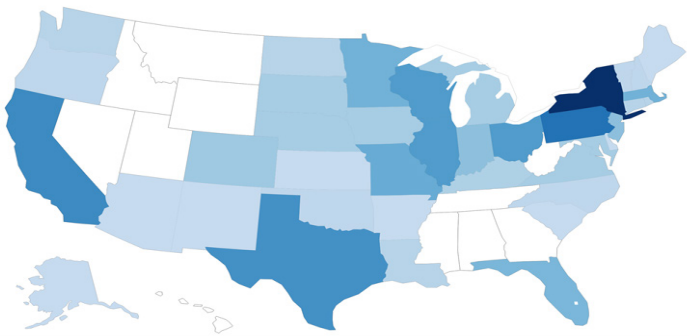
Table 3. Respondents' Self-Identified Categories for their Organizations

ORGANIZATION	# of Respondents	% of Respondents
Women's religious community	102	37%
Archdiocese/diocese	38	14%
Non-profit	37	14%
Non-profit, other	24	9%
Non-profit, volunteer program	9	3%
Non-profit, orphan care ministry	4	2%
University/college	36	13%
Men's religious community	32	12%
Parish	14	5%
High school	9	3%
Other	3	1%
Donor, individual	2	1%

Note: n=273 respondents; 0 missing

The respondents' organizations were in 40 states across the U.S. New York and Pennsylvania were the states with the highest numbers of responses.

Figure 4. Map of Geographic Distribution of Respondents' Organizations Across the U.S.



Note: n=273 respondents; 0 missing

Table 4. Respondents' Organizations by State

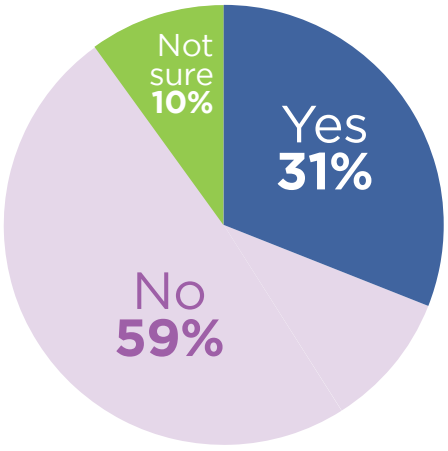
State	#	State	#	State	#	State	#
New York	33	Florida	10	Iowa	5	Oklahoma	2
Pennsylvania	22	New Jersey	8	Kentucky	4	Oregon	2
California	18	Indiana	8	Louisiana	3	Arizona	1
Texas	17	Colorado	6	North Dakota	3	Alaska	1
Ohio	15	District of Columbia	5	Rhode Island	3	Delaware	1
Wisconsin	15	Nebraska	5	Connecticut	3	South Carolina	1
Illinois	15	Maryland	5	Washington	3	Maine	1
Missouri	12	Virginia	5	Vermont	2	Kansas	1
Massachusetts	11	South Dakota	5	North Carolina	2	New Mexico	1
Minnesota	11	Michigan	5	New Hampshire	2	Arkansas	1

Note: n=273; 0 missing

Prevalence of Support for Residential Care

Eighty-six respondents (31 percent) said their organization supported one or more residential care facilities in 2018, 161 (59 percent) said they did not, and 26 (10 percent) were not sure.[12]

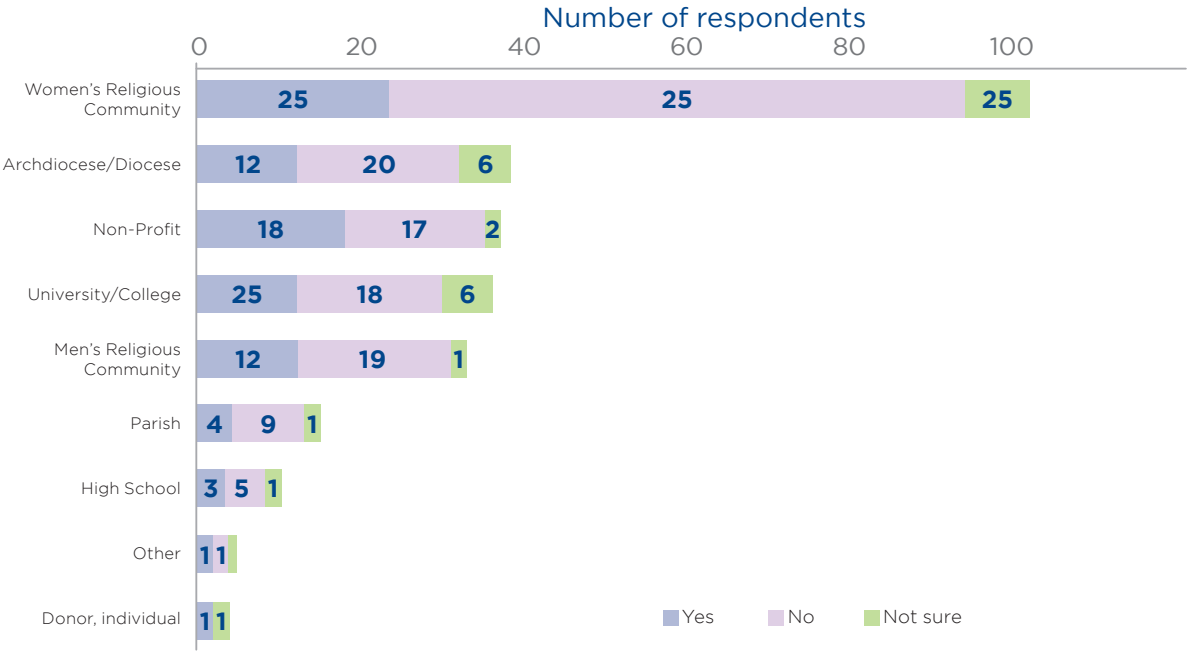
Figure 5. Whether Respondents' Organizations Supported Residential Care in 2018



Data disaggregated by type of organization; n=273 respondents, 0 missing

12 "Support" and "residential care" were framed in this way by the survey language: "During 2018, did your institution support any kind of children's residential care facility (orphanage) outside of the United States, including through volunteers, in-kind contributions, or financial donations? (Children's residential care facilities provide care in a non-family based overnight setting for children 0–18 years of age and include: boarding schools, small group homes, children's villages, and emergency shelters.)"

Figure 6. Categorization of Respondents' Organizations that Supported Residential Care in 2018

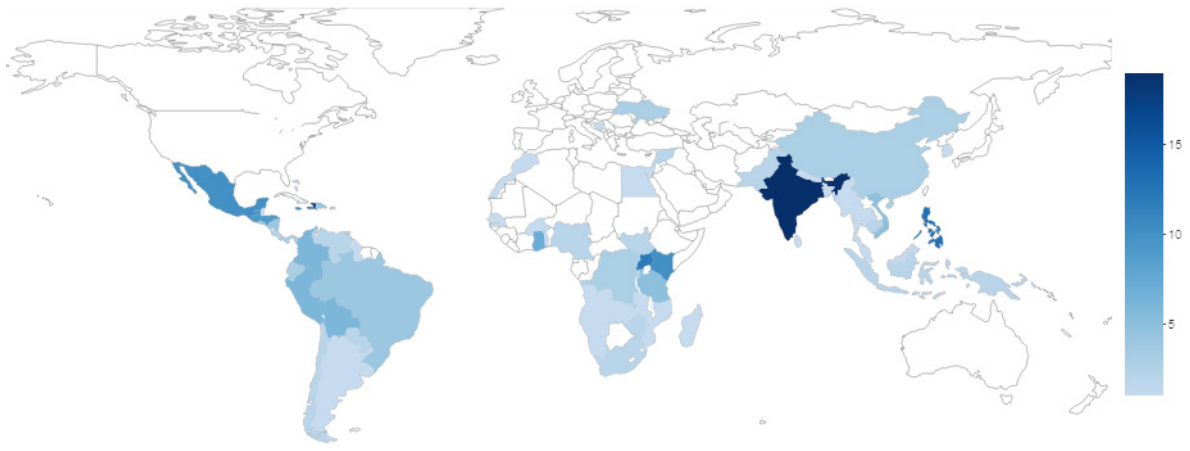


Data disaggregated by organization category; n=273 respondents, 0 missing

Geographic Spread of Catholic Support

Respondents reported that their organization supported residential care facilities across Asia, Latin America, the Caribbean, Africa, and Europe, in 2018. Figure 7 and Table 5 illustrate the approximate frequency[13] of locations of facilities.

Figure 7. Map of Approximate Locations of Catholic Support for Residential Care



13 These numbers are approximate. If a respondent supported five or more facilities, they were asked to select all the countries in which they supported facilities, without specifying how many facilities they supported within each country.

