Changing
THE WAY WE
care℠

Year 5 Household Survey

Understanding caregiver protective factors and child well-being amongst families in Guatemala, Kenya and Moldova

April 2024

CONTENTS

1. ACKNOWLEDGEMENTS

2. LIST OF ACRONYMS

APQ	Alabama Parenting Questionnaire
CCI	Charitable Children's Institution (Kenya)
CFAT	Couple Functionality Assessment Tool
CFM	Child Functioning Module
CNA	National Adoption Council (Guatemala)
COFE	Child Optimized Financial Education
CRS	Catholic Relief Services
CTWWC	Changing the Way We Care
HHS	Household Hunger Scale
MOLSP	Ministry of Labor and Social Protection (Moldova)
NCPP	National Child Protection Program (Moldova)
NGO	Non-Governmental Organization
OLS	Overall Life Satisfaction
PAPF	Parents' Assessment of Protective Factors
PFI	Protective Factor Index
PGN	Attorney General (Guatemala)
SBS	Secretariat for Social Welfare (Guatemala)
SILC	Savings and Internal Lending Community
USAID	United States Agency for International Development
WG-SS	Washington Group Short Set on Functioning
Y3	Year Three
Y5	Year Five

3. GLOSSARY OF TERMS

Alternative care: A formal or informal arrangement whereby a child is looked after at least overnight outside the parental home, either by decision of a judicial or administrative authority or a 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.

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

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

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

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

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

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

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

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

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

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

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[1] https://bettercarenetwork.org/sites/default/files/attachments/glossary.pdf
[2] American Psychological Association (APA) Dictionary of Psychology. https://dictionary.apa.org/well-being

4. INTRODUCTION

4.1. Changing the Way We Care

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

Decades of evidence shows the harmful impacts of residential care, particularly institutions, on children's development and life span outcomes[3] such that many countries have adopted laws, policies and practices promoting safe, nurturing family care aligned with global standards and best practices.[4] National, global and regional momentum, in part driven by investments by larger donors such as the European Union, USAID and UNICEF, has helped to build energy for change, i.e., "care reform." Civil society and, increasingly, young people with lived experience, have been key partners of care reform at the country, regional and global levels by coordinating policy advocacy; piloting and modeling family strengthening interventions; encouraging reintegration and family-based alternative care; developing and promoting standards of practice, guidance and training; and building the capacity of governments, communities and families. It is within this context that CTWWC has been operating to increase capacity, resources and partnerships in order to demonstrate components of care reform and models of family care across diverse contexts, building learning, best practices and innovations for global applicability. Demonstration includes verifying a theory of change; implementing effective family strengthening and care system components; providing related standards, guidance and tools; providing monitoring/feedback and adaptation mechanisms; and documenting lessons learned regarding how change occurs and how it can be sustained and scaled across different contexts.

Since 2018, CTWWC has been operating in three main demonstration countries: Guatemala, Kenya and Moldova. Guatemala was selected for demonstration because of the complexity of the governmental system and the significant, but relatively low, number of children in residential care (compared to other countries). The country was also chosen due to poverty and child protection issues which act as drivers for separation of children and the context of migration and its relationship with supporters of residential care from the United States, including its linkages with tourism.[5] Kenya was selected due to the scale of private residential care, strong political will from government, poverty and access to education as drivers of separation, and existing CRS programs that could be leveraged. Moldova, by contrast, has a heavily government-led care system and has had a focus on reducing large public residential institutions for many years. There are now

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[3] Van IJzendoorn, Marinus H, et al. "Institutionalization and deinstitutionalization of children 1: A systematic and integrative review of Evidence regarding effects on development." *The Lancet Psychiatry*, vol. 7, no. 8, 2020, pp. 703–720, https://doi.org/10.1016/s2215-0366(19)30399-2.
[4] United Nations. (2009). Guidelines for the Alternative Care of Children. https://bettercarenetwork.org/international-framework/guidelines-on-alternative-care
[5] https://www.theguardian.com/news/2018/sep/13/the-business-of-voluntourism-do-western-do-gooders-actually-do-harm.

comparatively fewer children in institutional care in Moldova, many of whom need additional support to return to family care due to disability and/or complex medical needs. The Moldova care reform effort was further complicated by war in neighboring Ukraine and the influx of displaced women and children. This context diversity has allowed CTWWC to compare and contrast across contexts and generate learning and evidence suitable for both national, regional and international audiences.

4.1.1. Guatemala

One of the key factors determining the need to strengthen the care system in Guatemala comes from past events, including the tragic 2017 fire at a government-run residential care institution, which caused the death of 41 girls. This event has been a motivating factor and, supported by CTWWC, care actors have come together over the last five years to establish a common language and vision for care reform in Guatemala. CTWWC Guatemala has worked closely with the four government entities mandated with specific responsibilities within the care system at the national level: the Secretariat for Social Welfare (SBS), the Attorney General (PGN), specialized courts within the judicial branch of government and the National Adoption Council (CNA). Some progress has been made at the sub-national level with the enactment of key commitments and policies even whilst political change and uncertainty has meant little political will for care reform. CTWWC Guatemala has been able to support progress through inter-institutional working groups in strategic areas of preventing separation through family strengthening, promoting family-based alternative care and transforming reintegration processes.

Between 2019 and 2022, CTWWC Guatemala directly supported family reintegration for 100 children living in residential care and the prevention of family separations within the Zacapa demonstration area, a department in the eastern region of Guatemala. This was achieved by building the capacity of case management processes, including assessment of children, adolescents and their families, in some cases including kinship care, development of care plans, follow-up and accompaniment of families. In the follow-up process, families are supported according to their needs and strengths, and parenting best practices and referrals to social services are provided. CTWWC Guatemala has also been working closely with several private residential care facilities to transition to providing community services and transferring skills and tools to promote the reintegration of children. The COVID-19 pandemic overwhelmed the health system and had a significant impact on those living in poverty. CTWWC Guatemala was able to bring additional supports to families facing greater risks at that time. In the last couple of years, the Guatemala team has significantly engaged in the promotion of family care and sharing of lessons in the wider Latin America region. This has included establishing a transition of care service capacity to Catholic women religious and non-governmental organizations (NGO) in Mexico, Peru and several other countries, and helping the government of Peru to improve case management for reintegration practices.

In addition, CTWWC Guatemala has promoted the prevention of unnecessary family separation and the development of parenting skills through advocacy for the creation of Municipal Children's Offices, psychosocial care and positive parenting clinics within a framework of family strengthening and prevention. CTWWC Guatemala has supported referrals of families identified by municipal level actors, including the PGN and other strategic partners, to social services in order to address risk factors and prevent separation.

This model of family strengthening and prevention of unnecessary family separation, which began in one municipality, has now been scaled to include all municipalities in the department of Zacapa and several municipalities in the Western Highlands of Guatemala. This demonstrates that it is possible to create locally-owned support networks within the municipalities that will promote linkages between existing social services with a focus on family strengthening.

CTWWC Guatemala supported the development of a positive parenting curriculum that was rolled out through parenting schools in demonstration municipalities. The families that attended the schools were identified through the municipalities and voluntarily participated in talks on children's rights and their responsibilities, as well as parents' rights and obligations. The curriculum was a response to their interest in strengthening their parenting skills and better understanding the best way to care for their children in a loving, healthy environment free of violence. The parenting schools are currently facilitated by staff of the municipalities with whom CTWWC Guatemala collaborates.

The CTWWC household survey targeted all families in Guatemala who had participated in a case management process with CTWWC due to a reintegrating child or a child identified as at risk of separation, as well as a sample of households where the caregiver had attended a parenting school.

4.1.2. Kenya

In the last few years, the government of Kenya, with the support of CTWWC, UNICEF and other actors, has taken bold steps to promote and coordinate family care for children. The Cabinet Secretary in charge of children's care led other senior government leaders in developing and endorsing the National Care Reform Strategy (2021) which provides a clear, coordinated framework to guide the implementation of care reform efforts for the next 10 years. Situation analyses completed by CTWWC Kenya and county government partners across four counties and a national care system assessment informed this national strategy.

Since 2018, CTWWC Kenya has worked with others to implement care reform demonstrations in four counties, chosen in agreement with the government: Kisumu, Nyamira and Siaya[6] counties in the west and Kilifi county on the coast of the Indian Ocean. These counties represent varied sizes, locations, contexts and previous investment in care system strengthening, and their selection ensures that demonstration learning reflects the diversity within the country. Using the demonstration counties as models, CTWWC Kenya has documented the process and impact of change in order to promote wider reform in additional counties and nationally. CTWWC Kenya has worked in partnership with local governments and civil society to support children who have returned to their families from residential care institutions by providing case management capacity building and monitoring progress toward sustainable reintegration. Many of the children included in this survey returned to family care due to COVID-19 protocols issued by the government in early 2020.[7] In order to benefit both families with children returning from residential care and those who are assessed to be at risk of child-family separation, CTWWC Kenya has also invested in family strengthening interventions to address the drivers of family separation. The model includes training and support for the implementation of case management, positive parenting, disability inclusion and household economic strengthening. This support is based on needs assessments and is aimed at building resilience and the active engagement of caregivers, children and other family members for family decision-making. As the result of a multi-year private grant, CTWWC Kenya was able to implement significantly more family strengthening work than originally planned. At the time of this household survey, CTWWC Kenya has supported close to 1,000 children reintegrating from residential care to family care and a further 18,000 children in families identified to being at risk of separation have also been supported.

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[6] Implementation in Siaya started shortly before the first round of the household survey. Consequently, no families from that county are included in that round, but a sample has been included in this second round.
[7] In demonstration counties where CTWWC was operating at the time, 1,905 children (over 60% of children in residential care) returned home due to COVID-19. CTWWC followed up with the development of case plans and provision of services to many families. Cash transfers were provided to vulnerable households to help meet the immediate, unanticipated costs of children returning home and the need for COVID-19-related supplies were identified for both families and facilities.

Interest in care reform has also spread from Kenya to neighboring countries, in part due to CTWWC Kenya's partnership with UNICEF's East and Southern Africa Regional Office. Government actors and practitioners have been joining regular webinars and reading thematic briefs produced in part with learning from CTWWC Kenya. There is keen interest to understand how case management and family strengthening are helping families reunite and stay together.

The CTWWC household survey targeted all families in Kenya who have participated in a case management process with CTWWC Kenya due to a reintegrating child as well as a sample of households where the family has received individualized or group-based support because the family was identified as being at risk of family-child separation.

4.1.3. Moldova

In Moldova in 2022, the Ministry of Labor and Social Protection (MOLSP) (the government agency mandated to oversee child protection), with support from CTWWC Moldova and UNICEF, launched the National Child Protection Program (NCPP). This five-year roadmap outlines how Moldova will leverage previous reform efforts and secure a system that is centered on ensuring a minimum package of inclusive social services and family care for all children. The NCPP is anchored in family strengthening efforts that address the main risk factors that result in family separation and increasing inclusive social services, including education, to ensure that children at risk of separation (or who are already separated from family), including children with disabilities and young children (0–6 years of age), are enabled to live within safe and supportive families and communities. The NCPP was complemented by the Financing Family Strengthening and Child Protection Services in the Context of Moldova Conference held in June 2023. The conference highlighted critical issues outlined in the European Union Association Agenda, including decreased reliance on institutional care and the need to increase national and local budgets to secure a minimum package of social services aimed at securing safe and nurturing family care for all children. The investment case that was released during the conference found that Moldova can serve 14 children at home for every dollar spent to care for a child in an institution.[8]

CTWWC Moldova works in close coordination with the government of Moldova at both the national and sub-national levels. CTWWC Moldova utilizes a collective impact approach to engage with several key implementing partners include Keystone, Child Community and Family (CCF), Partnership for Every Child (P4EC), AudioViz and other local NGOs and faith-based organizations. CTWWC Moldova is responsible for several core activities outlined in the NCPP, including strengthening the social service workforce, aligning case management processes and tools to reflect global good practices, demonstrating meaningful participation of people with lived experience, foster care for children with complex needs, social service mapping to inform planning and budgeting processes, and initiating actions leading to the prevention and, subsequently, termination of placement in residential institutions of children aged 0–6 years. Activities are designed to strengthen the existing system, leverage care reform efforts to date and transfer skills and knowledge with the aim of scaling models and long-term sustainability. CTWWC Moldova has been leading efforts aimed at decreasing reliance on institutional care. This has included comprehensive financial and human resource assessments of six remaining institutions as well as child and family assessments of more than 180 children and young people living in the institutions. Informed by the assessments, CTWWC Moldova has supported the reintegration, or placement into family-based alternative care, of 146 children. This has included providing technical support to local public authorities, skills transfers, pre- and post-placement preparation for children and families, and the provision of targeted financial support to facilitate family placements. At the same time, the provision of post-reintegration services (i.e., the monitoring of

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[8] CTWWC. (2023). Investing in family care for Moldova's future: The case for meeting Moldova's human capital needs. https://bettercarenetwork.org/sites/default/files/2023-09/final_en_investing_in_family_care_for_moldovas_future.pdf

children's evolution within the family and the provision of social counseling and psychological counseling) in situations where a need for this was identified, led to improvements at the level of inter-family and inter-community relations.

The CTWWC household survey targeted all families in Moldova who have participated in a case management process with some involvement from CTWWC Moldova due to a child reintegrating from residential care.

4.1.4. CTWWC's family strengthening approach[9]

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

Family strengthening is important as a strategy to prevent family separation amongst families who are at risk. It is also critical to the support of families with a child who is reintegrating (after leaving alternative care, for instance) and with families who are providing alternative family-based care. Children do well when their families do well, and families do better when they live in supportive neighborhoods and communities.

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

Evidence suggests that a range of drivers, both push and pull factors, result in children separating from their families and ending up in alternative care. Although poverty, abuse and neglect are the main reasons for children's entry into alternative care, most families in poverty and most families in which there is abuse and neglect do not separate. It is the presence of **protective factors** that enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences when a family is exposed to risks or shocks. Protective factors are divided into five core areas:[10]

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

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[9] https://bettercarenetwork.org/library/strengthening-family-care/changing-the-way-we-care-family-strengthening-framework
[10] Adapted from the Center for Study of Social Policy. About Strengthening Families and The Protective Factors Framework. Accessed at: https://cssp.org/wp-content/uploads/2018/10/Core-Meanings-of-the-SF-Protective-Factors-2015.pdf

Figure 1: CTWWC model of protective factors

4.1.5. CTWWC's support to children and families

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

In line with global good practices, CTWWC utilizes a case management process to ensure that children and families who are reunifying have their needs for care, protection and support met and that the reintegration is sustainable. The process of case management is the responsibility of an allocated case worker (this can include an employee of CRS as part of the CTWWC consortium, staff from the residential care facility, or a civil society partner or government agency, depending on the country) who meets with family members, including children, to assess, plan, deliver or refer for services, and who will monitor and review progress. Strengths-based case planning is used throughout the process by the case worker, in collaboration with the child and family, to identify the goals to be reached with support. When case management is supporting the reunification and reintegration of children from residential care into family-based care, the process is designed from the beginning as a whole package that begins with assessing a child and their family and works through multiple steps, including preparation and placement, toward monitoring, follow-up and eventually case closure.