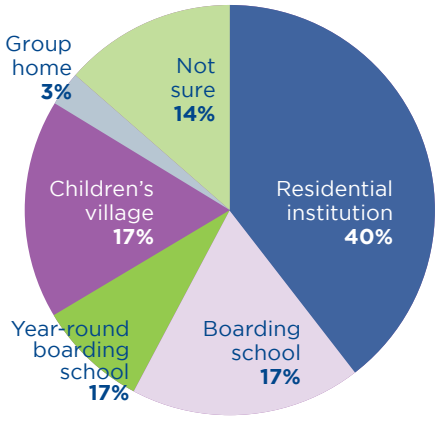
Table 5. Approximate Numbers of Facilities Supported by Respondents' Organizations per Country

Country	#	Country	#	Country	#	Country	#
India	19	Nicaragua	4	South Sudan	2	Micronesia	1
Haiti	17	China	3	Syria	2	Morocco	1
Philippines	13	DRC	3	Venezuela	2	Mozambique	1
Uganda	12	Ecuador	3	Zimbabwe	2	Myanmar	1
Jamaica	10	Panama	3	Angola	1	Namibia	1
Kenya	10	Ukraine	3	Argentina	1	Nepal	1
Mexico	10	Burundi	2	Bahamas	1	Senegal	1
Guatemala	9	Cambodia	2	Bangladesh	1	South Korea	1
Honduras	9	Cameroon	2	Belize	1	Sri Lanka	1
Ghana	7	Chile	2	Bosnia and Herzegovina	1	Swaziland	1
Bolivia	6	Costa Rica	2	Burkina Faso	1	Thailand	1
Colombia	6	Indonesia	2	Egypt	1	Timor-Leste	1
Peru	6	Nigeria	2	Gaza Strip	1	Togo	1
Tanzania	5	Pakistan	2	Guyana	1	Trinidad and Tobago	1
Vietnam	5	Papua New Guinea	2	Israel	1	Uruguay	1
Brazil	4	Paraguay	2	Lebanon	1	Zambia	1
Dominican Republic	4	Rwanda	2	Madagascar	1		
El Salvador	4	South Africa	2	Malaysia	1		

Residential Care Facilities

We asked respondents to provide detail about the facilities their organizations supported in 2018. 60 respondents provided information about 89 facilities that their organizations supported.[14] This distribution is represented in Figure 8 *(n=80 facilities; 9 missing)*.

Figure 8. Facility Categories



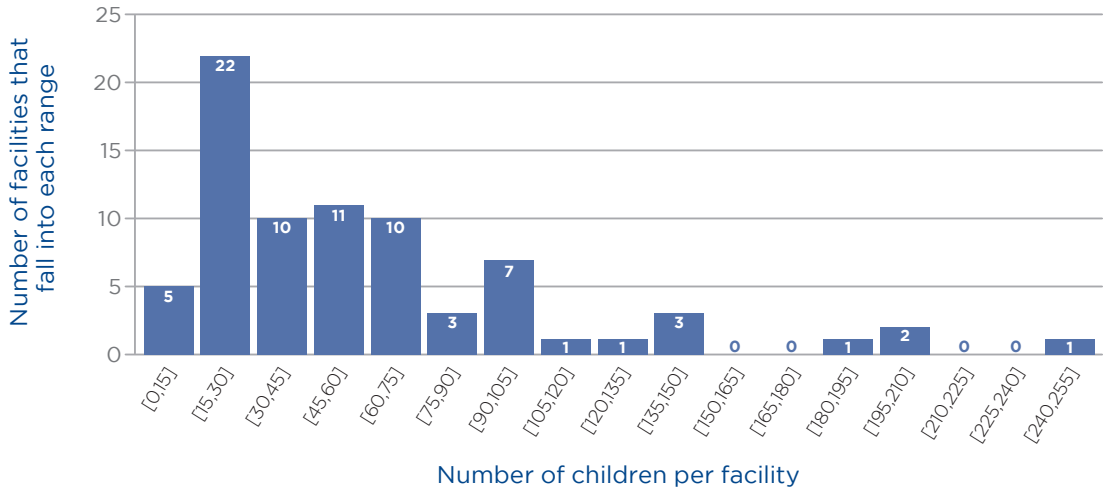
Forty percent of the facilities that the respondents' organizations supported were residential institutions (i.e., housed 11+ children in one building), according to the respondents. Seventeen percent were boarding schools where children went home to families for vacation, 17 percent were children's villages (multiple group homes on one campus), 9 percent were year-round boarding schools (children had no alternate accommodations) and 3 percent were group homes (i.e., housed less than 10 children). Fourteen percent

14 It was possible that more than one respondent provided information on the same residential care facility; for example, two respondents provided detail about Farm of the Child, Honduras. These duplicates were treated as distinct in the analysis, because the respondents provided different support.

were unsure to which category the facility they supported belonged (80 facilities had data for this question; 9 were missing).

Respondents were asked how many children the facility housed (n=81 responses; 8 missing). The responses ranged from 0–1,000, with a mean of 83 (standard deviation: 151) and a median of 50.

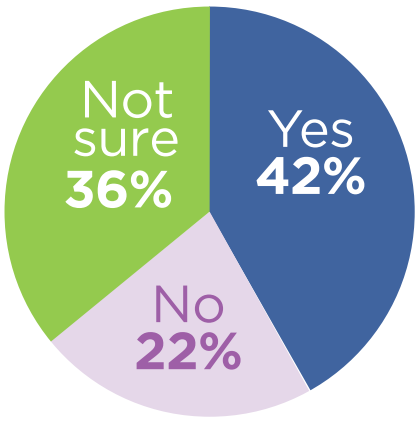
Figure 9. Histogram of How Many Children Reside in Each Facility



Note: n=81 facilities, 8 missing; [0, 15] can be read as "between 0 and 15 children," [15, 30] as "between 15 and 30 children," etc.

A plurality of facilities (22 facilities, or 27 percent of answers) housed 15 to 30 children, and 5 were smaller than 15 children. One respondent categorized their facility as a "group home with 10 or fewer children" even though they reported that it housed 65 children. Excluded from this chart are two outliers.

Figure 10. Whether the Facility Supports Children with Disabilities



Respondents provided information about whether the facility supported children with disabilities. Less than half of facilities (42 percent) supported children with disabilities, while under a quarter (22 percent) did not. For 36 percent of facilities, the respondent was not sure if the facility supported children with disabilities *(n=81 facilities; 8 missing)*.

It should be noted that Catholic constituencies support a wide variety of types and sizes of residential care facilities. Overall, the results of this study highlighted some important trends that give fresh opportunity for enhanced communication to further clarify details about these facilities. As shown in the analysis, constituencies tended to be

unsure of the details or had limited information about the residential care facilities they supported. This may also indicate limited knowledge about key priorities of CTWWC, such as how to go about transitioning to family-based care.

Financial support

We asked respondents to report the financial support their organizations provided to each facility during 2018. We cannot reliably report what percentage of facilities received financial support from the respondent because not all respondents answered the question; therefore, we cannot distinguish between respondents who did not provide any financial support and respondents who skipped the question. Given the trend uncovered earlier that many respondents had limited information about the facilities they support, the person answering the survey may not have known how much financial support they are providing at any given time. In other cases, they may have preferred not to say.

Forty-six respondents reported their organization provided some type of financial support to 65 facilities in 2018; 25 reported their organization provided the facility between $1,000–$6,000; and 6 reported their organization provided more than $71,000. This is illustrated in Figure 11 (n=68 facilities whose respondents reported any financial support). Detail by respondent and facility can be found in Table 6.

The numbers in Figure 11 should be interpreted with caution since respondents used a slider to report the approximate dollar amount provided. They were unable to type in precise numbers (see survey questions in the annex).

Figure 11. Total Reported Financial Support Provided by Each Respondent to Each Facility in 2018

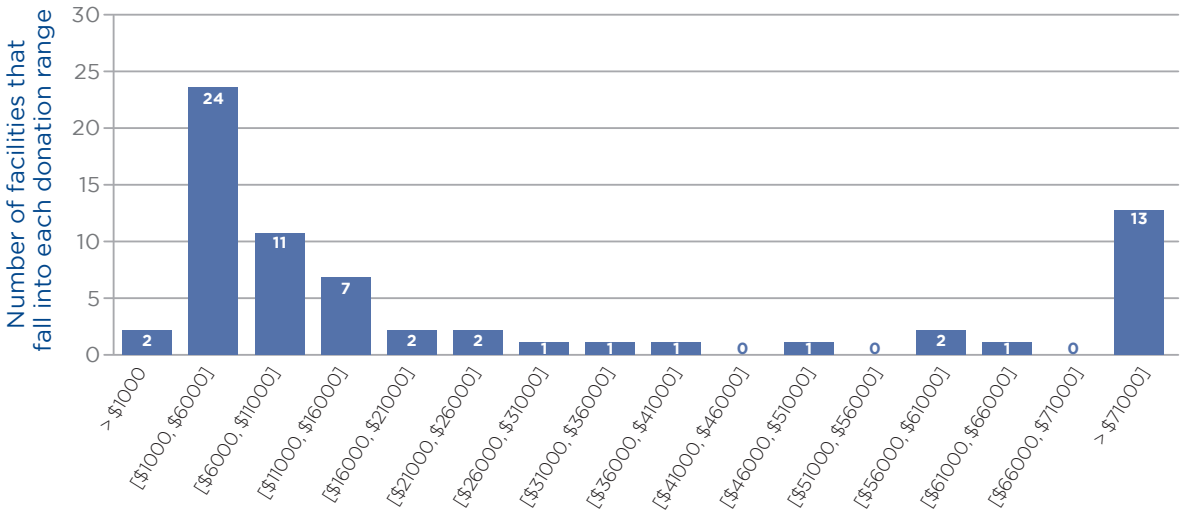
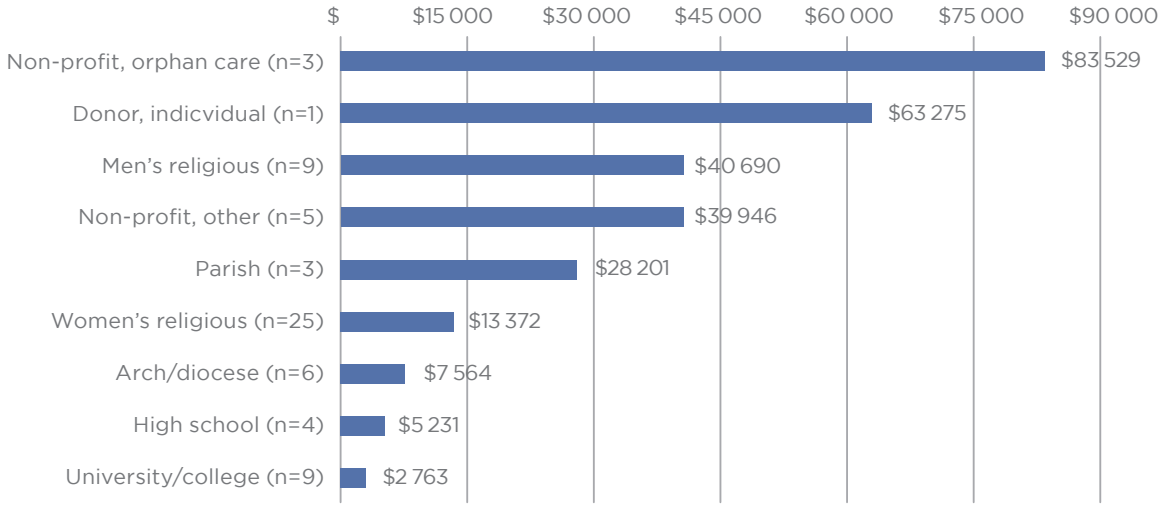


Figure 12 illustrates the reported mean amount of donations received by each facility by responding organization category.[15] It excluded amounts over $75,000 (n=65 facilities whose respondents reported any financial support, excluding those who only reported support of $75,000+ in each category).[16] On average, orphan care non-profits provided the highest amount of financial support: three facilities supported by orphan care non-profits received a mean of $84,000 in financial support from their respondent in 2018. Nine facilities supported by men's religious communities received a mean of $41,000 from their respondent. Twenty-five facilities supported by women's religious communities received a mean of $13,000 from their respondent.

These means should be interpreted with extreme caution because the maximum amount accepted by the survey per donation category was $75,000, and respondents could not indicate the exact amount donated, only "more than $75,000." This was to improve user friendliness as we expected most respondents would report small contributions. Therefore, any "$75,000+" answer was excluded from the subsequent analyses and reported separately as outliers. There were 9 respondents who reported any amounts over $75,000; these are noted in bulleted lists in the pages immediately following, as well as in Table 6.

Figure 12. Mean Reported Financial Support Received in 2018 (disaggregated by respondent type)



Next, the financial support is broken down by type of fundraising. These numbers exclude amounts over $75,000.

15 These averages only account for facilities that received any financial support; no zeros were included in the averages. No amounts over $75,000 were included.
16 The single "individual donor" wrote that they were representing Nuestros Pequeños Hermanos (NPH) on the survey, but there was reason to believe this was not true. The person was likely answering on behalf of a parish or other group. Although contacted several times to seek clarification about the relationship to NPH, there was no response.

Table 6. Types of Financial Support Provided to Each Facility

Type of financial support	Individual/ community fundraising	Grant writing	Child sponsorship
Number of respondents reporting their organizations provided this type of financial support	36	7	15
Number of facilities receiving this type of financial support	51	8	16
Mean amount of financial support received per facility per respondent	$11,313	$17,297	$21,675
Range of amounts received per facility per respondent	$500–$75,000	$1,000–$52,000	$100–$75,000

Individual or community fundraising

Thirty-six respondents reported their organizations financially supported 51 facilities with individual or community fundraising. The range of donations received via individual/community fundraising was $500–$75,000 (mean: $11,313; median: $5,256), excluding those who provided more than $75,000. The following lists the number of facilities financially supported by amounts $75,000 and less via individual/community fundraising, disaggregated by organization type:

Respondent type and number of facilities

Women's religious	19	High school	4
University/college	9	Non-profit	4
Arch/diocese	6	Parish	3
Men's religious	5	Individual donor	1

Grant writing

Seven respondents reported their organizations financially supported 8 facilities with grant writing. The range of donations received via grant writing was $1,000–$52,000 (mean: $17,297; median: $9,698), excluding those who provided more than $75,000. The following lists the number of facilities financially supported by amounts $75,000 and less via grant writing, disaggregated by organization type:

Respondent type and number of facilities

Women's religious	3
Men's religious	3
Non-profit	2

Child sponsorship

Fifteen respondents reported their organizations financially supported 16 facilities with child sponsorship. The range of donations received via child sponsorship was $100–$75,000 (mean: $21,675; median: $14,151). The following lists the number of facilities financially supported via child sponsorship, disaggregated by organizations type:

Respondent type	number of facilities
Non-profit	5
Women's religious	4
University/college	2
Men's religious	2
Parish	2

Other financial support

Twelve respondents reported their organizations financially supported 17 facilities with other types of financial support. Many of the respondents reported donations in this category that belonged in other categories. They described this support as:

- general donations
- small donations from individual donors
- bake sales
- congregation common fund
- congregational donations
- church partnerships
- tithing of donations
- home for at-risk young men
- in-kind
- first aid supplies, school supplies, soccer balls, toys, dolls, tennis balls
- gift from a local high school
- scholarship for education needs
- education
- collegiate partnerships
- religious order's ministry fund
- grants
- child sponsorship
- "education for children; clothing, food for immigrants"
- "homes for the poor"

These data indicate that most Catholic constituencies provide a relatively low amount of financial support to each facility (under $6,000). The outliers who provide very large donations are non-profits that specifically focus on orphan care.

In addition, most groups provide financial support through individual and community fundraising rather than more formalized methods like grant writing and child sponsorship.

Catholic nonprofits and religious communities were shown to be the primary ones that provided the highest amount of financial support to residential care facilities.

Non-financial support

Respondents gave details regarding non-financial support of their institutions to 81 facilities (8 missing). In this section, as above, many of the respondents reported support that belonged in other categories. Respondents' institutions supported 20 of the facilities (22 percent) via in-kind contributions. They described these as follows:

- supplies for activities with children
- books
- dental needs
- food
- medical supplies
- clothing
- shoes
- school supplies
- athletic equipment
- personnel
- volunteer work

Respondents' institutions supported 27 of the facilities (30 percent) via sharing of expertise. They described these as follows:

- facility oversight
- consulting
- medical services
- companionship
- therapy services and education
- doctors
- *campamentos* (translated from Spanish as "camps" or "groups")
- scholarships
- organizational support by program and finance committees
- leadership, administration, project management and financial oversight
- carpentry
- electrical work
- job training
- expertise related to water systems and accounting processes
- teacher training
- liturgy

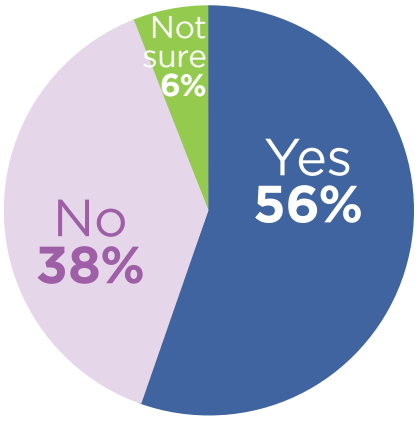
Respondents' institutions supported 25 of the facilities (28 percent) via other non-financial methods. They described these as follows:

- providing transportation
- [being the] owner and sponsor
- overseeing the facility
- supplying two summer interns annually
- establishing person-to-person relationships
- building relationships
- becoming prayer partners
- teachers for bilingual school
- mission outreach
- physical labor, painting, etc.
- nursing care

These data are difficult to interpret due to respondents' miss-classifications, but about one-third or more of facilities receive various types of non-financial support.