As CTWWC's prevention of separation work increases, some families have been found to only need supported referrals to services and one-off types of support such as a food package or a one-time cash transfer. Thus, not all families identified as being at risk for separation are enrolled in a case management process. An example of a family who would be enrolled in case management would be a Guatemalan family who the judicial body has determined needs strengthening or else the court will remove their child. In family strengthening to prevent

separation, CTWWC has found that most families can benefit from positive parenting training and connection to community groups.

Some examples of family strengthening approaches include:

- **Positive parenting training**: Guidance on positive parenting practices and skills delivered during home visits by a case worker or through a group setting.
- **Cash transfers**: Emergency economic support consisting of cash payments (Kenya) or food exchange cards (Guatemala) to meet immediate needs (including education costs) or for up to six months until a viable income-generating activity is established or the family can cover their own needs.
- **Referrals**: Referrals by the family case worker based on assessments and case plans to social services, health care providers, disability support, education, community support, etc.
- **Gifts in kind**: Purchase for the family of items needed, often specifically to support the child who is returning to the home (such as bedding) and including food packages (a selection of food stuff gifted to a family whose contents have been reviewed by a nutrition professional).
- **Kitchen garden training:** Specific to Kenya and working with the Kenyan Ministry of Agriculture, Livestock, Fisheries, caregivers are trained and supported to establish kitchen gardens for nutrition.
- **Savings and Internal Lending Community (SILC):** Specific to Kenya, these groups mobilize caregivers to save and obtain loans within their own groups for child welfare support.
- **Child Optimized Financial Education (COFE)**: Specific to Kenya, this financial literacy training focuses on bringing benfit to children within a household and has been delivered through SILC and positive parenting groups.

4.2.   Measuring well-being

Governments and development organizations have shifted away from developing policy solely by relying on one-dimensional indicators like household income, recognizing that individuals hold diverse perspectives regarding which facets of life are important to their overall well-being.[11] The field of well-being research has seen two important developments in thinking: (1) human well-being is multifaceted, made up of various aspects and domains, and (2) the salient domains of well-being may differ by context and life circumstances.

Well-being can be objective or subjective. Objective well-being refers to observable indicators of life quality (e.g., yearly income, illness diagnosis) while subjective well-being (sometimes referred to as happiness or life satisfaction) is based on an individual's own perspective on their life.[12] One individual's objective and subjective well-being may not be the same: for example, a person may be "objectively" assessed as having low well-being if they have health problems or live in poverty, but subjectively, they may state that they are satisfied with their life. Similarly, an "objective" metric might determine a child is enjoying well-being if their nutritional and educational needs are being met, even if, when asked, the child reports being unhappy with their living situation.

Conceptualizations of subjective well-being can differ by cultural context. These nuances have led some researchers to use qualitative methods, including focus groups and ranking exercises, to determine what matters to well-being according to different populations. For example, Oxfam Great Britain used participatory, qualitative methods in Scotland to create an index of well-being that could inform policymaking for the country.[13] For children, the Personal Well-Being Index – School Children was developed to measure subjective well-being in seven domains using items

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

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

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

like, "How happy are you about the things you have? Like the money you have and the things you own?" and "How happy are you about how safe you feel?"[14]

Vulnerable sub-populations, including children who live in or have previously lived in residential care institutions, have unique priorities and needs.[15] Their marginalization makes it even more important to elevate their perspectives and voices via participatory methods. In Europe, child welfare researchers have used participatory methods to ascertain what dimensions of well-being matter to children and young people separated from their parents due to child protection concerns, using the results to recommend improvements in national and local child protection policies.[16,17] In England, researchers used qualitative and participatory methods to create a quantitative survey of well-being for children involved in the child protection system.[18,19,20]

Unfortunately, the research team could not find any documentation of such a process being conducted with children from residential care institutions in Latin America or Sub-Saharan Africa. Nor was anything conducted for Eastern Europe when a further search was done upon including Moldova in this study. One systematic review of positive adjustment in children in residential care institutions found some studies used subjective well-being as outcome measures, including one developed with adults (the World Health Organization's Quality of Life Brief Version), one developed with children in the United Kingdom (the Generic Children's Quality of Life Scale), and one developed for children involved in the child protective system in the United Kingdom (the Children's Happiness Scale).[21] No measures of subjective well-being were tailored for children with experience in residential care institutions in Africa, Latin America or Eastern Europe. In fact, as a whole, only seven of the 38 studies were done in Africa and only four occurred in Latin America.

4.3.   Aims of the household survey

A key part of the CTWWC theory of change is the flow of learning from the demonstration work out to the wider country, region and world. CTWWC is committed to building evidence in key areas related to children's care, care systems and care reform, including around outcomes for children and families. There continues to be a dearth of current evidence in relation to reintegration, transitions to alternative family-based care and prevention of separation, especially

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

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

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

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

[18] Ibid.

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

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

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

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in low resource settings.[22] In the design of CTWWC's monitoring and evaluation plan, a focus was placed on tracking outcomes at the child and family levels through routine monitoring and periodic evaluation. CTWWC's Year 3 (Y3) Review was the first opportunity for in-depth data collection, analysis and reflection on child and family experiences. Now, after five years of implementation, CTWWC has again conducted data collection, analysis and reflection. Thus, this is the second household survey (Y5).

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

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

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

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

5. METHOD

5.1.   Measures

The survey tools used in each country were based on the tool used during the 2021 survey in Guatemala and Kenya. All measures were retained for Guatemala and Kenya, with some minor adjustments to clarify wording in the child well-being section. Two additional measures were added: a couples functionality scale to capture inter-couple communication dynamics as anecdotal evidence suggested this was an area that parenting training was impacting in Kenya; and a school belonging scale since this did not appear to be adequately addressed in the existing child-welling section. For use in Moldova, the CTWWC team reviewed the existing tool and removed or adapted some elements that were considered irrelevant for the context (e.g., questions relating to school fees given that education is free in the country). Variations in the survey tool are noted in the appendix.

Previously validated translations of existing instruments were utilized when available whilst other instruments were translated by team members in country and validated by a second person. Further adjustments were made, if needed, by the enumeration team after pilot testing. In Guatemala, surveys were administered in Spanish. In Kenya, enumeration teams translated key terms into Kisii, Luo and Kiswahili, which were displayed on the survey to aid enumerators in spot-translating from English to the most appropriate language for each family. In Moldova, the survey was translated into both Romanian and Russian with enumerators choosing the appropriate language for each family.

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

5.1.1. Measures about caregivers

Washington Group Short Set on Functioning

Caregiver respondents completed the Washington Group Short Set on Functioning (WG-SS) about their functional difficulties.[23] A respondent was considered as having a disability if they had "a lot of difficulty" with or "could not [function] at all" in one or more domains of functioning (the threshold the Washington Group calls "Disability 3"). The survey asked about the domains of vision, hearing, mobility, cognition/remembering, self-care and communication.

This tool was designed to be used cross-culturally and its development was commissioned by the United Nations Statistical Commission.

Parents' Assessment of Protective Factors

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

The PAPF assesses "presence, strength and growth of parents' self-reported beliefs, feelings and behaviors" that build a caregiver's protective factors that mitigate risks and promote well-being.[24] This tool included the constructs of parental resilience (α=.861 in Guatemala, α=.795 in Kenya and

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[23] https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/
[24] https://cssp.org/resource/papf-user-guide/

α=0.979 Moldova), social connections (α=.882 in Guatemala, α=.915 in Kenya and α=.976 in Moldova), concrete assistance in times of need (α=.834 in Guatemala, α=.777 in Kenya and α= .939 in Moldova), and social and emotional competency (α=.891 in Guatemala, α=.805 in Kenya and α=.978 in Moldova).[25]

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

To our knowledge, this instrument has not been used outside of the United States before this study. The Center for the Study of Social Policy published both the English and Spanish versions of the tool and other necessary translations were completed by the CTWWC team as described above.

Alabama Parenting Questionnaire

To measure parenting practices, caregiver respondents completed the Alabama Parenting Questionnaire (APQ) subscales on parental involvement, positive parenting and corporal punishment.[26] These subscales were selected due to the CTWWC parenting trainings' emphases on positive parenting, positive discipline and involvement in children's lives.

Caregiver respondents were presented with practices/activities and asked to rate (on a scale from 0 [never] to 4 [always]) how often they did them with any of their children. The parental involvement subscale consisted of six statements (α=.695 in Guatemala, α=.680 in Kenya, α=.825 in Moldova), and the positive parenting subscale also consisted of six statements (α=.694, in Guatemala, α=.747 in Kenya, α=.838 in Moldova). These scores were calculated as sums such that the minimum possible score was 0 and the maximum was 24, with higher scores representing higher levels of positive parenting and involvement. Parental involvement questions were only asked if the caregiver had a child between the ages of 5–17.

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

The APQ has been used in many low-resource contexts.[27]

Couple Functionality Assessment Tool: communication scale

The Couple Functionality Assessment Tool (CFAT): communication scale was included in this round of the survey since participants and facilitators of CTWWC's parenting programs had noted a positive impact of the training on intra-couple relationships. Improvements in couple relationships are known to help bring benefits to children in their care.[28] Caregiver respondents who confirmed they were married or living with a partner were asked to respond to seven statements about how likely they were to respond to a problem via different forms of communication such as discussing problems, expressing feelings and blaming each other (α=.839 in Kenya, α=.880 in Moldova).[29] Each statement was responded to on a scale from 0 (very unlikely) to 4 (very likely). Four of the

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

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

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

[28] CPC Livelihoods and Economic Strengthening Task Force 2011; Woller, et al. 2011.

[29] A programming error means that the results from Guatemala could not be used.

questions were reverse-coded. Scores across all statements were averaged to give a final score that could range from 0 to 4, with higher scores representing better communication.

The seven statements in the CFAT communication scale were taken from the Constructive Communication Subscale of the Communication Patterns Questionnaire,[30] but utilized an adapted scoring scale. The CFAT was designed by CRS and field-tested by CRS Malawi in 2015.

5.1.2. Measures about households

Household Hunger Scale

The Household Hunger Scale (HHS) was included alongside other questions on household economic stability.[31] Caregiver respondents were asked if over the past four weeks their household ever lacked food entirely, if anyone in their household went to sleep hungry, or if anyone in their household ever went a whole day and night without eating. Each question was scored as 0 for no, 1 for rarely or sometimes, and 2 for often. The three questions were summed into a score in which 0–1 represented little or no household hunger, 2–3 represented moderate hunger and 4–6 indicated severe hunger.

5.1.3. Measures about children

Washington Group/UNICEF Child Functioning Module

Caregiver respondents completed the Washington Group/UNICEF Child Functioning Module (CFM) about each child selected for the survey.[32] The CFM assesses functional difficulty in the following domains: hearing, vision, communication/comprehension, learning, mobility and emotions. Questions differed for children between ages 2–4 and children older than 5. A child was considered as having a disability if they had a "a lot of difficulty" or "could not [function] at all" in one or more domain.

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

Contextualized child well-being tool

This set of questions was specially designed by CTWWC for use with children aged 11 and above who have lived in residential care or experienced risk of separation. Focus groups with young people in Guatemala and Kenya helped to identify areas they considered important in order for a young person to be doing well in life, especially after reunification to family care. The results from these group discussions indicated some variation in perspectives, but since the aim was to create a tool general and flexible enough for use across countries, but specific to the experiences of children who have lived in residential care, the findings from both countries were used. The measure went through a member checking and cognitive testing process to ensure it was reflective of the focus group discussions and was easily understood by children in both countries.[33] In addition, a factor analysis was undertaken to understand what subscales

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[30] ,Christensen, A., & Sullaway, M. (1984). Communication Patterns Questionnaire. Unpublished Manuscript. University of California, Los Angeles. Heavey, C. L., Larson, B. M., Zumtobel, D. C., & Christensen, A. (1996). The Communication Patterns Questionnaire: The reliability and validity of a constructive communication subscale. Journal of Marriage and the Family, 796–800.

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

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

[33] Neville S.E. and T. M. Crea (2022) *Child- and Adolescent-Defined Well-being: Designing a Household Survey with Children and Young People.* https://bettercarenetwork.org/library/social-welfare-systems/data-and-monitoring-tools/child-and-adolescent-defined-well-being-designing-a-household-survey-with-children-and-young-people

statistically emerged from the items. This led to the creation of three subscales: basic needs, care and safety, and leisure and freedom.

Respondents were presented with 44 statements and indicated whether each statement applied to them all the time (2), some of the time (1), or none of the time (0). Items were averaged into a mean well-being score (α=.651 in Guatemala, α=.894 in Kenya, α =.914 Moldova) and mean subscale scores, after reverse coding, if necessary. Thus, scores could range from 0 to 2, with higher scores representing greater well-being.

Overall life satisfaction

Child respondents were asked to rate how happy or satisfied they were with their life overall on a scale of 0 to 10, where 0 represented not at all satisfied and 10 completely satisfied, on the Overall Life Satisfaction (OLS) scale.[34] A visual aid was provided to help respondents understand the scale. If the child had lived in residential care, the child was also asked to think about when they lived in residential care, and rate how happy they were with their life at that time.

Family and community acceptance

Child respondents also completed a family and community acceptance scale, which was selected due to prior literature suggesting some children reunified from residential care can struggle with integration, stigma and belonging.[35] In the 2021 round of the survey, these scales were only used with child respondents who had left residential care. In this round of the survey, all children were presented with these questions as it was seen to be important to know how accepted a child at risk of separation felt, given learning around the role of stigma and acceptance for all children.

The scale is comprised of six items about family acceptance (α=.919 in Guatemala, α=.941 in Kenya, too few cases for Moldova) and six items about community acceptance (α=.644 in Guatemala, α=.883 in Kenya, too few cases for Moldova).[36] Respondents rated how true each statement was for them on a scale from 0 (not true) to 2 (very true). The means of these items were calculated to form a family acceptance score and a community acceptance score. Thus, scores could range from 0 to 2, with higher scores representing greater acceptance.

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

School belonging

The School Belonging Instrument was added to this round of the survey as a factor analysis of the contextualized child well-being results from the 2021 round, which did not bring educational well-being to the fore. The school belonging scale included six items to understand how well a child feels they connect with teachers and peers in their school environment. Responses were scored from 0 (strongly disagree) to 4 (strongly agree), and an average score across the six items (α=.835 in Guatemala, α=.829 in Kenya, α =.640 Moldova) was calculated.