Volunteers

Figure 13. Whether Facilities Had Any Volunteers Sent to Them by the Respondent



Out of 81 facilities (8 responses missing), respondents sent volunteers to 45 (56 percent) of them during 2018. Thirty-one (38 percent) of facilities did not receive volunteers from their respondent, and respondents were unsure about 5 (6 percent). Below, we break down the data by short-term versus longer-term volunteers.

Short-term volunteers

- Twenty-six respondents provided information about immersion/mission groups to 35 facilities.
- Twenty-three facilities (61 percent) received one trip from their respondent in 2018; 10 facilities (22 percent) received between 2–4 trips from the respondent in 2018.
- Almost all the facilities received between 1 and 50 volunteers from their respondent in 2018. There were two outliers of organizations that sent about 150 volunteers each.
- The total cost of immersion/mission trips (per facility per respondent) was between $1,300 and $300,000 for the year 2018. The average (median) cost of short-term trips was $20,000 (cost information provided for 25 facilities; 10 missing).

Longer-term volunteers

- Ten respondents provided information about longer-term volunteers (i.e., those who volunteered for more than one month) to 13 facilities. Facilities received between 1 and 8 longer-term volunteers from these respondents in 2018.
- These longer-term volunteer trips cost between $1,000 and $55,000 per organization per facility (cost information provided for 9 facilities; 4 missing).
- The data on volunteering indicate that a great number of Catholic organizations—at least half of our respondents—send volunteers to the residential care facilities they support (note that respondents who supported 5+ facilities did not provide survey data on volunteers). They also spend significant financial resources on sending these volunteers.

Survey Results: Behavior Change

Background and Theory

What is now known as the *Stages of Change* model of behavior change originated in smoking cessation work in the public health field.[17] The model theorizes that actors do not change their behaviors quickly and decisively, but rather move through various phases of transition. Likewise, CTWWC also theorizes that in order for individuals or organizations to move their support away from residential care facilities and toward family-based care, they also progress through such phases.

These stages are known as *pre-contemplation*, wherein the actor has no intention of changing their behavior; *contemplation*, wherein they are aware a problem exists but have not committed to action; *decision/preparation*, wherein they intend to act to address the problem; *action*, the stage in which the individual is actively changing their behavior; and *maintenance*, wherein they sustain this new behavior.

Thus, the Stages of Change theory allows us to determine a shift toward a behavior before it has effectively changed, and also allows us to measure movement toward change. The Stages of Change theory is also suitable for CTWWC because existing research uses it not only with individuals,[18] but also as a theory of organizational change.[19]

Therefore, we designed a survey question to gauge respondents' progress through the Stages of Change, described in Table 7. We asked respondents, "Which of the following statements best describes your U.S. organization's approach to residential care for vulnerable children?"

17 Prochaska, J. O. and DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51(3), 390–395. https://doi.org/10.1037/0022-006X.51.3.390.

18 Prochaska, J. O. and Velicer, W. F. (1997). The Transtheoretical Model of Health Behavior Change. *American Journal of Health Promotion*, 12(1), 38–48. https://doi.org/10.4278/0890-1171-12.1.38.

19 Prochaska, J. M., Prochaska, J. O. and Levesque, D. A. (2001). A Transtheoretical Approach to Changing Organizations. *Administration and Policy in Mental Health and Mental Health Services Research*, 28, 247–261. https://link.springer.com/article/10.1023/A:1011155212811.

Table 7. Description of Stages of Change and Their Corresponding Survey Responses

STAGE	Description	Corresponding Survey response
Pre-contemplation	No intention of changing behavior	"Orphanage-based care is the best option for the vulnerable children we support."
Contemplation	Aware a problem exists but with no commitment to action	"We are currently considering transitioning our support of orphanages to providing family care."
Decision/ preparation	Intent on taking action to address the problem	"We have decided to support reintegrating children into family care but have not yet started doing so."
Action	Active modification of behavior	"We are currently supporting our orphanage(s) to reintegrate children into family care."
Maintenance	Sustained change (new behavior replaces old)	"Our orphanage(s) have transitioned and no longer provide residential care."

The theory suggests that actors' knowledge, attitudes, skills and enabling environment all influence behavior change. It posits that depending on what stage of change the audience is in, the appropriate intervention point will either be knowledge, attitudes and skills, and/or an enabling environment.

For example, an actor in the "pre-contemplation" stage, who believes without question that supporting residential care facilities is the best way to support children, may need interventions at the knowledge/attitude level. Advocacy materials could focus on sharing evidence and facts about the harms of residential care or could create positive messages around donating to family preservation programs.

On the other hand, an actor in the "action" stage, who is in the process of transitioning their support toward family-based care, may need more support around building skills. CTWWC could provide technical support for case management, household economic strengthening and effective fundraising for family-based care initiatives.

An enabling environment (e.g., diocesan support, national laws and donor trends) is also necessary to support behavior change toward family-based care. CTWWC aims to do this type of high-level systems work through government systems strengthening and high-level (in addition to actor-specific) advocacy.

This survey focused on gauging knowledge and attitudes. Table 8 describes knowledge/attitudes behavior-change questions and their relation to CTWWC's theory of behavior change. The survey posed knowledge/attitudes questions to all survey respondents; some were only relevant to respondents who reported supporting facilities.

We asked respondents, "To what extent does your U.S. organization agree or disagree with these statements?"

Table 8. Behavior-Change Questions, Justifications and Relationship to Theory

Intervention point	Survey item	Justification	Audience
Knowledge	"Most children are in orphanages because their parents are no longer living."	Available data suggest that about 80% of children in residential care facilities have a living parent;[20] thus, we consider this statement incorrect.	Posed to all respondents whether or not they supported any facilities
	"There are some situations where residential institutions will always be necessary, such as for unaccompanied refugee children or children with complex care needs in low-income countries."	Even children with disabilities have the right to a family,[21] and even children in emergency situations should be in family-based care whenever possible.[22] Thus, we consider this statement incorrect.	
	"Babies in orphanages can receive the same nurturing care and stimulation as babies raised in family care."	Available evidence suggests that for very young children, being in residential care facilities "can incur developmental damage across diverse domains" including "physical growth, cognitive function, neuro-development and social-psychological health."[23] Thus, we consider this statement incorrect.	
Attitudes	"Given the choice, money should be given to families living in poverty conditions to keep children at home rather than to orphanages."	Keeping children in residential care facilities is more expensive than family-based care. Estimates show that 6–10 children in families can be served for each one in a residential care facility.24	
	"A primary goal for organizations that support orphanages should be to reunite children with their families."		
	"In general, my organization thinks reintegrating children from orphanages to family-based care is important."		Only posed to respondents who supported residential care facilities
	"Everyone in my organization is on board about wanting to reintegrate children into family-based care."		
	"My organization has sufficient knowledge/skills to reintegrate children into family-based care."		

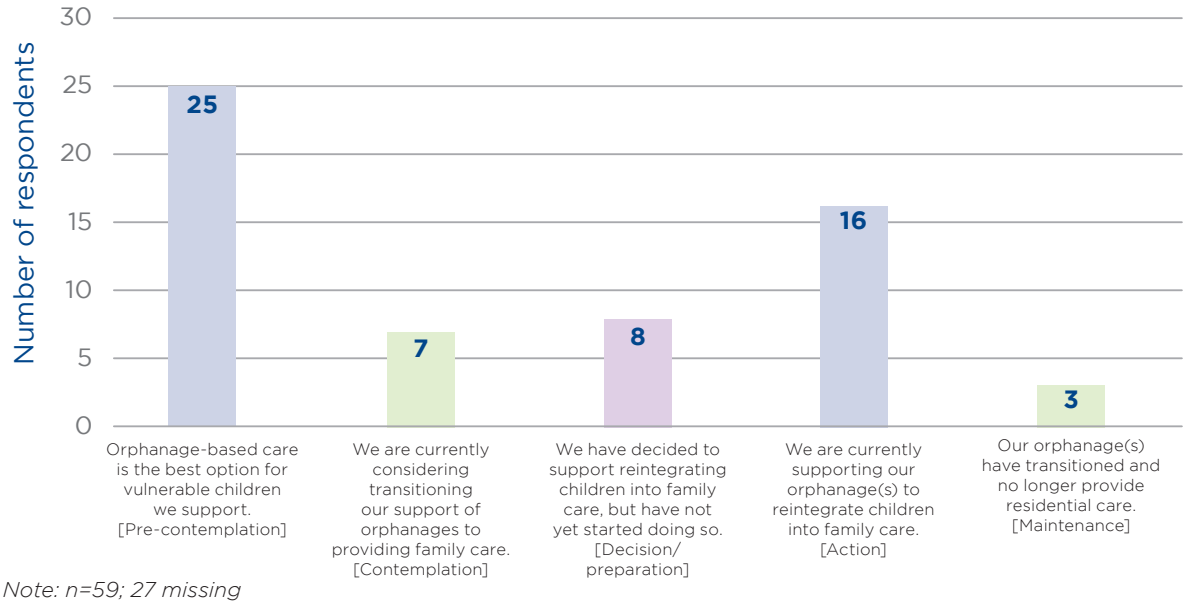
20 Csáky, C. (2009). *Keeping children out of harmful institutions: Why we should be investing in family-based care*. Save the Children. https://resourcecentre.savethechildren.net/library/keeping-children-out-harmful-institutions-why-we-should-be-investing-family-based-care.
21 United Nations General Assembly. (2006). Convention on the rights of persons with disabilities. https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf.
22 Fulford and Smith. (2013). *Alternative care in emergencies toolkit*. Save the Children. https://www.unicef.org/protection/files/ace_toolkit_.pdf.
23 Berens, A. E. and Nelson, C. A. (2015). The science of early adversity: Is there a role for large institutions in the care of vulnerable children? *The Lancet*, 386(9991), 388–398. https://doi.org/10.1016/S0140-6736(14)61131-4.
24 Williamson, J. and Greenberg, A. (2010). Families, not orphanages: Better care network working paper. http://bettercarenetwork.org/BCN/details.asp?id-23328&themeID-1003&topicID-1023.

Results

Overall, 59 respondents answered the question about Stages of Change. The survey only posed this question to respondents who said they supported residential care facilities. Twenty-seven (31 percent) responses were missing.

Forty-two percent of respondents fell into the "pre-contemplation" phase, while more than a quarter (27 percent) fell into the "action" phase.

Figure 14. Responses to "Stages of Change" Question (posed only respondents who supported residential care facilities)



Note: n=59; 27 missing

Table 9 disaggregates these results by respondent type. First, average "scores" were calculated where 0 represents pre-contemplation (the least "advanced" stage) and 4 represents maintenance (the most "advanced"). Excluded due to small samples sizes were individual donor, high school, parish, other.

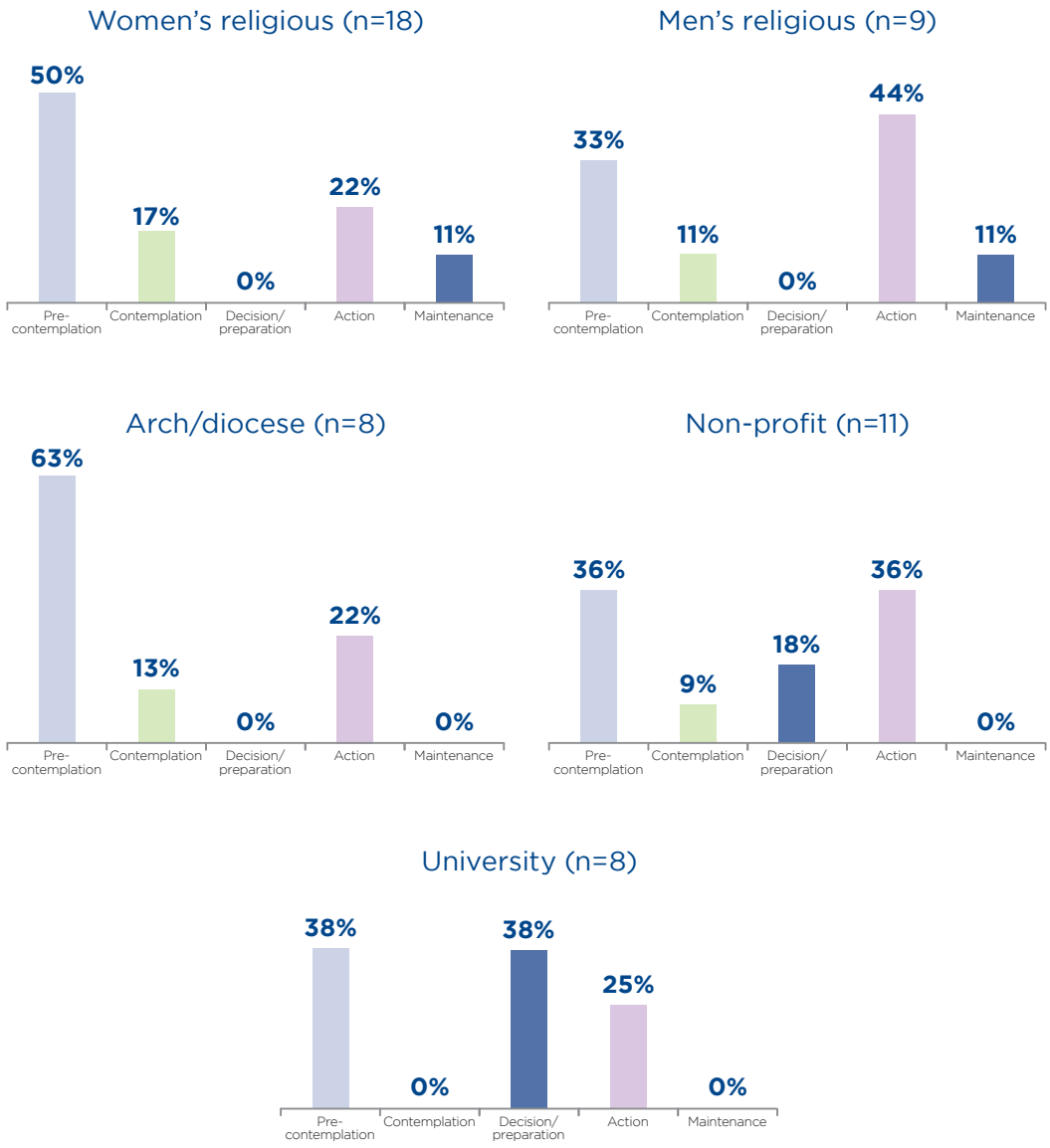
Table 9. Mean "Stages of Change" Score (by respondent type)

ORGANIZATION TYPE	MEAN STAGE OF CHANGE SCORE	STANDARD DEVIATION
Non-profit (n=11; 7 missing)	1.5	1.4
University/college (n=8; 4 missing)	1.5	1.3
Women's religious (n=18; 5 missing)	1.2	1.6
Men's religious (n= 9; 3 missing)	1.0	1.6
Archdiocese/diocese (n=8; 4 missing)	0.9	1.4

Note: n=59; 27 missing

Figure 15 shows the distribution of responses by respondent category. They mirror the response options of Figure 14; we omitted full labels to save space.

Figure 15. Responses to "Stages of Change" Question (disaggregated by respondent type)[25]



These data indicate that Catholic constituencies tend to fall into the relative "early" stage and need to make significant progress before transitioning toward family-based care. Broken down by respondent type, it appears that men's religious organizations tend to be somewhat further along in the Stages of Change, with 44 percent of respondents falling

25 In these charts, sample sizes are as follows: women's religious (n=18; 5 missing); men's religious (n=9; 3 missing); arch/diocese (n=8; 4 missing); non-profit (n=11; 7 missing); university (n=8; 4 missing). Other categories were excluded due to small samples sizes (individual donor, high school, parish, other).

into the action stage. Women's religious communities and archdioceses/dioceses, however, are more likely to remain in the "pre-contemplation" phase than other types of respondents. For the questions on knowledge and attitudes, in order to enable averages and comparisons, we coded answers into numerical data, which indicated to what extent they agreed with the provided statement. For these, strongly disagree = 0, somewhat disagree = 1, neither agree nor disagree = 2, somewhat agree = 3, and strongly agree = 4.

Table 10 shows that respondents generally agreed the most with the statement "my organization thinks reintegrat[ion]...is important." They agreed the least with the statement about babies receiving the same type of care in residential care facilities as in families, which is a factually incorrect statement according to CTWWC.