The scale was originally based on the Organization for Economic Cooperation and Development's (OECD) Programme for International Student Assessment's (PISA) student well-being scale used

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

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

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

internationally, and Morgan et al.'s young person's social capital framework used in England and Spain.[37]

5.2.   Sample and participants

The household survey aimed to collect data about children, and their families, who had been reunified from residential care, and who had received some form of support from CTWWC in Guatemala, Kenya and Moldova. This included biological families in all three countries and foster families in Moldova. In addition, families who received support after being identified as at risk of family-child separation in Guatemala and Kenya were included. A final group of caregivers who had participated in CTWWC's "parenting schools" in Guatemala were added in that country. A family was considered eligible if they had begun receiving services from CTWWC before April 1, 2023.

All households who participated in the 2021 survey in Guatemala and Kenya were included in this second round. In addition, any household with a child who had been reunified with support from CTWWC Kenya between June 1, 2021 (the cutoff date for eligibility for round one) and April 1, 2023, in Kilifi, Kisumu, and Nyamira counties were included, along with a random sample of 90 (15%) households who had been identified as being at risk and had received support in Siaya county. In Guatemala, a random sample of 66 (15%) households with caregivers who had participated in parenting schools were included. Participation in the parenting schools was open to all community members in specific vulnerable communities. In Moldova, all households where a child had been placed from residential care with support from CTWWC partners (Keystone, P4EC and CCF) were included.

The primary caregiver within each family completed a survey about him or herself and their household (*caregiver survey*). Primary caregivers were identified as the individual already listed as such in CTWWC's case management and/or monitoring systems. They also completed a survey about each child in their care who was receiving individualized case management support or about an index child if the family was supported as a whole with or without case management (*caregiver report on the child*) (see Measures section for further details). It was possible for one household to have more than one child receiving individualized case management. In these cases, the caregiver completed the report for each child.

In Kenya, an index child was selected in all households that were receiving services to prevent family-child separation, and in Guatemala, an index child was selected in households who had participated in parenting schools. In these households, support was provided to benefit the family as a whole. In these cases, one child in the household between 2–17 years of age was randomly selected using a random number generator.

In reintegrating and prevention households where the child was aged 11 or older, the child was also invited to complete a survey (*child self-report*). However, it was decided not to include any children from households in Guatemala who had only participated in parenting schools as there would have been no easy way to follow-up with and support these families if any safeguarding risks had presented.

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[37] OECD. PISA 2015 results (Volume III): students' well-Being, PISA. OECD Publishing: Paris; 2017. https://doi.org/10.1787/9789264273856-en. Morgan A, Rivera F, Moreno C, Haughland BJA. (2012). Does social capital travel? Influences on the life satisfaction of young people living in England and Spain. BMC Public Health. 2012;12:138.

Overview of survey structure

Caregiver survey (once for each household)

- Household and caregiver demographics
- Caregiver disability (WG-SS)
- Services received from CTWWC
- Household economic stability
- Caregiver protective factors (PAPF)
- Parenting practices (APQ)
- Couples' communication (CFAT)

Caregiver report on child (once for each eligible child)

- Child demographics, family structure, care status
- Care history (children who had reunified only)

If child is age 2–4 ↓	*If child is age 5–10* ↓	*If child is age 11–18* ↓
- Child disability (WG/UNICEF CFM age 2–4)	- Child disability (WG/UNICEF CFM age 5+)	

- Health and wellbeing for children aged 2–10

Child self-report
(once for each eligible child)

- Health and wellbeing for children aged 11+
- Family and community acceptance
- School belonging
- OLS
- OLS reflecting on residential care (children who had reunified only)

To promote trust and legitimize the survey activity, case managers or other team members first contacted households about this survey and sensitized each caregiver about the household survey via phone. Enumerators from research partners then called to formally invite the family to the study and schedule interviews.

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

5.2.1. Response rates

Guatemala

In the first five years of CTWWC implementation in Guatemala, support was provided to 100 children reintegrating into family care, 100 children at risk of separation and 1,000 caregivers who received support for reintegration or prevention of separation.

From this population, 59 households who have received support through case management (mostly for reintegration) met the inclusion criteria to be surveyed. All of their cases were closed during 2022, and they had not been in contact with CTWWC since that time. Forty-seven of these households ultimately had a caregiver complete a survey (80%). The reasons that households did

not participate were: change of location (5), not finding anyone at home (2), the caregiver no longer having contact with the child/young person (2), death of caregiver or child (2) and separation of the couple (1).

In addition, a random sample of 66 households where someone had participated in a parenting school in Zacapa Department (as a prevention of separation strategy) were contacted, with 61 caregivers participating in the survey (92%). Contact was not possible with five households.

Data was provided by caregivers on 69 children from 38 of the households supported through case management[38] (39 children who were reintegrating and 25 children who were considered at risk of separation). Amongst these children, there were 45 children aged 11 and over who were eligible to complete a child survey. Of these, 30 children completed a survey (67%).

In Guatemala, there were 47 caregivers and 72 children who responded to both the Y3 and Y5 surveys. Their responses were included in the analysis looking at change over time.

Kenya

In the first five years of CTWWC in Kenya, support was provided to 780 children reintegrating into family care, 18,300 children in households assessed to be at risk of separation and 6,100 caregivers received support for reintegration or prevention of separation. Between rounds one and two of this survey, all households with a child reintegrating from residential care were eligible whilst only a random sample of households who were supported to prevent separation were invited to participate.

A total of 321 households were approached to be surveyed in Kenya, and 278 (87%) of these had the primary caregiver take a survey (see Table 1). The reasons caregivers were unable to be surveyed were: relocation to outside the county (20 caregivers), unable to be contacted (8), illness/disability (3) and other (12).

Data was provided on 358 children by their caregivers, 232 were reintegrating from residential care and 126 were index children in households supported to prevent separation. There were 216 children aged 11 and above eligible to be surveyed, and 166 (77%) of these completed a survey. Children were unable to be surveyed due to relocation and/or no longer living with the caregiver (32), being away at a boarding school (21), disability/illness (2) and other (4).

In Kenya, there were 156 caregivers and 180 children who responded to surveys at both Y3 and Y5. Their responses were included in the analysis looking at change over time. It should be noted that in order to be included at both time points, children had to be between the ages of 11 and 18 during both Y3 and Y5. In addition, the Y3 child response rate was relatively low, at 55%, because the household survey was conducted while many children were away at boarding school.[39]

Moldova

In the last two years (2021–23), CTWWC in Moldova supported 146 children reintegrating into family care and 249 caregivers. Not all of these families were eligible for this survey due to the timing of the child's placement.

In Moldova, 68 households were identified as eligible to be surveyed, of which 42 participated in the survey (see Table 1). Of the caregivers who were unable to be surveyed, 12 declined to

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[38] No information was gathered about children from caregivers participating in the parenting schools and no child from their households participated in the survey.

[39] CTWWC (2022) Year 3 Review: Guatemala and Kenya Household Survey. https://bettercarenetwork.org/library/social-welfare-systems/data-and-monitoring-tools/year-3-review-guatemala-and-kenya-household-survey

participate, 12 could not be contacted and two were no longer caring for the child who had previously been placed with them.

Data was provided on 70 children by their caregiver, 26 of these children were in foster care placements and the rest had been placed with a member of their biological family. Sixteen children aged 11 and over were identified to participate as respondents, of whom 14 completed the survey. The two children who did not participate were not available in the household due to one studying away from home and one having gotten married and living elsewhere.

Change over time was not analyzed in Moldova because there was no Y3 Moldova survey. CTWWC had not yet started working directly with families in the country at that time.

Table 1. Survey response rates

	Caregivers			Children age 11+		
	Completed survey	*Total attempted*	*Response rate*	*Completed survey*	*Total attempted*	*Response rate*
Kenya total	**278**	**321**	**87%**	**166**	**216**	**77%**
Kilifi	69	84	82%	37	52	71%
Kisumu	96	108	88%	59	83	71%
Nyamira	30	39	77%	26	28	92%
Siaya	83	90	92%	44	53	83%
Guatemala total	**109**	**125**	**87%**	**30**	**45**	**67%**
Case management	47	59	80%	30	45	67%
Parenting schools	61	66	92%	-	-	-
Moldova total	**42**	**68**	**62%**	**14**	**16**	**87%**

5.3.   Ethics

The research protocols were originally designed for the Y3 round of the survey and were approved by the Boston College Institutional Review Board in the United States and the Maseno University Ethical Review Committee in Kenya.[40] For the Y5 round of the survey, the study protocols were submitted again to the Maseno committee as an amendment to the original submission, and a new research permit was received from the Kenyan National Commission for Science, Technology and Innovation. At each household at the time of data collection, enumerators obtained verbal informed consent from caregivers, consent from caregivers for their children to participate, and assent from children.

CTWWC safeguarding leads in each country directed the development of a detailed safeguarding protocol and decision-making flow charts. The protocols specified what actions enumerators were to take in cases of explicit or observed risk of harm, disclosures of maltreatment, observed child injuries or participants becoming distressed. Training was provided by CTWWC to the enumerators, and they were directed to report safeguarding concerns, depending on severity, to CTWWC supervisors, case managers and/or local authorities. The survey was programmed in CommCare such that if caregivers or children gave any answers that indicated a possible risk of harm, the enumerator received an alert that they must escalate the concern. At the close of data

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[40] Laws governing research in Kenya specify that all studies conducted by international researchers must receive ethical approval from a Kenyan research ethics committee as well as one from the researchers' home country. Guatemala and Moldova, however, do not have laws that required this study to undergo ethical review. Instead, individuals from CTWWC Guatemala and Moldova reviewed the protocol for cultural appropriateness, and adjustments were made accordingly. All consent and safeguarding protocols included in the original design were followed in all three countries.

collection, a report was compiled on any safeguarding alerts and actions taken to ensure the safeguarding leads could follow-up appropriately.

5.4.   Analysis

The survey results were analyzed separately for each country. First, all univariate (descriptive) statistics for each sample were reported. Second, bivariate statistics were run (i.e., how two variables could be related to one another). There were two types of bivariate statistics: independent samples t-tests, which examined differences in the means of two groups, and Pearson's correlations, which examined how two continuous (numerical) variables were related to one another.

■ For caregiver data, independent samples t-tests were run to examine how caregivers' PAPF, APQ and various household economic stability outcomes differed by caregiver sex, disability status, urban/rural status, widow status and whether the household had any reintegrated children. Pearson's correlations were examined between caregivers' PAPF, APQ and household economic stability scores and caregiver age, number of adults per household, number of children per household and caregiver education level. For the one binary outcome variable (whether caregivers had saved any money in the past month), cross-tabs and chi-squared tests were used to examine relationships with caregiver sex, disability status, urban/rural status, widow status and whether the household had any reintegrated children. T-tests were used to examine its relationships with caregiver age, number of adults per household, number of children per household and caregiver education level.
■ For child data, independent samples t-tests were run to examine how children's various well-being outcomes differed by child sex, disability status, reintegrated vs. at-risk children, parental care status (children living with neither biological parent vs. children living with one or both parents), orphanhood status (single/double orphans vs. non-orphans) and whether or not children lived with any adult who was not their relative. Pearson's correlations were used to examine the relationship between children's well-being scores and child age, age at reunification, age at entrance to residential care and number of years spent in residential care.

Then, to explore the third research question, the study ran Pearson's correlations to examine whether various children's well-being scores were correlated with various caregiver protective factors scores. These bivariate relationships are reported in the text if they were statistically significant at the $p<.05$ level. Full statistical information for each analysis can be found in the appendix.

Finally, to explore change over time, survey responses from participants who had responded to both the Y3 and Y5 surveys were analyzed. Paired t-tests were used to examine if the mean scores on a measure were significantly different at Y3 and Y5. Then, to see if change over time differed for participants with different characteristics, change scores for each measure were calculated (i.e., score at Y5 minus score at Y3); t-tests were run to see if mean change scores were significantly different for different groups (i.e., males vs. females or urban vs. rural households), and Pearson's correlations were calculated to see if change scores were correlated with continuous measures (i.e., if change scores were correlated with HHS or the number of children in a household).

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

5.5.   Limitations

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

As there was no comparison group in the sampling strategy, conclusions can only be made about families in CTWWC's programs and cannot be generalized to children in residential care in entire countries. Since children were not randomly selected to receive services from CTWWC, causality cannot be attributed to any differences between at-risk children and reunified children. In other words, the survey cannot say that living in residential care caused certain outcomes amongst reunified children.

Caregivers may not have accurately reported their receipt of CTWWC family strengthening interventions. For example, they may not have remembered that they received home visits from CTWWC, or they may not have known the difference between what CTWWC and other service providers offered.

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

In Kenya, it is important to note that most families depend on the informal economy, and interviewing them, with or without notice, can cause them to stop earning money, which has repercussions on the family economy. This round of the survey was undertaken when it was possible to reach more children as it was during the school break, but there were still some children at boarding schools who were not present at their family home and who could not be surveyed.

In Moldova, the interaction between the families and CTWWC was different as there is a much stronger government involvement in case management, reunification and the foster care process compared to Guatemala and Kenya. There was a lower response rate from families in Guatemala, which is attributed in part to this different relationship as well as to a more general challenge of building trust in data collection processes, as were faced even in undertaking the national census in Moldova.

In Guatemala and Moldova, the survey's small sample size limited its power to detect differences between groups or correlations between variables.

6. RESULTS

6.1. Guatemala results

6.1.1. Guatemala participant characteristics

Household characteristics

A total of 109 households took part in the survey, 47 from households who had participated in a case management process and 62 from households where a caregiver had participated in a parenting school.

Amongst households who had participated in a case management process, 19 (40%) were from the department of Guatemala, and 13 (28%) were from the department of Zacapa. The remaining percent were from other departments. All but one of the households where a caregiver had participated in a parenting school were in the department of Zacapa (Table 2). In both groups, close to 60% of households were from rural areas with 40% from urban areas (Table 3).

The respondents included households who had participated in a case management process with children reintegrating from residential care or with children at risk of separation (43%). These households had all participated in the first round of the survey in Y3 of the initiative. The remaining 57% were households where a caregiver had participated in a parenting school. This report will mostly present findings separately between households supported with case management and those where a caregiver participated in a parenting school. This is because the level of interaction with CTWWC was quite different between the two. Case management is a much more personalized and intense process to support reintegration of a child and involves the whole family, usually for over a year, whilst the parenting schools were a single intervention only involving one caregiver and for a limited period of time (see Introduction section). The intention is not to compare the two groups, but to ensure that the different results are understood in the context of how each group interacted with CTWWC.

On average, each household had three adults (SD: 1.174, min: 1, max: 7), although the most common scenario was households having at least two adults (45%). In terms of the number of children per household, the mean number was three (SD: 2.300, min: 1 max: 20), with 32% having at least one child and 31% of households having at least two children.