The statement "my organization has sufficient knowledge/skills to reintegrate children..." had the highest standard deviation, meaning that respondents had the most variation in their agreement with this statement.

Table 10. Mean Agreement Scores and Standard Deviations for Knowledge and Attitude Questions (sorted by highest agreement)

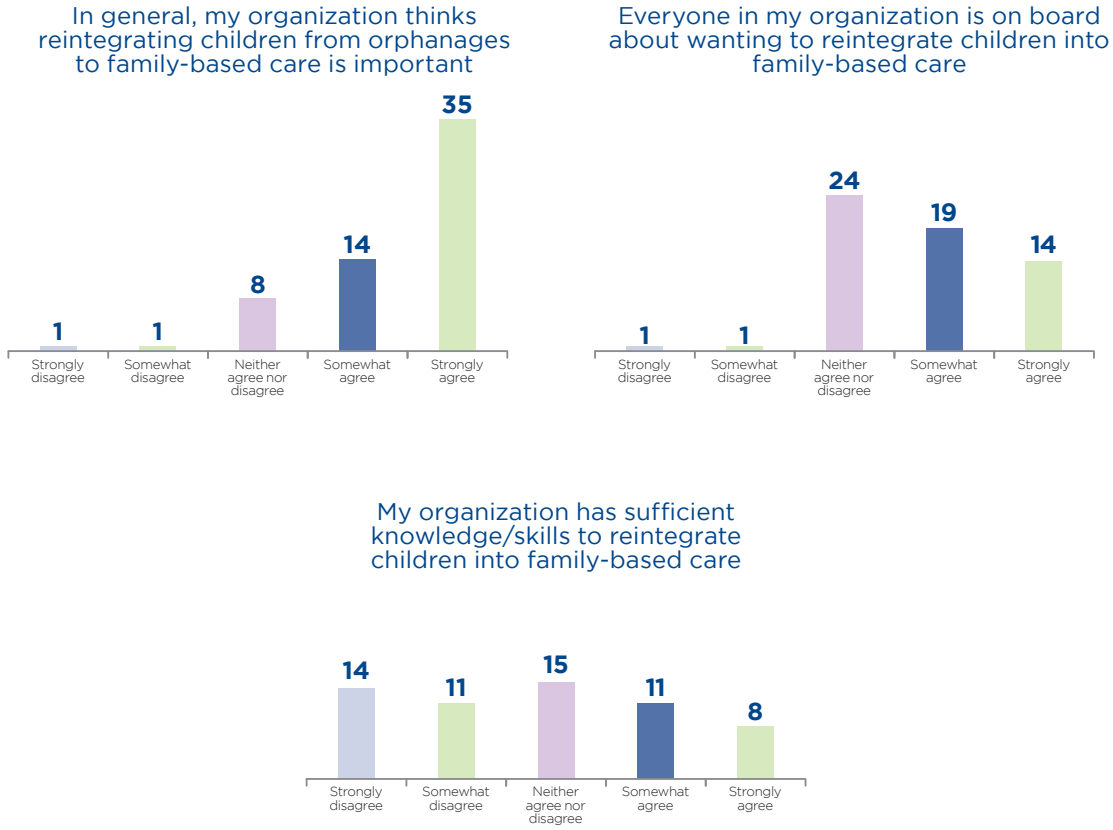
Statement	Mean agreement score	Standard Deviation	Question posed to
In general, my organization thinks reintegrating children from orphanages to family-based care is important.	3.4	0.9	Residential care supporters
A primary goal for organizations that support orphanages should be to reunite children with their families.	3.2	0.9	All
There are some situations where residential institutions will always be necessary, such as for unaccompanied refugee children or children with complex care needs in low-income countries. (According to CTWWC, this statement is factually incorrect.)	3.1	0.9	All
Given the choice, money should be given to families living in poverty conditions to keep children at home rather than to orphanages.	3.0	0.9	All
Everyone in my organization is on board about wanting to reintegrate children into family-based care.	2.7	0.9	Residential care supporters
My organization has sufficient knowledge/skills to reintegrate children into family-based care.	1.8	1.4	Residential care supporters
Most children are in orphanages because neither of their parents are living. (According to CTWWC, this statement is factually incorrect.)	1.5	1.1	All
Babies in orphanages can receive the same nurturing care and stimulation as babies raised in family care. (According to CTWWC, this statement is factually incorrect.)	1.0	1.1	All

Figures 16 and 17 elaborate on this table by showing the distributions for these data.

Figure 16. Results for Knowledge and Attitudes Questions (posed to all respondents)

Note: n=232 respondents; 41 missing

Figure 17. Results for Attitudes Questions (posed only to respondents who support residential care facilities)

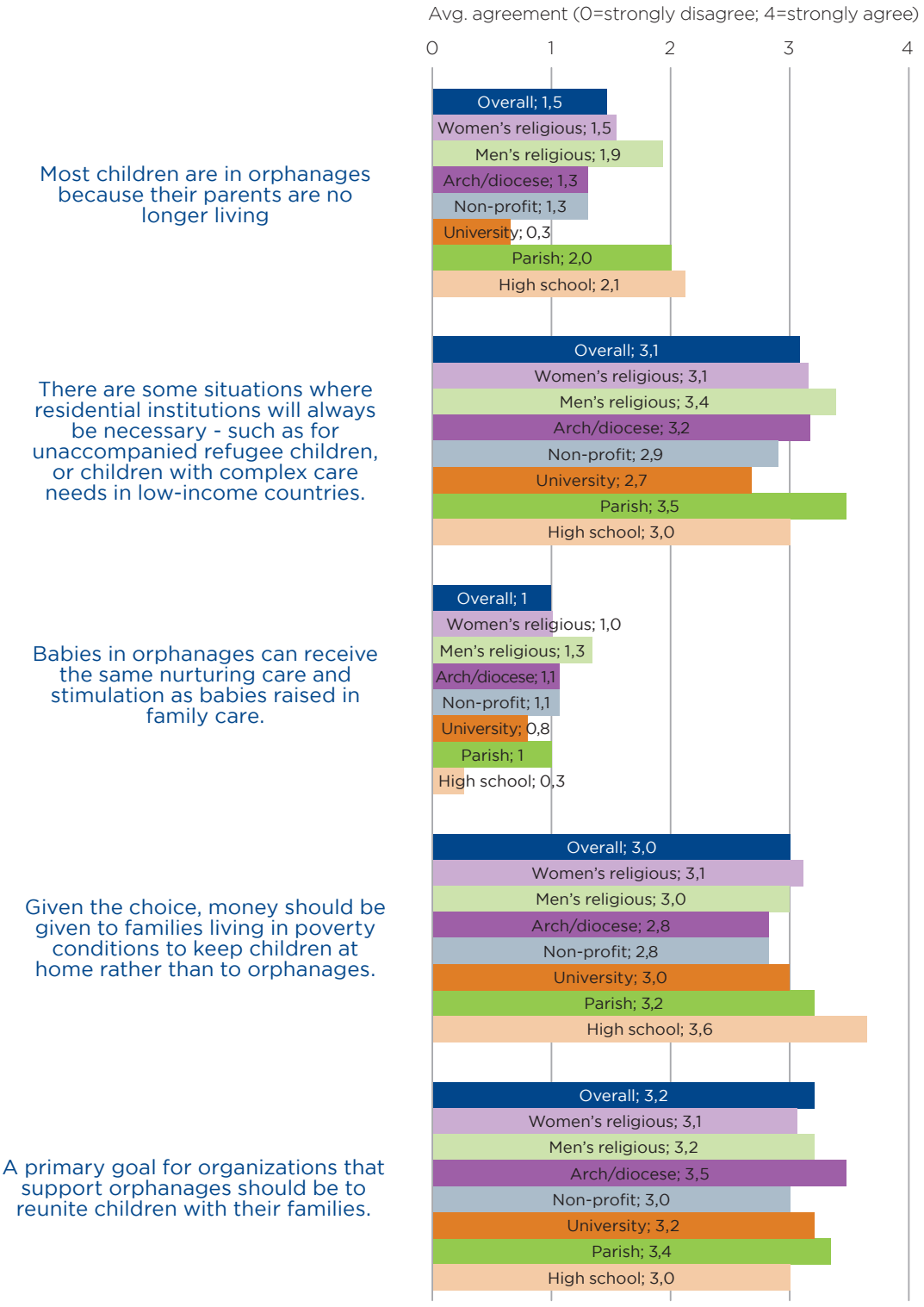


Note: n=59 respondents; 27 missing

These data illustrate that most respondents agree that family care should be prioritized, and so messaging around how to support families, keep children with their families, and strengthen family care will be effective. However, many (about 42 percent) do not feel they have the knowledge and skills necessary to transition.