Table 2: Number of participating households per department and municipality, Guatemala

Departments (bold) and municipalities	Case management households	Parenting school households
Zacapa	**13**	**61**
Zacapa	3	61
Teculután	4	
Río Hondo	2	
Usumatlán	2	
Cabañas	1	
La Fragua	1	
Guatemala	**19**	**1**
Guatemala	7	
Mixco	4	
Chinautla	3	
Chiantla	1	
San José Pinula		1
San Miguel Petapa	1	
San Pedro Sacatepéquez	1	
Villa Canales	1	
Villa Nueva	1	
Escuintla	**4**	**0**
Puerto de San José	3	
Escuintla	1	
Santa Rosa	**2**	**0**
Chiquimulilla	1	
Taxisco	1	
Jutiapa	**5**	**0**
Jutiapa	2	
Chiquimula	1	
Esquipulas	1	
Santa Catarina Mita	1	
Izabal	**2**	**0**
Morales	1	
Puerto Barrios	1	
Suchitepequez	**1**	**0**
Río Bravo	1	
San Marcos	**1**	**0**
Río Blanco	1	
Total	**47**	**62**

Table 3: Household urban/rural location, Guatemala

Type of household	Case management households	Parenting school households	All households
Rural	30 (64%)	35 (57%)	65 (60%)
Urban	17 (36%)	27 (43%)	44 (40%)
Total	**47 (100%)**	**62 (100%)**	**109 (100%)**

Caregiver demographics

Respondents were the primary caregivers in the households, and the majority of the 109 respondents were women (94%) (Table 4). Amongst the households who had been supported with case management, there were only six male respondents, and there was only one male respondent amongst parenting school caregivers. The average age of caregivers from households supported with case management was 43 years and for caregivers who had attended parenting schools it was 36 years (Table 4).

Most caregivers (58%) were married (Table 4). Amongst caregivers from case management households, 23% were single (never married) and 17% were widowed or divorced. Within caregivers who had attended parenting schools, 36% were single and very few were widowed or divorced, just four individuals (7%).

Caregivers' educational attainment varied between the two groups of households. Amongst caregivers who had received case management, 68% had completed primary education, with a further 14% completing secondary (Table 4). Amongst caregivers who had attended parenting schools, 60% had only attended primary, but 24% had completed secondary.

A total of 19 caregivers (17%) were identified as having disabilities based on the WG-SS assessment. The most common type of disability among them was cognitive disability (7%), followed by mobility and visual impairment (6% each).

Table 4: Caregiver characteristics, Guatemala

	Case management (n=47)	Parenting schools (n=62)	Total (n=109)
Sex			
Female	41 (87%)	61 (98%)	102 (94%)
Male	6 (13%)	1 (2%)	7 (6%)
Age			
Mean	43 years	36 years	39 years
Marital status			
Single/never married	11 (23%)	22 (36%)	33 (30%)
Married	28 (60%)	35 (57%)	63 (58%)
Widowed	6 (13%)	1 (2%)	7 (6%)
Divorced/separated	2 (4%)	4 (7%)	6 (6%)
Education level			
Less than primary	2 (7%)	9 (16%)	11 (13%)
Primary	19 (68%)	24 (44%)	43 (52%)
Secondary	4 (14%)	13 (24%)	17 (20%)
Higher than secondary	3 (11%)	9 (16%)	12 (14%)

Child demographics

The survey collected information about 69 children from their caregivers in households where case management had been provided to support reintegration from residential care or to prevent separation. Across 38 households, there were 39 children who were reintegrating and 25 children who were considered at risk of separation. No child information was gathered from households where a caregiver had participated in a parenting school.

Amongst the children for whom data was provided, 55% were girls and 45% were boys. The average age of child respondents was 12 years, with an age range spanning 4 years to 18 years (Figure 2).

According to the responses given by caregivers on the CFM, 7% of children had a functional limitation. The domains where children had functional limitations were: concentrating (4%), making friends (4%), remembering (3%), behavior control (3%), vision (3%) and transitions/accepting change (1%).

Figure 1: Child age, Guatemala
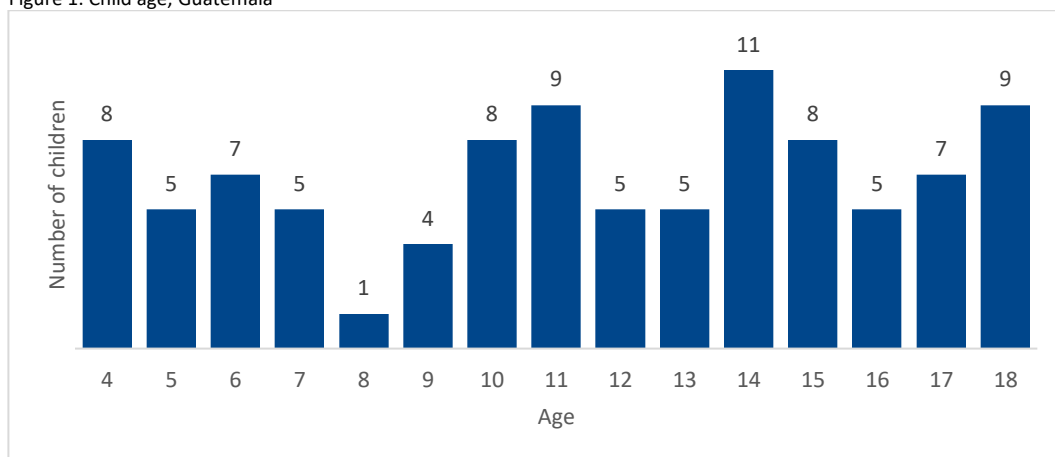
Child's relationship to household

The primary caregiver (who was responding to the survey) was most frequently the child's biological mother (88%) and all of the children were being cared for by a relative (Figure 3). The majority of children were also living with at least one biological sibling (80%) (Figure 4). In addition, 10 children (16%) were living with an adult who was not related to them by blood. These often included a stepparent or caregiver's romantic partner, true for seven of the 10 children. Most children were not orphaned (78%), but 16% were paternal orphans (Figure 5).

If a child's parent was alive but they did not live with them, the respondent was asked about the child's frequency of contact with the parent. In Guatemala, just four children did not live with their biological mothers, although they (i.e., the mothers) were still alive, and in all cases the children never had contact with their mothers. There were 17 children not living with their fathers, although they (i.e., the fathers) were still alive. Of these, half of the children never had contact with the fathers.

Figure 2: Caregiver relationship to child, Guatemala
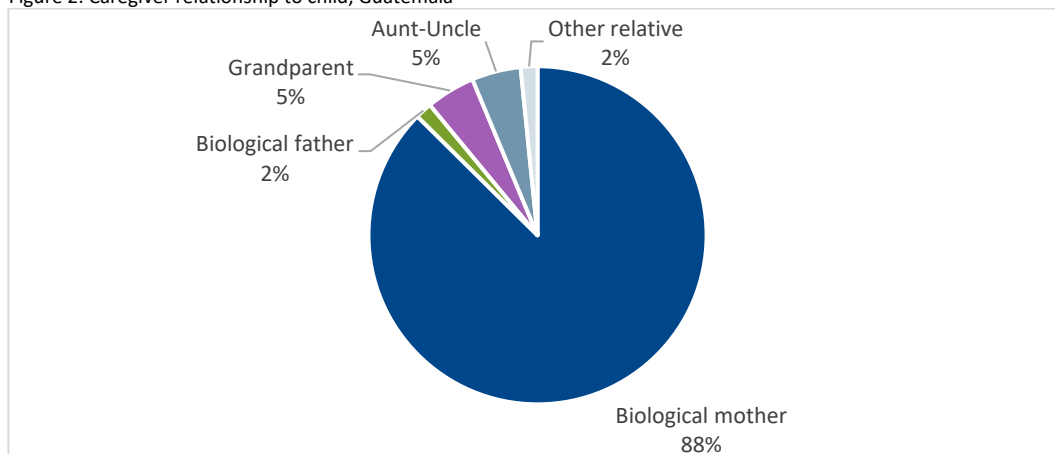
Figure 3: Child's relationship to other children in household, Guatemala

Other relative
7%

Non relative
2%

Cousins
5%

Half sibling
5%

Bilogical sibling
80%
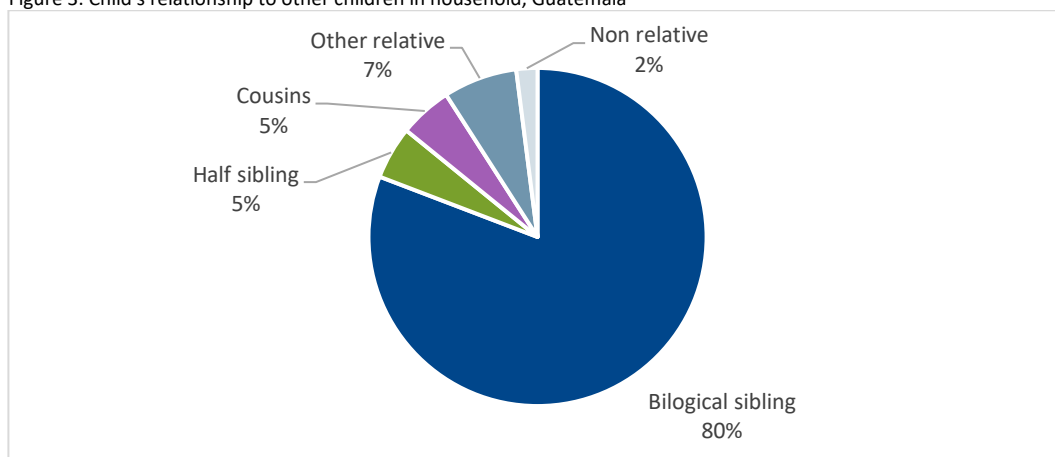
Figure 4: Orphanhood status, Guatemala

Double orphan
2%

Unknown
3%

Maternal orphan
2%

Paternal orphan
16%

Not an orphan
78%
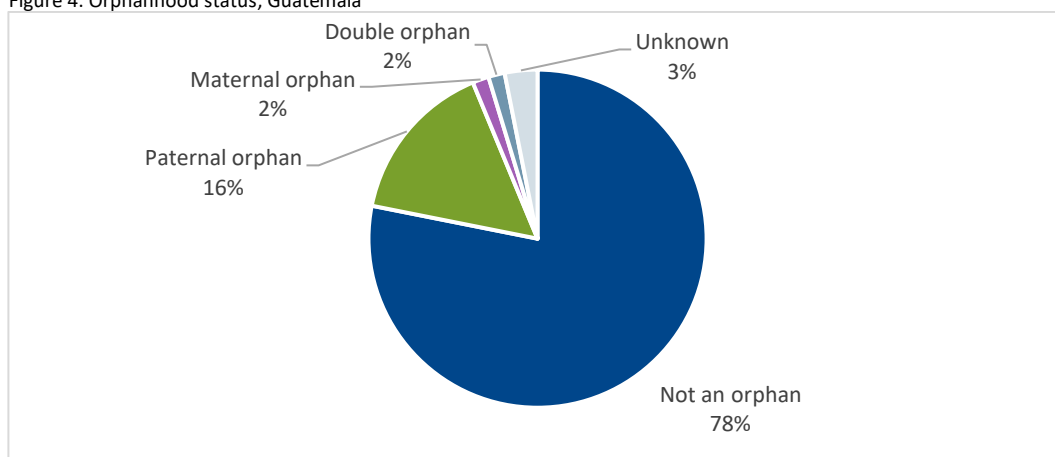
Care histories of children who have been reunified

Of the children on whom data was collected, 39 had been reunified from residential care. On average, these children entered care at the age of 8 (min:<1, max:16) and left at the age of 9 (min:<1, max:16), having spent an average of one year in care (min:<1, max:6).

The majority (73%) had lived with the same caregiver who was responding to the survey prior to entering residential care (Figure 6), and 79% had lived with their biological parents before entering residential care (Figure 7). Almost half of the children had been in residential care with siblings and of these, 94% were reunified with their siblings. Just seven children (19%) remain in communication with someone in the residential care institution, most commonly a staff member such as a social worker or caregiver, but also friends.

Finally, the survey sought to determine whether children moved in and out of care during the period of time they were in residential care. The primary caregivers of children who had been reunified were presented with the following question: "Think back to the whole period of time [child] lived in the residential care institution (between ages [age of entrance] to [age of reunification]). Did [child] ever leave the residential care institution to live with you or another family member, but then return to the residential care institution again?" Only two out of 37 children had experienced multiple reunifications, and it was reported that this happened about once a year. None were as a result of the COVID-19 pandemic responses.

Figure 5: Children's prior caregivers, Guatemala
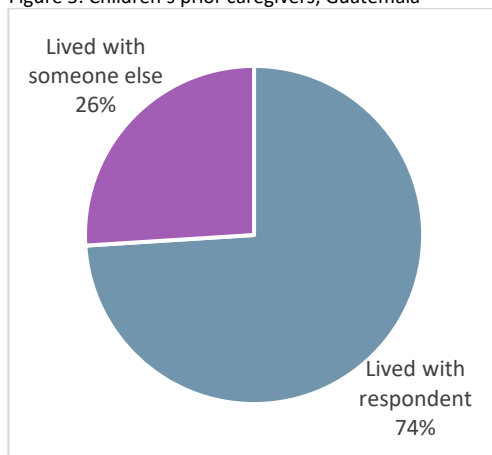
Figure 6: Children's prior placement, Guatemala
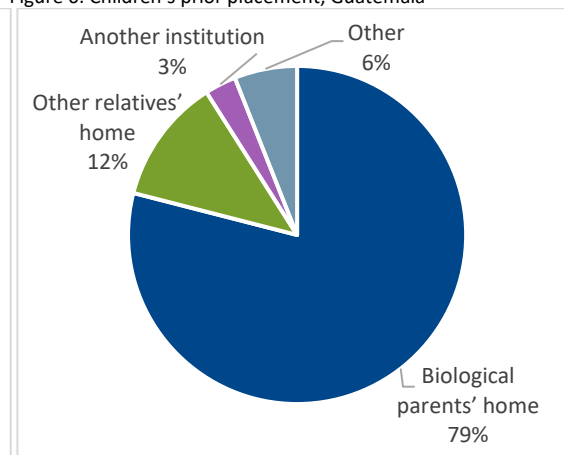
6.1.2. CTWWC Guatemala support

The survey assessed how the support from CTWWC was received by the caregivers. They were asked if they received different kinds of family strengthening support from CTWWC. If the caregiver reported that they received a service, they were also asked to rate how helpful the service was in terms of taking care of their children. A score of 0 corresponded to "didn't help at all," 1 meant "helped a little," and 2 was "helped a lot."

Among caregivers who participated in a case management process, the majority reported receiving home visits and cash transfers (79% and 83%, respectively), and 57% reported receiving positive parenting training (Table 5). Only 15% reported receiving referrals. As expected amongst caregivers who had attended parenting schools, 92% reported parenting trainings. Additionally, 26% reported receiving cash transfers, 10% home visits and 6% referrals. These additional services were likely not to have been directly received from CTWWC.

According to the caregivers who had received case management, nearly all felt each service had been helpful (only two caregivers rated the home visits as not being helpful). Cash transfers, in the form of gift cards (*tarjetas de intercambio de productos*), received a mean score of 1.93, parenting trainings 1.82, referrals 1.86 and home visits 1.71 (Figure 8). Caregivers who had attended parenting schools gave a mean score of 1.89 to the training they received.

In addition, since CTWWC closed all of its cases a year prior to the survey, the caregivers who participated in a case management process were asked to what extent they felt prepared for that support to come to an end. Most (78%) reported that they were fully prepared for the support to come to an end while 16% felt partially prepared and 6% felt they were not well prepared (Figure 9).

Table 5: CTWWC services reported to be received by caregivers, Guatemala

	Case management (n=47)	Parenting schools (n=62)	Total (n=109)
Home visits	37 (79%)	6 (10%)	43 (39%)
Positive parenting training	27 (57%)	57 (92%)	84 (77%)
Cash transfers (gift cards)	39 (83%)	16 (26%)	55 (51%)
Referrals	7 (15%)	4 (6%)	11 (10%)

Figure 7: Helpfulness of CTWWC support by case management and parenting school households (scale 0-2, with 2=very helpful), Guatemala
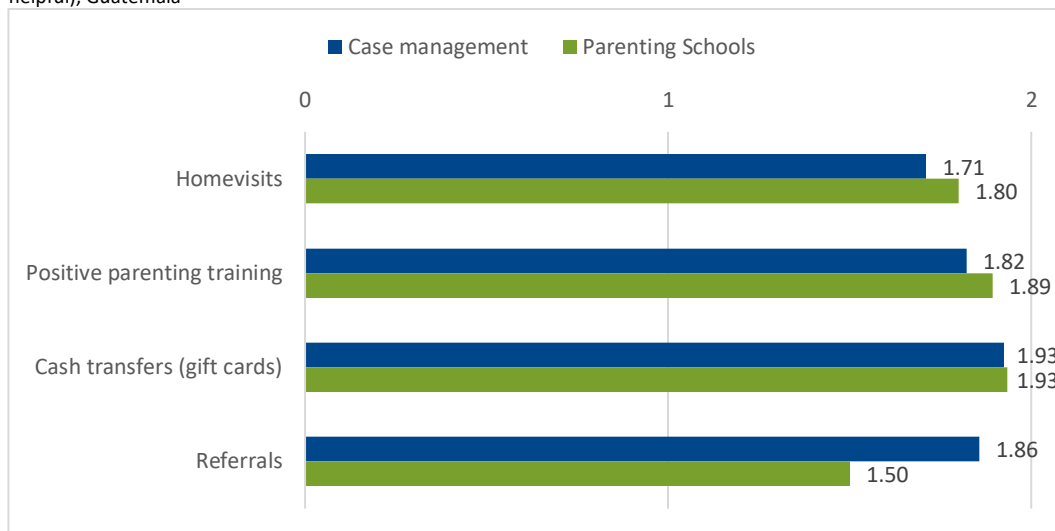
Figure 8: Caregivers rating of preparedness for the end of home visits, Guatemala
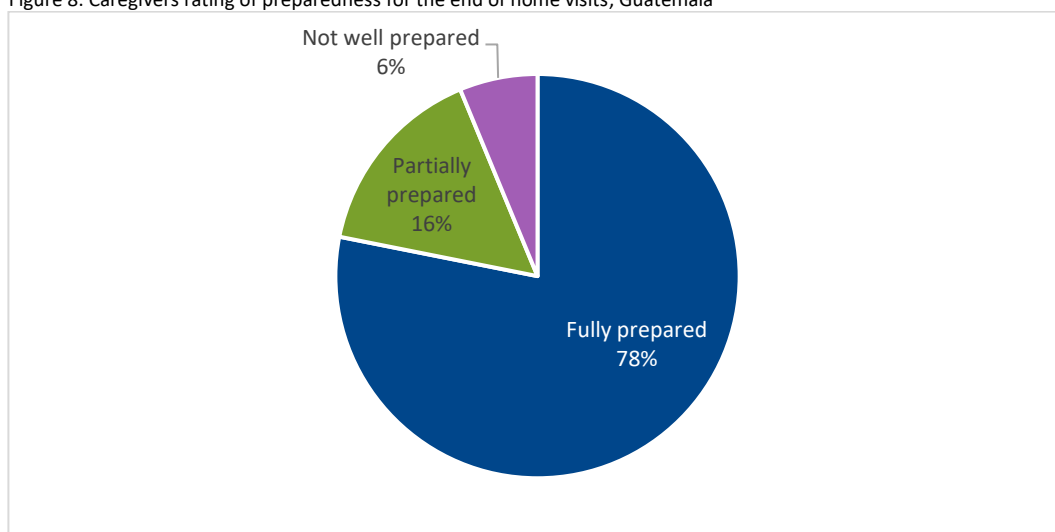
6.1.3. Guatemala caregiver protective factors

Caregiver protective factors, which strengthen a caregiver's ability to be resilient and care for their children, are examined in the household survey through three sets of measures as presented below: four types of protective factors measured in the PFI, three different parenting practices and a set of measures linked to economic stability.

Protective factors index

Figure 9: Caregiver protective factor definitions

> **Parental resilience:** Managing stress and functioning well when faced with challenges, adversity and trauma.
> **Social and emotional competence:** Interacting with children in a way that helps them develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships.
> **Social support and connections:** Positive relationships that provide emotional, informational, instrumental and spiritual support.
> **Access to concrete support in times of need:** Access to concrete support and services that address a family's needs and help minimize stress caused by challenges.

A score for each of the four areas of protective factors (Figure 10) was calculated and an overall PFI score was calculated. These were based on a scale of 0–4, where 4 represents higher protective factors. There are no set cut offs that indicate whether a score should be considered high, medium or low. The text of each of the survey questions that make up these scales are included in the appendix.

Caregivers who participated in a case management process had an overall mean PFI of 3.2; with mean scores of 3.4 for caregiver resilience, 3.3 for social and emotional competence, 3.0 for social support and connections, and 3.0 for access to concrete support (Table 6). Caregivers who had participated in parenting schools had an overall mean PFI score of 3.0; with mean scores of 3.4 for caregiver resilience, 3.1 for social and emotional competence of children, 2.9 for social support and connections, and 2.8 for access to concrete support.

When looking at caregiver and household characteristics of case management households, some statistically significant differences were found. Social and emotional competence was higher in households with more adults (r=.394, p<.01) whilst more children in a household indicated higher levels of caregiver resilience (r=.345, p<.05), concrete assistance (r=.503, p<.001) and overall PFI (r=.464, p<.01). In addition, widows had lower resilience and overall PFI scores than non-widows (resilience: widows 2.89, non-widows 3.51, p<.01; PFI: widows 2.53, non-widows 3.26, p<.01). In case management households, there were no significant correlations or differences between looking at caregiver age, education, sex, disability, rural/urban location or reintegrating vs. at-risk. Amongst households of caregivers who attended parenting schools, some similar differences were also noted. Social and emotional competence was also higher in households with more adults (r=.299, p<.05), however, the correlation between the number of children in a household and levels of concrete assistance was reversed, with more children correlating with lower concrete assistance (r=-.350, p<.001). In households of caregivers who attended parenting schools, there were no significant correlations or differences between looking at caregiver age, education, disability and rural/urban location.[41]

For the caregivers who had participated in a case management process and participated in two rounds of the survey, protective factors between Y3 and Y5 were compared. The overall PFI score decreased from 3.5 in Y3 to 3.2 in Y5 (p<.05) (Table 7). In terms of individual factors, the scores decreased for the two external-facing factors: social support and connection from 3.4 in Y3 to 3.0 in Y5 (p<.05) and access to concrete support from 3.5 in Y3 to 3.0 in Y5 (p<.01). There was no significant difference in mean scores for caregiver resilience and social and emotional competence between Y3 and Y5, which are the two internal factors.

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[41] Sex and widow status were not used as variables as there was only one male caregiver and one widow amongst caregivers who attended parenting schools.

Table 6: Protective factors index mean scores, Guatemala

Factors	Case management (n=46)	Parenting schools (n=58)
Caregiver resilience	3.4	3.4
Social and emotional competence	3.3	3.1
Social support and connections	3.0	2.9
Access to concrete support	3.0	2.8
Protective factor index	**3.2**	**3.0**

Table 7: Change over time protective factors, caregivers who received case management (n=47), Guatemala

Factors	Case management Y3	Case management Y5	p value
Caregiver resilience	3.6	3.4	.13
Social and emotional competence	3.4	3.2	.29
Social support and connections	3.4	3.0	.03*
Access to concrete support	3.5	3.0	.002**
Protective Factor Index	**3.5**	**3.2**	**.01***

Significance levels: *** p<.001, ** p<.01, * p<.05

Parenting practices

Assessment of parenting practices focused on how caregivers were involved in the day-to-day life of their child and the extent to which they practiced positive parenting and corporal punishment. The survey used a scale of 0–4 with 0 being never, 2 sometimes and 4 always. For parental involvement and positive parenting practice, the scores across six items were summed. There are no set cut offs that indicate whether a score should be considered high, medium or low, but higher scores represented more parental involvement and more positive parenting. Corporal punishment results are presented showing the frequency of responses to each of the three types of punishment considered. The items of which these scales consist are included in the appendix.

Caregivers who have participated in a case management process reported an average total score of 18.90 for involvement and a positive parenting mean score of 20.50 (Table 8). Caregivers who attended parenting schools reported an average score of 20.72 for involvement and 21.02 for practicing positive parenting. Interestingly, amongst the items on the involvement scale, most caregivers scored highly on those involving talking with their children, but those asking about activities scored lower (games, helping with homework and special activities). On the positive parenting items, five out of the six scored highly (close to 3.5 or above, on average), only the practice of rewarding a child scored lower (around 2.7, on average) (Figure 11).

Amongst caregivers who had received case management, 77% reported that they never or almost never spank their children using their hands, 100% reported that they never or almost never slap a children on the face and 83% reported that they never or almost never hit their children with an object (such as a cane or belt). The rates were similar amongst caregivers who have attended parenting schools, with 64% reported that they never or almost never spank their children using their hands, 100% reported that they never slap their children on the face and 73% reported that they never or almost never hit their children with an object.

When considering variances by caregiver and household characteristics for case management households, only a couple statistically significant differences were found. Male caregivers hit children with an object more frequently than female caregivers, but this is still very infrequent (male 1.17, female 0.27, p<.01). Caregivers in urban areas were found to more frequently spank their children compared to those in rural locations, but again, the use of spanking is still very infrequent (urban 1.12, rural 0.43, p<.05). In case management households, there were no significant correlations or differences when looking at involvement or positive parenting for any characteristics; when looking at corporal punishment by caregiver age, education, disability, widowhood or reintegrating vs. at-risk; nor when looking by number of children or adults in the household. Amongst households of caregivers who attended parenting schools only one

significant correlation was found. The higher a caregiver's level of education the more frequent their use of spanking (r=.279, p<.05).

For the caregivers who had participated in a case management process and participated in two rounds of the survey, no significant changes were found in the total scores for parental involvement and positive parenting (Table 9), nor in the scores for corporal punishment (Table 10), between Y3 and Y5.

Table 8. Frequency of practice of parental involvement and positive parenting, mean scores (min=0, max=24, higher score indicates more frequent involvement or positive parenting), Guatemala

	Case management (n=47)	Parenting schools (n=59)
Parental involvement	18.90	20.50
Positive parenting	20.72	21.02

Figure 10: Frequency of practice of parental involvement and positive parenting, mean scores per item (scale of 0–4 with 0 being never and 4 always), Guatemala
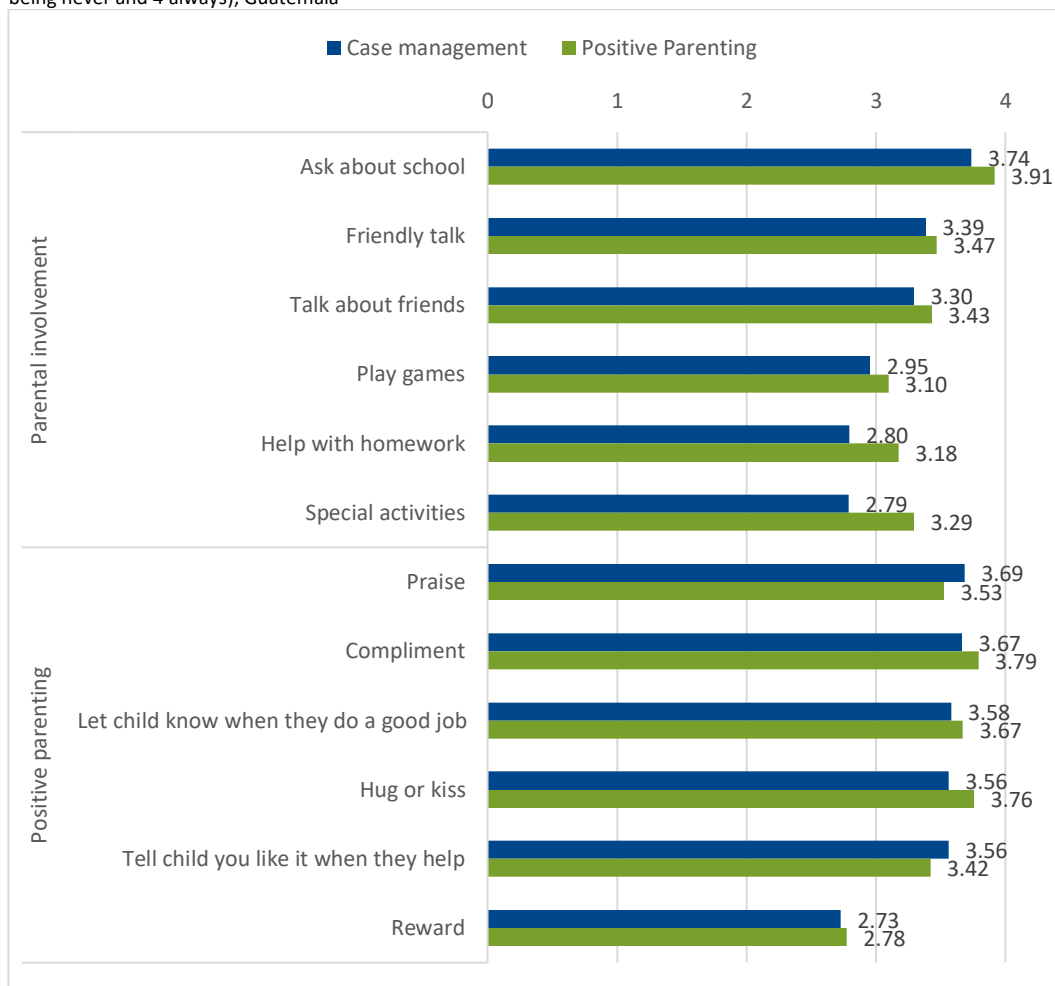
Figure 11: Frequency of practice of corporal punishment (possible options never, almost never, sometimes, always), Guatemala
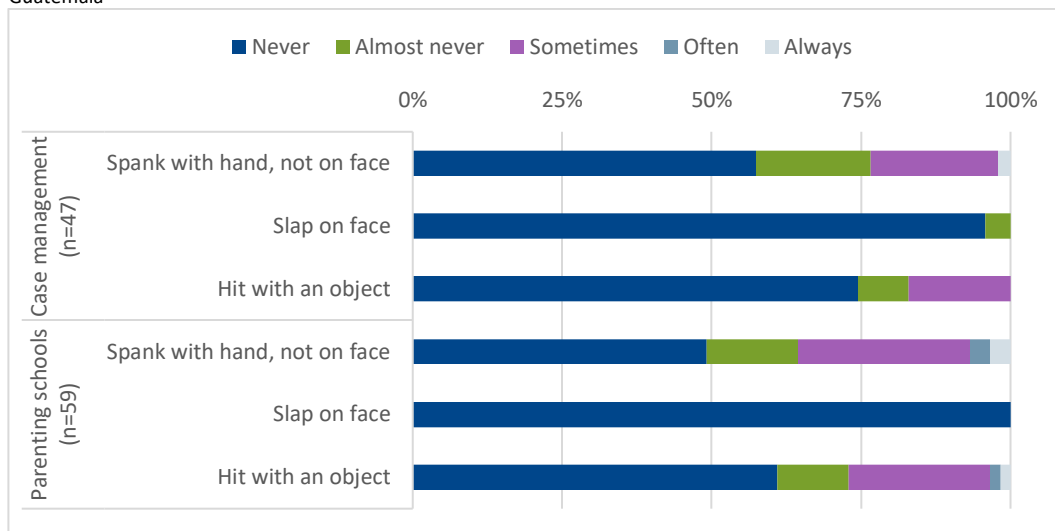
Table 9: Change over time in parenting practices, caregivers who received case management (n=47) (min=0, max=24, higher score indicates more frequent involvement or positive parenting), Guatemala