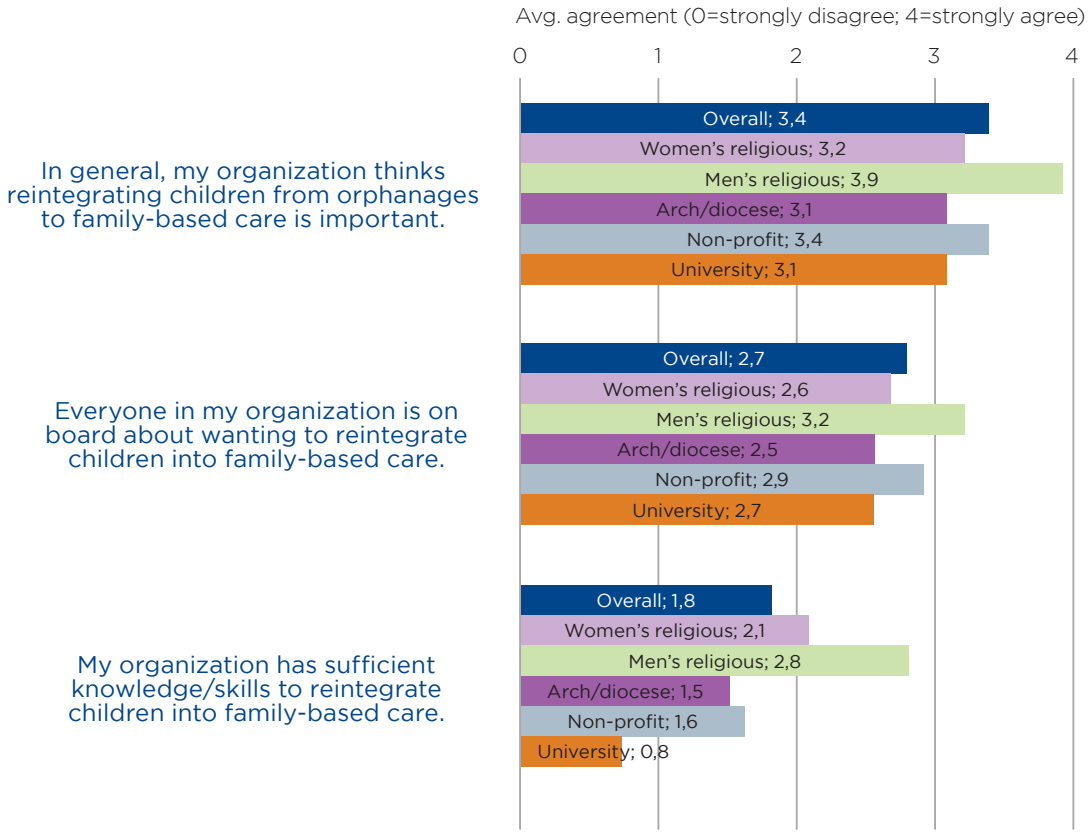
Comparisons by respondent type are presented in Figures 18 and 19. Due to the small sample sizes of some groups, we did not conduct statistical analyses to determine if the differences between groups were statistically significant.

Figure 18. Results for Knowledge and Attitudes Questions (posed to all respondents, disaggregated by respondent type)[26]



26 Samples sizes are as follows: Overall (n=232; 41 missing); women's religious (n=93; 9 missing); men's religious (n=27; 5 missing); arch/diocese (n=33; 5 missing); non-profit (n=27; 10 missing); university (n=30; 6 missing); parish (n=11; 3 missing); high school (n=8; 1 missing). Other categories were excluded due to small sample sizes (individual donor, other).

Figure 19. Results for Knowledge and Attitudes Questions (posed only to respondents who support residential care facilities, disaggregated by respondent type)[27]



These data indicate that knowledge and attitudes are relatively similar across respondent type.

Finally, we ran correlational analysis to see if respondents' stage of change was associated with the amount to which they agreed with the knowledge and attitudes statements.

27 Sample sizes are as follows: overall (n=59; 27 missing); women's religious (n=18; 5 missing); men's religious (n=9; 3 missing); arch/diocese (n=8; 4 missing); non-profit (n=11; 7 missing); university (n=8; 4 missing). Other categories were excluded due to small samples sizes (individual donor, high school, parish, other).

Table 11. Pearson's r Correlations Between Stages of Change and Individual Knowledge/Attitudes Questions

Knowledge or attitude statement	statistics28	Interpretation
Most children are in orphanages because neither of their parents are living.	r = .01 p = .91 (not significant)	No statistically significant relationship between respondents' stage of change and agreement with the statement
Babies in orphanages can receive the same nurturing care and stimulation as babies raised in family care.	r = .07 p = .57 (not significant)	
Given the choice, money should be given to families living in poverty conditions to keep children at home rather than to orphanages.	r = .24 p = .06 (not significant)	
There are some situations where residential institutions will always be necessary, such as for unaccompanied refugee children or children with complex care needs in low-income countries.	r = -.28 (very weak) p = .03 (significant)	The less "advanced" a respondents' stage, the more they tended to agree with the statement
A primary goal for organizations that support orphanages should be to reunite children with their families.	r = .27 (very weak) p = .04 (significant)	The more "advanced" a respondents' stage, the more they tended to agree with the statement
In general, my organization thinks reintegrating children from orphanages to family-based care is important.	r = .34 (weak) p = .009 (significant)	
Everyone in my organization is on board about wanting to reintegrate children into family-based care.	r = .48 (weak) p = .0001 (significant)	
My organization has sufficient knowledge/skills to reintegrate children into family-based care.	r = .40 (weak) p = .002 (significant)	

Note: n=59 respondents who support residential care; 27 missing

These results indicate that respondents' stage of change does not have any relationship with their agreement on the statements about 1) why children are in residential care facilities, 2) the care babies can receive in residential care facilities and 3) whether money should be given to families instead of residential care facilities. That is, even if respondents were in relatively "progressed" stages of change toward supporting family-based care, they did not tend to have greater agreement with CTWWC's positions on these topics.

However, there were statistically significant (though relatively weak) relationships between stage of change and the other five knowledge and attitude items. These indicate support for CTWWC's theory of change: it is likely that respondents' stage of change indicates the strength of knowledge and attitudes targeting necessary to shift them toward behavior change.

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28 *r* refers to Pearson's *r* statistic, which indicates the strength of an association; *p* refers to the statistical significance of the *r* statistic. If *p* is greater than .05, the association may be due to random chance. If *p* is less than .05, there is at least 95% confidence that the association was not by random chance; if *p* is less than .01, there is 99% confidence; if *p* is less than .001, there is 99.9% confidence.

Conclusions

The research confirmed that the types of institutions CTWWC reached out to were supporting residential care for children overseas, as expected. Key findings include:

- A common funding mechanism for men and women religious involves creating a small foundation as a means by which to raise money for their ministries, both domestic and overseas. In many cases they are sending money to support the work of their own sisters, brothers or priests; in other cases, they are supporting the work of other local men and women religious.
- Most dioceses, parishes and universities supporting residential care for children are sending small amounts of money but larger numbers of volunteers, both short- and long-term. These volunteers are most likely to be supporting the work of women or men religious. Women and men religious are widely respected within the Church, and these volunteers are most likely to be supporting their work, whatever it might be.
- Larger Catholic NGOs tend to support the work of women and men religious overseas. These organizations are receiving funding from individual Catholics as well as foundations. In some cases, the volunteer groups coming from dioceses, parishes, universities or schools, are also funneled through these larger organizations. This is not the case in every instance, but it is the trend. In some cases, they are supporting the work of a local diocese or parish residential care facility which may or may not be operated by women or men religious.

The survey and research included questions designed to understand what kind of interventions (messaging, communication, educations materials) would be needed to support an outreach and influencing strategy. In other words, through the behavior-change questions, the survey addressed where respondents fell on the Stages of Change continuum, and what kinds of interventions would be needed to facilitate movement from one stage to the next. Key findings include:

- The data indicate that Catholic constituencies tend to fall into the earlier stages, meaning that either they have no intention of changing their behavior, or they recognize that there is a problem but have no plans to take any action. The exception is men religious, with 44 percent of respondents representing men's religious communities falling into the action stage. On the other hand, women's religious communities and archdioceses/dioceses are slightly more likely to be in the "pre-contemplation" phase than other types of respondents.
- Although most respondents believe that there will always be instances where residential care is necessary, they overwhelmingly agree that family care should be prioritized.
- The majority of respondents that currently support residential care facilities do not believe they have the knowledge or skills needed to transition to family-based care.
- Answers to the knowledge and attitudes questions did not vary significantly across audience segments.

There were statistically significant (though relatively weak) relationships between stage of change and the five knowledge and attitude items. Those in the "earlier" three stages, the majority of respondents, will benefit from interventions that address knowledge and attitudes.