	Case management Y3	Case management Y5	p value
Parental involvement	19.4	19.1	.75
Positive parenting	21.8	20.8	.07

Table 10: Change over time in corporal punishment, caregivers who received case management (n=47) (scale of 0=never to 4=always), Guatemala

	Case management Y3	Case management Y5	p value
Spank with hand, not on face	.83	.68	.40
Slap on face	.02	.04	.57
Hit with an object	.43	.38	.67

CTWWC indicator results: Positive Parenting

The parenting practices results, as presented above, were used to calculate results for the CTWWC outcome indicator on the percentage of caregivers who completed training in positive parenting and were subsequently assessed as practicing positive parenting with the targeted level of frequency (a total score of 15+ for positive and involved parenting and little corporal punishment).

Almost half (46%) of caregivers who had received positive parenting met all the criteria to meet this indicator, an increase on the results in Y3 when only 39% met all the criteria (Table 11). In Y5, almost all caregivers were frequently involved and practicing positive parenting techniques, but only half had reached the minimal level of corporal punishment the indicator was aiming for (Figure 13).

Table 11. Indicator 8: Positive parenting, Guatemala

Percentage of caregivers who completed training in positive parenting who are subsequently assessed as practicing positive parenting skills	Y3 N	Y3 %	Y5 N	Y5 %
Guatemala	14	39%	32	46%
Household type: *at risk*	2	40%	23	47%
reintegrating	12	39%	9	45%
Sex: *male*	1	20%	1	25%
female	13	42%	31	48%

Figure 12: Indicator 8: Positive parenting, positive responses to each item, Guatemala
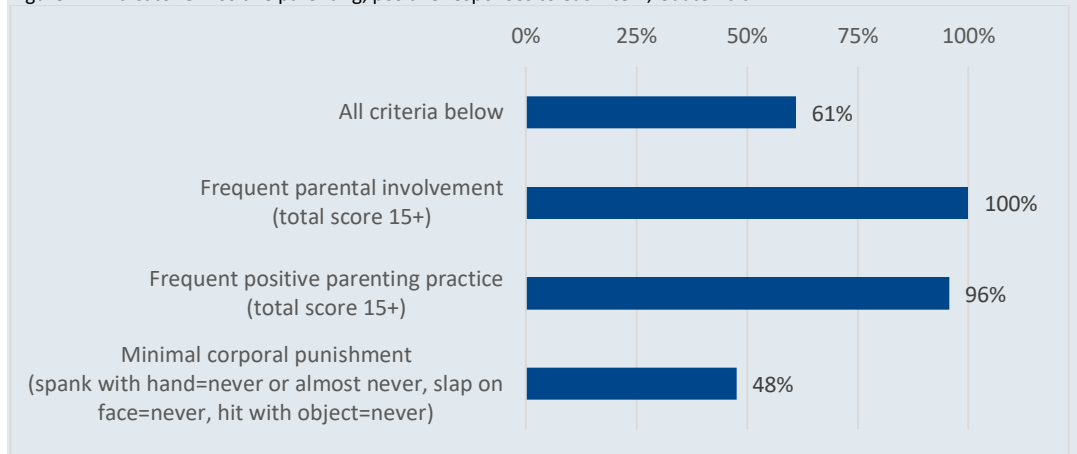
Couple Functionality Assessment Tool: Communication

The survey includes, for the first time, the communication subscale from the CFAT to understand how well caregivers who are married or living together communicate when a problem arises in their relationship. The tool used a scale of 0–4 where 0 was very unlikely and 4 very likely, so that a higher score indicates a greater likelihood of communicating positively when problems arise. Unfortunately, the survey responses were missing an option in Guatemala and so the results were not usable.

Economic Stability

To gauge the economic stability of households, respondents were asked about financial practices in their households:

- Over 66% of caregivers who had participated in a case management process reported often or sometimes having worried about money in the four weeks preceding the survey, whilst 86% of caregivers who had attended parenting schools reported the same (Figure 14).
- One third of caregivers who had participated in a case management process reported that they had managed to save money in the past month, whilst 15% of caregivers who had attended parenting schools reported being able to save (Figure 15).
- Three quarters of caregivers who had participated in a case management process could get 550 quetzales (GTQ) during emergencies (both responses: "easy to get money" and "hard, but possible to get money") as well as 89% of those who had attended parenting schools (Figure 16).

Nearly all households who had received case management (94%) faced little or no hunger based on the household hunger scale. The remaining 6% had moderate hunger. Similarly, households where a caregiver had attended parenting schools also faced little or no hunger (92%).

The survey also assessed what households can pay for when it is necessary:

- The majority of households were able to fully pay all educational costs for their children—78% of households supported with case management and 59% of households where a caregiver had attended parenting schools (Table 12). As a result, only four households reported that children had to miss some school because of an inability to cover costs.
- Across all households, 57% of caregivers reported that a child in their household was sick or needed health services. Amongst households supported with case management, 67% of those who needed health services sought such services, and 92% of households where a caregiver had attended parenting schools did the same (Table 12). Of those seeking health care services, 81% of all households were able to pay for their children's health care expenses.
- Around a quarter of households reported having unexpected household costs in the three months preceding the survey. Of these, 83% of households supported with case management could meet the unexpected expenses, and 59% of households where a caregiver had attended parenting schools (Table 12) could do the same.

When considering correlations and differences based on caregiver or household characteristics amongst those receiving case management, only a few significant variances were found. Caregivers with a disability worried more than those with no disability (with a disability: 2.63, without a disability: 1.49, $p<.01$) and reported a lower ability to obtain funds in an emergency (with a disability: 0.25, without a disability: 1.18, $p<.005$). Caregiver education was linked to saving practices, with those who were able to save having less education on average than those who were not saving. No significant differences were found for economic stability variables in households receiving case management support when looking at caregiver age, sex or widowhood, nor by household rural/urban location, reintegrating vs. at-risk or number of children or adults. In households with a caregiver who had attended parenting school, the only significant difference was in caregivers with a disability when considering household hunger. Households with a caregiver with a disability had a higher degree of hunger than those with a caregiver with

no disability, although still at a level indicating little hunger (with a disability 1.00, without a disability 0.37, p<.05).

When comparing economic stability results from households supported with case management who participated in both rounds of the survey to understand change over time from Y3 to Y5, there were no significant changes in economic measures (Table 13).

Figure 13: How often worried about money in past month, Guatemala
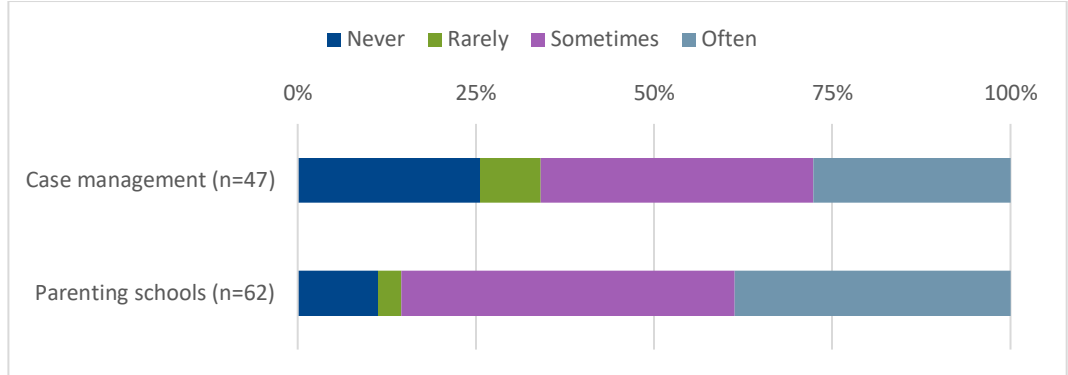
Figure 14: Ability to save in the past month, Guatemala
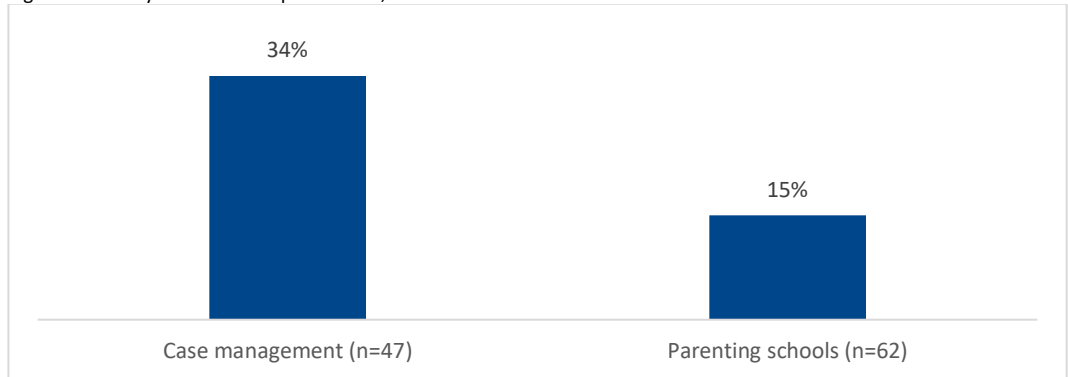
Figure 15: Ability to get GTQ 550 in an emergency, Guatemala
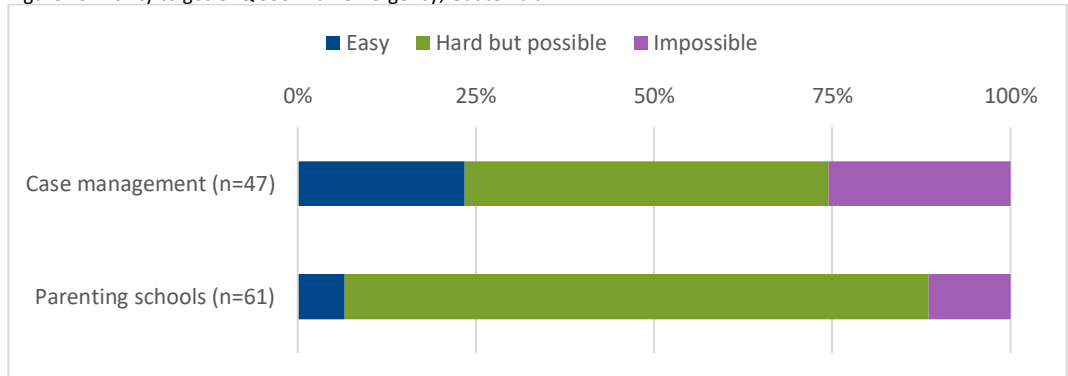
Table 12: Ability to pay for household expenses when needed, Guatemala

Education expenses	Case management	Parenting schools
Able to pay all education expenses	32 (78%)	30 (59%)
Unable to pay all education expenses	9 (22%)	21 (41%)
Child did not miss school as a result of not paying	6 (86%)	18 (86%)
Child missed school as a result of not paying	1 (14%)	3 (14%)
Health care expenses		
Did not seek health care	8 (33%)	3 (9%)
Sought health care	16 (67%)	32 (91%)
Able to pay for health care	13 (81%)	26 (81%)
Unable to pay for health care	3 (19%)	6 (19%)
Unexpected expenses		
No unexpected expenses	41 (87%)	37 (63%)
Unexpected expenses	6 (13%)	22 (37%)
Able to pay unexpected costs	5 (83%)	13 (59%)
Unable to pay unexpected costs	1 (17%)	9 (41%)

Table 13: Caregiver economic stability change over time, case management households, Guatemala

	Y3	Y5	p value
Worried about money (scale of 0=never worried to 3= often worried)	1.7	1.7	.70
Able to cover emergency (scale of 0=impossible to 2=easy)	0.8	1.0	.11
Household Hunger Score (scale of 0–6, higher score=more hunger)	.30	.38	.63

The economic stability results, as presented above, were used to calculate results for the CTWWC outcome indicator on the percentage of caregivers who received economic support who were subsequently assessed as being economically stable within the targeted factors (i.e., not worried about money, able to save, able to meet emergency costs, little or no hunger).

Only 13% of caregivers who received economic support (cash transfer/gift cards) met all of the criteria to meet this indicator, an increase from Y3 when only 8% met all of the criteria (Table 14). In Y5, the majority of caregivers could meet emergency costs and their households were not facing hunger, however, only one quarter (25%) were able to save and just 22% were not worried about money (Figure 17).

Table 14. Indicator 7: Economic stability, Guatemala

Percentage of caregivers who received economic support who subsequently assessed as being economically stable	Y3 N	Y3 %	Y5 N	Y5 %
Guatemala	**3**	**8%**	7	13%
Household type: *at risk*	0	0%	2	9%
reintegrating	3	9%	5	16%
Sex: *male*	3	75%	2	33%
female	2	6%	5	10%

Figure 16: Indicator 7: Economic stability, positive responses to each item, Guatemala
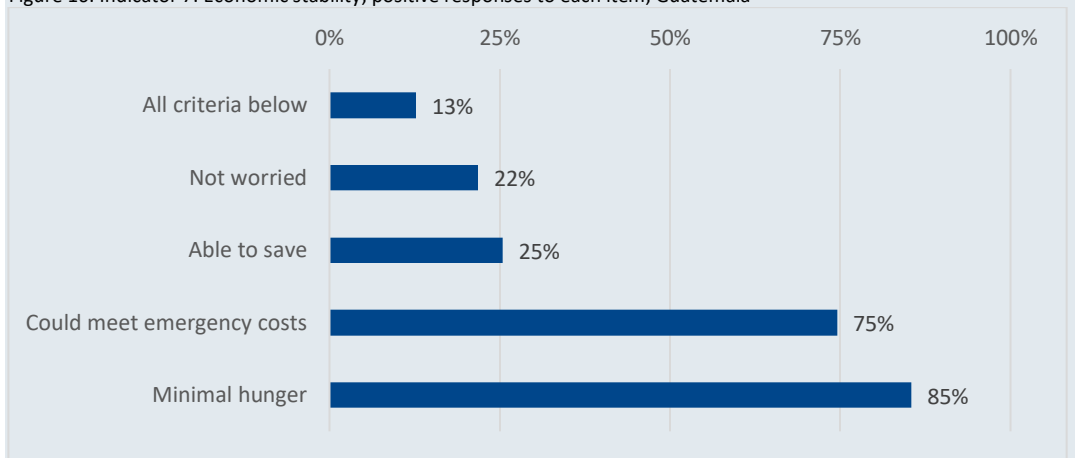
6.1.4. Guatemala child well-being

Information about child well-being was only gathered from households who have been supported with case management.

Health

The survey assessed the overall health of children aged 2–10 years (n=80) and 11–18 years (n=163). The assessment of overall health was conducted using a scale ranging from 0 to 4, with 0 representing poor health, 2 indicating good health and 4 indicating excellent health. Caregivers responded on behalf of children aged 2–10 years, giving an average score of 2.77, indicating good health. Overall, nearly 90% of respondents classified their child's health as either good, very good or excellent (Figure 18). Children aged 11–18 years were asked directly about their health and provided an average score of 2.48. As with the younger children, 87% said their health was either good, very good or excellent (Figure 18).

Amongst children aged 2–10 years, when looking at different child characteristics and their reported health, higher levels of health were found with increasing age at the time of the survey (r=.41, p<.05), at the time of entering care (r=.57, p<.05) and at the point of reunification (r=.57, p<.05). Health was not correlated with years in care. Health results for children aged 2–10 years did not differ significantly when looking at sex, disability status, reintegrating vs. at-risk, orphanhood or parental care status. Amongst children aged 11–18 years, no significant correlations or differences were found when looking at any variables.

Figure 17: Health of children (scale 0=poor to 4=excellent), Guatemala
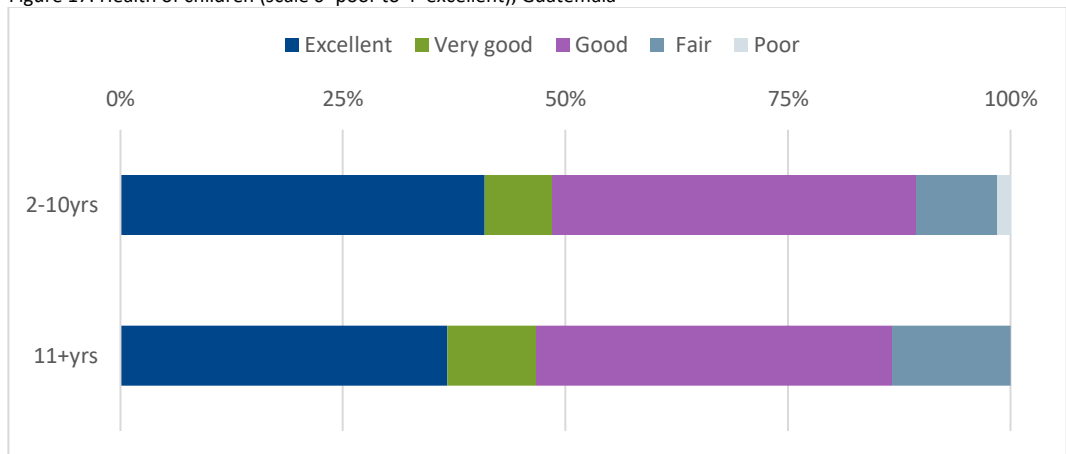
Education

Caregivers of children aged 2–4 years were asked if their child was enrolled in any sort of early childhood education (ECE) program. Two out of six (33%) were enrolled in ECE. Availability of ECE is known to be limited in Guatemala and unequally distributed throughout the country.[42]

In addition, 82% of children ages 5+ years were enrolled in school (n=60). Of the 18% not enrolled, the main reasons were that the child does not like school, is too young/old or the school is too far

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[42] Marra K, Espinosa I. (2020) "Bottlenecks and barriers to effective coverage of early childhood health and development interventions in Guatemala: A scoping review" Rev. Panam Salud Publica.44:105. doi: 10.26633/RPSP.2020.105. Palacios, A M., L. M. Villanueva, M. B. Flynn, E. et al. (2022) "Children Receiving a Nutrition and High-Quality Early Childhood Education Intervention Are Associated with Greater Math and Fluid Intelligence Scores: The Guatemala City Municipal Nurseries" Nutrients 14:7 doi.org/10.3390/nu14071366.

away. Of those enrolled in school, 18% had missed school four or more days in the last month because the child was sick.

ECE enrollment and stimulation could not be compared between Y3 and Y5 because there were no children who were eligible for the relevant questions at both time points. However, for school enrollment, there was no significant change in the proportion of children aged 5+ enrolled in school between Y3 and Y5 amongst the same children (Table 15).

Table 15: School enrollment change over time, case management households, Guatemala

	Y3	Y5	p value
School enrollment	88.2%	84.3%	ns

Child well-being, children 2–10 years old

Caregivers of children aged 2–10 years answered 10 questions about various aspects of their children's well-being. These questions were on a scale of 0 to 2, where 2 represents greater well-being. In Guatemala, caregivers reported an average score across 10 statements of 1.86. All caregivers felt their children liked school and were treated well there, were safe and were growing well (Figure 19). They indicated some concern about having sufficient school materials, which aligned with some households struggling to meet education costs (see economic stability section above) and about how well their children are treated by family members.

The average score across the 10 items allowed for analysis by child characteristics. Children who are not orphans had better well-being than children who are orphans (non-orphans=2.06, orphans=1.67, $p<.001$). There were no significant differences when looking at children's ages at the time of the survey, at entry into residential care and at reunification, nor for length of time in care. Well-being was not correlated significantly with sex, reintegrating vs. at-risk or parental care status.[43]

When looking at change over time for children aged 2–10 years whose caregiver participated in both Y3 and Y5 rounds of the survey, there was an improvement in child well-being. Between the two time points, the average score across all 10 items increased from 2.0 to 2.3 (Table 16).

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[43] For children aged 2–10 in Guatemala, disability was not used as a variable in the bivariate analysis as only one child had a functioning limitation.

Figure 18: Child well-being (2–10 yrs) mean scores per item, caregiver reported (scale of 0-2, 2=greater well-being), Guatemala
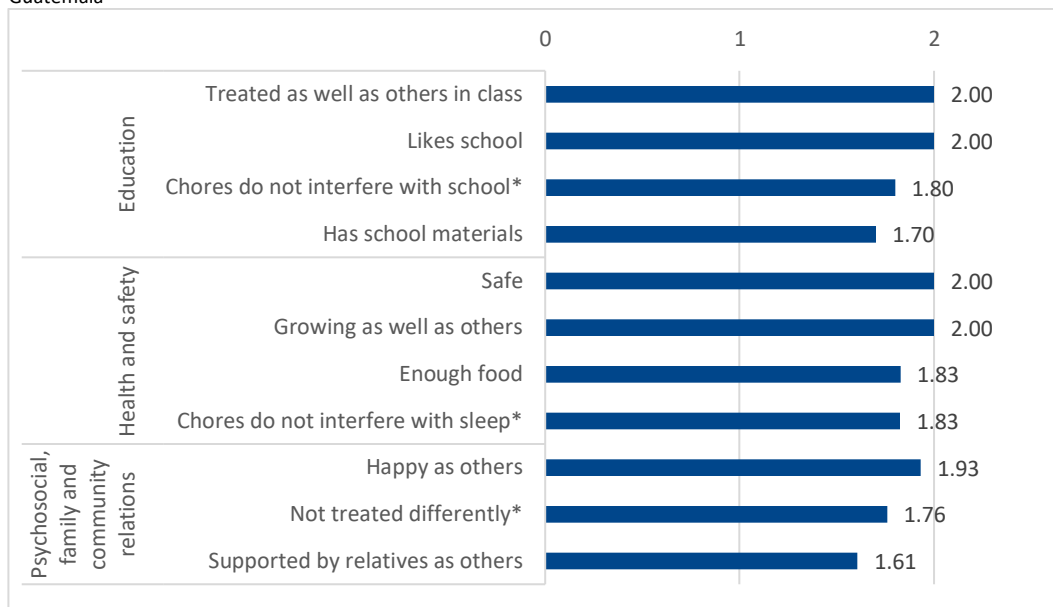
* Item asked in negative and results reverse coded for comparison with other items.

Table 16: Child (2–10 yrs) well-being change over time, case management households, Guatemala

	Y3	Y5	p value
Child well-being (2–10 yrs) – average of all items (0=lowest well-being, 2=greatest well-being)	2.0	2.3	.02*

Significance level: * is p<.05, ns=not significant.

Child well-being, 11+ year olds

Children aged 11 years and above answered questions about various aspects of their own well-being. These questions were designed with children who had experience of residential care and reintegration. Responses were given on a scale of 0 to 2, where 2 represents greater well-being. In Guatemala, the average score was 1.74, showing positive well-being on average, and for the three subscales, the average scores were:

- Care and safety: 1.85
- Basic needs: 1.74
- Leisure and freedom: 1.63

On average, most of the items received positive responses, with areas of highest well-being including having someone to turn to for guidance, having adults who can teach them how to be successful, a comfortable place to sleep, liking the food they eat, having good health, receiving medicine when needed, not being treated differently from others in their household and having enough time to sleep (all scored 1.9 and above, on average) (Figure 20). By contrast, one item received an average score of less than one, indicating lower well-being: being afraid of parents if they did not listen to them (scored 0.79, on average).[44] Further, three scored just above one, both of which were related to success at school: work or chores impacting their ability to do well in school (1.17), worrying about having enough money for education (1.17),[45] and freedom to go out (1.23) (Figure 20).

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[44] This item was reverse coded to ensure the responses were comparable to those on positively worded items.
[45] Both of these items were reverse coded to ensure the responses were comparable to those on positively worded items.

All of these items were averaged into an overall well-being score that could range from 0 to 2, with 2 representing highest well-being. This allowed for comparisons to be made between groups of children aged 11 and above and across different variables. The results revealed that children who are orphans reported lower well-being than those who are not orphans (orphans=1.46, non-orphans=1.81, p<.01), which is the opposite of what was found in round one of the survey. The difference in well-being between children with functional limitations and those without was almost significant (p=0.05). There were no significant differences by child sex, reintegrating vs. at-risk or parental care status. There was also no correlation with child age at the time of the survey or when entering or leaving care. When considering only children aged 11 and above who were reintegrating with family from residential care, there was a significant difference in well-being between those who returned to parental care and those in the care of other family members. Children reintegrating with their parents had slightly better well-being (parental care 1.80, non-parental care 1.45, p<.05). No other significant differences were found amongst children who were reintegrating.

When looking at change over time for children who participated in both Y3 and Y5 rounds of the survey, there was no significant change over the three years (Table 17).

Figure 19: Child well-being (11yrs+) mean scores per item, self-reported (scale of 0–2, 2=greater well-being), Guatemala

		Score
Food, clothing, bedding	Comfortable place to sleep	1.93
	Like the food I eat	1.90
	Happy with clothing	1.87
	Two meals a day	1.83
	Balanced diet	1.83
	Eat until satisfied	1.77
	Choose what/when to eat	1.77
Education**	Teachers respect me	1.88
	Time to study	1.88
	Have school materials	1.88
	Home is good for study	1.79
	Like teachers	1.75
	Chores don't impact study*	1.17
	Don't worry about money for education*	1.17
Health	Health is good	1.90
	Get medicine when needed	1.90
	I can keep clean	1.90
	Taken to health provider when needed	1.87
Community relations	Someone to turn to for advice	1.97
	Adults teach me to be successful	1.93
	Adults who understand me	1.87
	People to talk to about problems	1.80
	Treated same in community	1.69
	Others who would help me	1.57
Family relations	Caregivers love and care	1.93
	Treated the same in family	1.90
	Caregivers respect me	1.87
	Part of my family	1.87
	Happy with family time	1.83
	Supported by relatives	1.80
	Caregivers help me improve	1.77
	Caregivers consider my wants	1.73
	Not afraid of caregivers*	0.79
Psychosocial	Time to rest and sleep	1.90
	Happy with friends	1.80
	Happy as others	1.77
	Pursue hobbies	1.69
	Play	1.67
	Get along with friends	1.63
	Have fun with friends	1.50
Safety	Feel safe	1.87
	Someone to ask for help if unsafe	1.83
	Peaceful home	1.80
	Freedom to go out	1.23

* Item asked in negative and results reverse coded for comparison with other items. ** Only asked of children enrolled in school.

Table 17: Child (11yrs+) well-being change over time, case management households, Guatemala

	Y3	Y5	p value
Average score of all items	1.8	1.7	ns
Care and safety subscale average score	1.8	1.8	ns
Basic needs subscale average score	1.8	1.7	ns
Leisure and freedom subscale average score	1.6	1.6	ns

Significance level: ns=not significant.

Family and community acceptance

In this round of the survey, all child respondents were asked about how accepted they felt in their family and community (in round one, these questions were only asked of children who had been reunified). The average family acceptance score and the average community acceptance score in Guatemala was 1.8 on a scale of 0–2 (with 2 representing higher acceptance).

Comparisons by child characteristics showed that family acceptance was higher for children in parental care compared to those not living with their parents (parental care 1.91, non-parental care 1.00, p<.01) and higher for children with two living parents compared to those who are orphans (non-orphan=1.91, orphan=1.52, p<.05). Community acceptance was also higher for children with two living parents compared to those who are orphans (non-orphan=1.83, orphan=1.45, p<.05) as well as being higher for children without functional difficulties compared to those with difficulties (without difficulties=1.85, with difficulties=1.00, p<.0001). Family acceptance was not correlated with age and did not differ by child's sex, disability status or reintegrating vs. at-risk. Community acceptance was not significantly correlated with age nor did it differ when compared by child's sex, reintegrating vs. at-risk or parental care.

When looking at change over time for children who participated in both Y3 and Y5 rounds of the survey, there was no significant change over the three years (Table 18).