Annex 1: Survey Questions

Thank you for your willingness to support the work of Catholic Relief Services (CRS). CRS has embarked on a new initiative, called Changing the Way We Care (CTWWC), in partnership with Maestral International and Lumos Foundation, to strengthen families, prevent institutionalization of children and support reintegration of children into safe and nurturing families. Part of the vision of Changing the Way We Care is to influence a global movement to shift the way we care for vulnerable children, and we hope that Catholic organizations will play a central role. To that end, we seek to better understand the role that US Catholic organizations are playing in supporting vulnerable children overseas, including through residential care. This survey is part of a research and data collection project to better understand the Catholic landscape. We really appreciate your assistance! Please note:

- The survey should take no more than 15 minutes to complete.
- Even if your US Catholic organization does not support residential care facilities for children overseas, we ask that you fill out this survey.
- On the last page, we invite you to share your contact information so that we may follow up if needed, and so that we may keep you informed about this work in the future.
- The data will only be shared with the CTWWC Team and the leadership of your organization.

In appreciation, on behalf of the Changing the Way We Care Team,
Kim Lamberty
Catholic Relief Services
Kim.Lamberty@CRS.org

What is the name of the US organization that you work with?_____
Location of US Organization
State [A drop-down list of states was provided here.]
Zip Code _____
US Organization Type

- ☐ Arch/Diocese
- ☐ Non-Profit, orphan care ministry
- ☐ Non-Profit, volunteer program
- ☐ Non-Profit, other
- ☐ Donor, individual
- ☐ Donor, organization
- ☐ Parish
- ☐ Men's Religious Community
- ☐ Women's Religious Community
- ☐ Primary School
- ☐ High School
- ☐ University/College
- ☐ OTHER _____

During 2018, did your institution support any kind of children's residential care facility (orphanage) outside of the United States, including through volunteers, in-kind contributions, or financial donations? *(Children's residential care facilities provide care in a non-family based overnight setting for children 0–18 years of age and include: boarding schools, small group homes, children's villages, and emergency shelters.)*

☐ Yes, **one** facility
☐ Yes, **multiple** facilities
☐ No
☐ Not Sure

You indicated that your organization supported multiple children's residential care facilities (orphanages) outside of the United States in 2018. Please share with us how many.

☐ 2
☐ 3
☐ 4
☐ 5
☐ **More than 5** (please specify:) _____
☐ **Not Sure** (please estimate:) _____

[The following question was only displayed to respondents who supported 5 or more facilities.]

Please share with us **all** the countries in which you supported at least **one** facility (check all that apply). Thank you.

[A checklist of countries was displayed here.]

FACILITY-LEVEL DETAIL

The following block of questions were displayed to respondents who supported 2–5 facilities, one time per the number of facilities they supported.

In what country is the children's residential care facility located?

[A drop-down list of countries was provided.]

As best you are able to provide, what is the name and city location of the facility in **[country]**?
Name of facility _____
City location in **[country]** _____

How would you best describe this children's residential care facility?

☐ **GROUP HOME**—10 or fewer children living in one house
☐ **CHILDREN'S VILLAGE**—children living in multiple group homes on one campus
☐ **RESIDENTIAL INSTITUTION** (orphanage)—11 or more children living together in one building

☐ **BOARDING SCHOOL** year-round—children do not have alternative residential accommodations out of term time
☐ **BOARDING SCHOOL** during the school year only—children return to their families during vacations
☐ Not Sure

How many children does this facility house? *If unsure, please estimate.* _____

Does this facility provide services to children with disabilities?
☐ Yes
☐ No
☐ Not Sure

Using the slider, please indicate the approximate amount your organization contributed to this overseas facility via each fundraising method in 2018 (in $USD). ***If unsure,*** *please estimate. Your answer does not need to be exact.* ***If not applicable,*** *please leave slider at $0.*

	0 12500 25000 37500 50000 62500 75000 More than $75k
Individual or Community Fundraising (individual donations, email solicitations, fundraising events, etc.)	 ❑
Grant Writing	 ❑
Child Sponsorship	 ❑
Other (please describe:)	 ❑
Other (please describe:)	 ❑

What additional types of support (non-financial) did your institution provide in 2018? *Please check and describe all that apply.*
☐ In-kind contributions _____
☐ Sharing of expertise _____
☐ Other _____
☐ None of the above

Did your organization send volunteer(s) to this facility in 2018?
☐ Yes
☐ No
☐ Not Sure

[If they responded "yes"]:
Please tell us more about the **volunteers** (short-term and longer-term) your organization sent to this overseas facility in 2018. If unsure, please estimate. *If not applicable, please add a 0.*

Number of immersion/mission trips in 2018: _____
Number of immersion/mission trip participants in 2018: _____
Total cost of immersion/mission trips in USD: _____
Number of longer-term volunteers in 2018 (*"Longer-term" means more than one month):*

_____
Total cost of longer-term volunteers in USD: _____

BEHAVIOR-CHANGE QUESTIONS

[The following question was only displayed to respondents who supported facilities.]
Thank you for your willingness to assist Catholic Relief Services with our work in support of family strengthening for vulnerable children. We are also interested in your experiences and approaches working with vulnerable families and children. Please take a moment to answer a couple of final questions.

Which of the following statements best describes your U.S. organization's approach to residential care for vulnerable children?

☐ Orphanage-based care is the best option for the vulnerable children we support.
☐ We are currently considering transitioning our support of orphanages to providing family care.
☐ We have decided to support reintegrating children into family care but have not yet started doing so.
☐ We are currently supporting our orphanage(s) to reintegrate children into family care.
☐ Our orphanage(s) have transitioned and no longer provide residential care.

[For respondents who reported not supporting facilities.]
Thank you for your willingness to assist Catholic Relief Services with our work in support of family strengthening for vulnerable children. You indicated that your organization *does not support* children's residential care facilities (orphanages) outside of the United States. However, we ask that you please take a moment to share your thoughts on the following statements. Thank you.

[For respondents who reported being unsure about supporting facilities.]
Thank you for your willingness to assist Catholic Relief Services with our work in support of family strengthening for vulnerable children. You indicated that you are *not sure whether or not* your organization supports children's residential care facilities (orphanages) outside of the United States. However, we ask that you please take a moment to share your thoughts on the following statements. Thank you.

[For all respondents.]

To what extent does your US organization agree or disagree with these statements?

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Most children are in orphanages because their parents are no longer living.	❍	❍	❍	❍	❍
There are some situations where residential institutions will always be necessary, such as for unaccompanied refugee children or children with complex care needs in low-income countries.	❍	❍	❍	❍	❍
Babies in orphanages can receive the same nurturing care and stimulation as babies raised in family care.	❍	❍	❍	❍	❍

To what extent does your US organization agree or disagree with these statements?

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Given the choice, money should be given to families living in poverty conditions to keep children at home rather than to orphanages.	❍	❍	❍	❍	❍
A primary goal for organizations that support orphanages should be to reunite children with their families.	❍	❍	❍	❍	❍

The following three questions were only shown to respondents who supported facilities:

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
In general, my organization thinks reintegrating children from orphanages to family-based care is important.	❍	❍	❍	❍	❍
Everyone in my organization is on board about wanting to reintegrate children into family-based care.	❍	❍	❍	❍	❍
My organization has sufficient knowledge/skills to reintegrate children into family-based care.	❍	❍	❍	❍	❍

CONTACT INFORMATION AND RECOMMENDED CONTACTS

This block was displayed to all respondents.

Catholic Relief Services and Changing the Way We Care are building a list of US Catholic organizations involved in caring for vulnerable children in residential care facilities. If you are willing to let us contact you again, please share your contact information with us. Thank you.

Your contact information:
Your First Name _____
Your Last Name _____
Email _____ Phone _____

Your Job/Position _____

What people and/or U.S. organizations who are also involved in caring for vulnerable children in residential care facilities (outside the United States) would you recommend we reach out to?

U.S. Organization _____
City _____ State _____
Name of Contact Person _____
Email _____ Phone _____

Please explain why you recommend we reach out to them: _____
_____
_____

Are there additional people or U.S. organizations that you recommend we reach out to?

☐ Yes

☐ No

[Respondents were given the opportunity to recommend 4 contacts.]

You're done! Before you go, is there anything else you would like us to know?

_____

_____

_____

_____

Thank you for your time.

Sincerely,

The Changing the Way We Care Team

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
or visit https://forms.office.com/r/LyyBMXg4Ed

USAID FROM THE AMERICAN PEOPLE
GHR FOUNDATION
MacArthur Foundation
Changing THE WAY WE care
CRS CATHOLIC RELIEF SERVICES
Maestral.