Figure 20: Family acceptance mean scores (scale of 0–2, 2=more acceptance), Guatemala
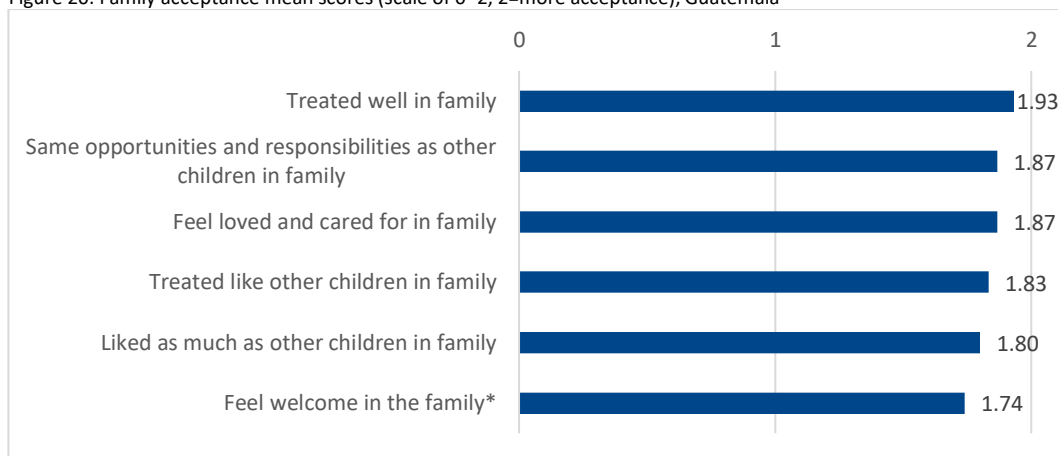
* Only asked of children who had lived in residential care.

Figure 21: Community acceptance mean scores (scale of 0–2, 2=more acceptance), Guatemala
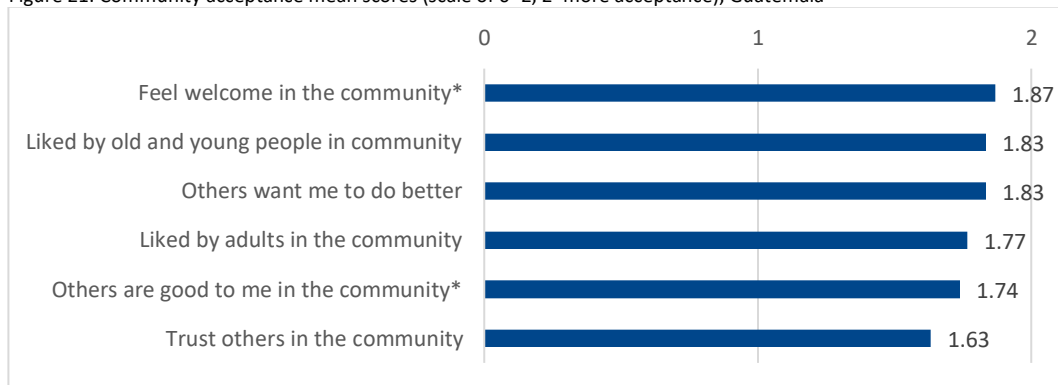
* Only asked of children who had lived in residential care.

Table 18: Family and community acceptance change over time, case management households, Guatemala

Acceptance variables	Y3	Y5	p value
Family acceptance	1.9	1.8	ns
Community acceptance	1.8	1.8	ns

Significance level: * is ns=not significant.

School belonging

As a new element in round two of the survey for children aged 11+ years, children's sense of school belonging was assessed using a scale of 0–4, with 0 being strongly disagree and 4 being strongly agree. The average overall score was 2.99.

When comparing children by different characteristics, it was found that the older a child (at the time of the survey) the lower their sense of school belonging (r=-.35, p<.05). Amongst just reintegrating children, the older a child was when they entered or left care, the lower their sense of school belonging (entered care r=-.501, left care r=-.415, p=.05*). School belonging did not vary by the length of time reintegrating children spent in care, but did vary by child's sex, disability, reintegrating vs. at-risk, parental care status and/or orphanhood.

Figure 22: School belonging mean scores (scale 0–4, with 4=greater sense of belonging), Guatemala
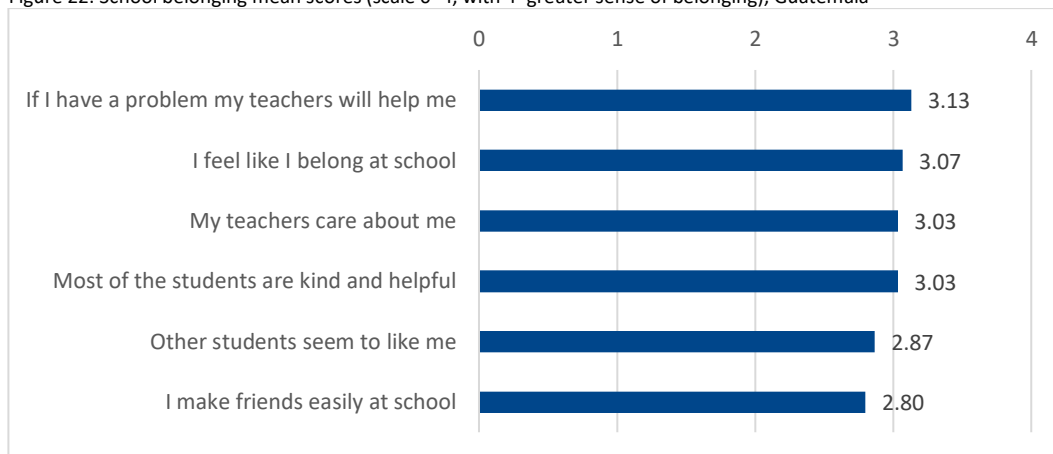
Overall life satisfaction

Children aged 11+ years were asked about their OLS at the time of the survey, on a scale from 0 to 10, with 10 meaning greater satisfaction, resulting in a mean of 8.93 (SD 1.824).

Amongst children who had been reunified from residential care, the mean score for their OLS at the time of the survey was 8.93 (SD 1.824). When they were asked to think back and reflect on when they were still living in residential care, the mean was 4.29 (SD 3.002) (Figure 24).

Comparisons by children's characteristics revealed that OLS was higher amongst children without a functional difficulty compared to those with a functional difficulty (no difficulty=9.20, difficulty=6.67, p<.05) and amongst those whose parents were both alive compared to those who were orphans (not orphaned=9.26, orphaned=7.40, p<.01). OLS was not significantly correlated with age at the time of the survey or at entry to or exit from residential care. It did not differ when compared by sex, reintegrating vs. at-risk, parental care or orphanhood status.

OLS did not significantly change between the two rounds of the survey in Y3 and Y5. This is likely due to the small number of respondents.

Figure 23: Overall life satisfaction mean score (scale 0–10, 10= greater satisfaction), Guatemala

How satisfied are you with your life as a whole?

Not at all satisfied   Completely satisfied

4.29
Thinking back to residential care

8.93
At time of survey, at home
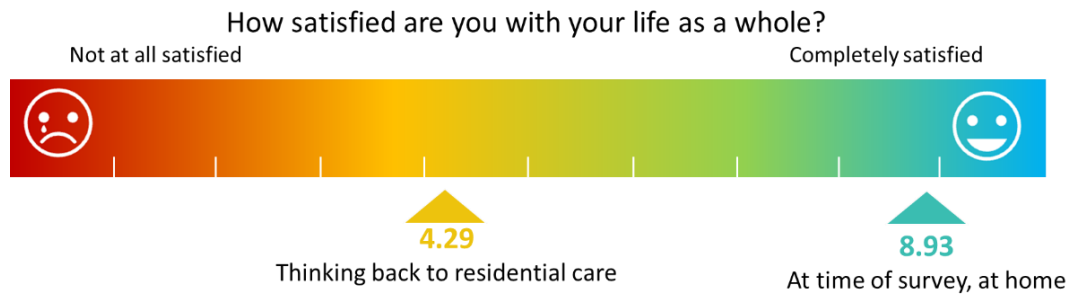
CTWWC indicator results: Children feel safe and nurtured

The child well-being results, as presented above for children aged 11 years and above, were used to calculate results for the CTWWC outcome indicator on the percentage of children, either reintegrating or at risk of separation, who feel safe and nurtured in their family (based on 12 items from the child well-being section about safety and family relationships).

Amongst children aged 11+ years who had been supported with case management to prevent separation, 57% felt safe and nurtured in their family, an increase on the results from Y3 when 30% of children felt safe and nurtured (Table 19). In Y5, all but one of the items used to calculate this indicator had close to 100% positive responses. The only item scoring lower was about children being afraid of what will happen if they do not listen to their caregivers (Figure 25).

Table 19 Indicator 3 & 11: Children who feel safe and nurtured, Guatemala

Percentage of targeted at-risk children (aged 11+ years) in vulnerable families who feel safe and nurtured in their family	Y3 N	Y3 %	Y5 N	Y5 %
Guatemala	**3**	**30%**	**4**	**57%**
Age: 11–14	3	60%	3	75%
15–17	0	0%	1	50%
18+	0	0%	0	0%
Sex: Male	2	29%	3	60%
Female	1	33%	1	50%
Disability: Disabled	3	100%	1	50%
Not Disabled	0	0%	3	60%
Percentage of children (aged 11+ years) who have been reunified, placed in family-based care or in independent living who feel safe and nurtured in their placement				
Guatemala	**21**	**53%**	**12**	**55%**
Age: 11–14	9	60%	5	42%
15–17	10	50%	5	63%
18+	2	40%	2	100%
Sex: Male	11	61%	2	18%
Female	12	55%	10	91%
Disability: Disabled	2	40%	0	0%
Not Disabled	19	56%	12	57%

Figure 24: Indicator 3 & 11: Children who feel safe and nurtured, positive responses to each item, Guatemala
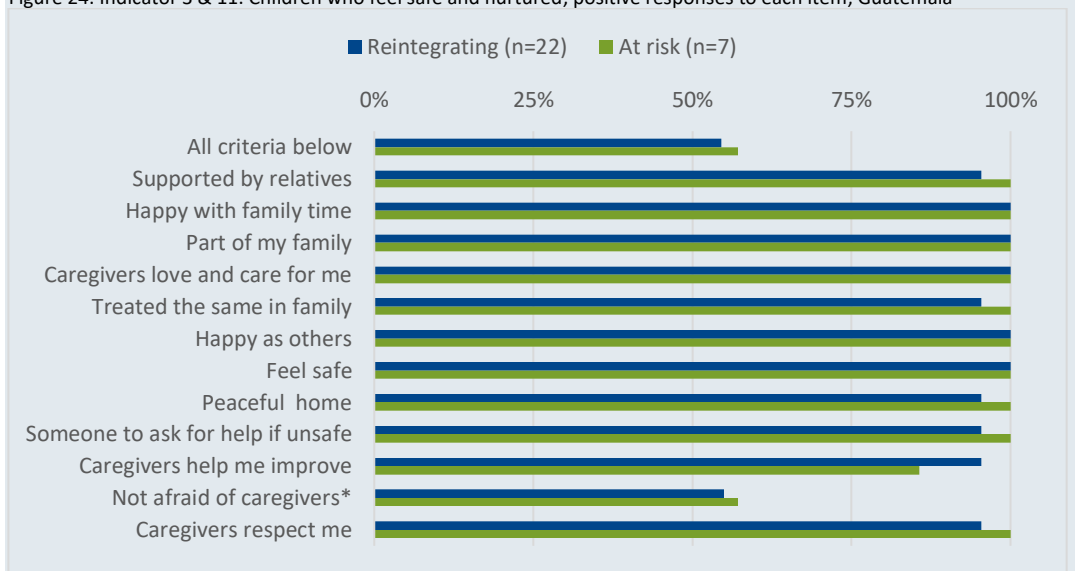
* Statements posed in reverse and results reverse coded for analysis.

6.1.5. Guatemala relationships between caregiver protective factors and child well-being

The following analyses examine whether caregiver protective factors are related to child well-being. This table presents correlation coefficients between different variables. Statistically significant correlations are denoted by asterisks.

Positive parenting practices were statistically correlated with children's (aged 11+ years) self-reported well-being, life satisfaction, family and community acceptance, and change in life satisfaction since reunification. Parental involvement was also positively correlated with some of these variables: life satisfaction, family acceptance and change in life satisfaction. More frequent practice of these parenting approaches relates to a higher sense of well-being in children.

Children's self-reported life satisfaction was correlated with all economic stability variables: hunger, emergency funding and worry about money. Children feel more positive about their lives when their households have lower levels of hunger, more chances of meeting emergency costs and less worry about money. Children who have reunified into households where there is less worry about money also report a greater change in their life satisfaction when reflecting back to being in residential care. Economic stability (less hunger and more ability to meet emergency costs) is also correlated with children feeling more accepted in their community.

Table 20 Pearson's r correlations between caregiver protective factors and child well-being measures for children aged 11+ years , Guatemala

		All children aged 11+				Reunified children 11+
		Overall well-being	Current OLS	Family acceptance	Community acceptance	Change in OLS
Protective factors index	Resilience	0.008	0.30	0.16	0.02	-0.10
	Social connections	-0.05	0.16	0.22	0.04	0.10
	Concrete assistance	-0.13	0.02	0.001	-0.02	0.10
	Social and emotional	0.20	0.20	0.02	0.28	0.10
	Overall PFI	0.12	0.26	0.12	0.22	0.07
Parenting practices	Positive parenting	0.46*	0.70***	0.42*	0.47**	0.50*
	Parental involvement	0.16	0.44*	0.43*	0.11	0.53*
Economic stability	Household Hunger Score	-0.16	-0.46*	-0.08	-0.40*	-0.37
	Ability to obtain funds in emergency	0.35	0.44*	0.26	0.52**	0.33
	Worried about money	-0.28	-0.46*	-0.20	-0.36	-0.49*

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

6.2. Kenya results

6.2.1. Kenya participant characteristics

Household characteristics

Overall, 58% of the participating households in Kenya were reintegrating while the remainder were households identified to be at risk of separation. This varied considerably by county (Table 21). CTWWC's programming in Siaya county was exclusively preventative, targeting families at risk of separation. There was a mix in the other three counties, but the survey focused more on collecting data from as many households as possible where a child had been reintegrated from residential care.

In Kenya, 76% of the 278 participating households were rural while the rest were urban (Figure 26). This varied among the three counties, with all households in Nyamira county being rural whilst Kilifi county had the highest percentage of urban households (48%).

The mean number of children per household in Kenya was 3.7 (SD: 1.9, min: 1, max: 11), and the mean number of adults was 2.8 (SD: 1.7, min: 1, max: 11). There was little variation between the counties.

Table 21: Household type, Kenya

County	Total (n)	Reintegrating	At risk
Kilifi	69	65 (94%)	4 (6%)
Kisumu	96	67 (71%)	27 (29%)
Nyamira	30	29 (97%)	1 (3%)
Siaya	83	0 (0%)	83 (100%)
Total	**278**	**161 (58%)**	**115 (41%)**

Figure 25: Household rural/urban location by county, Kenya
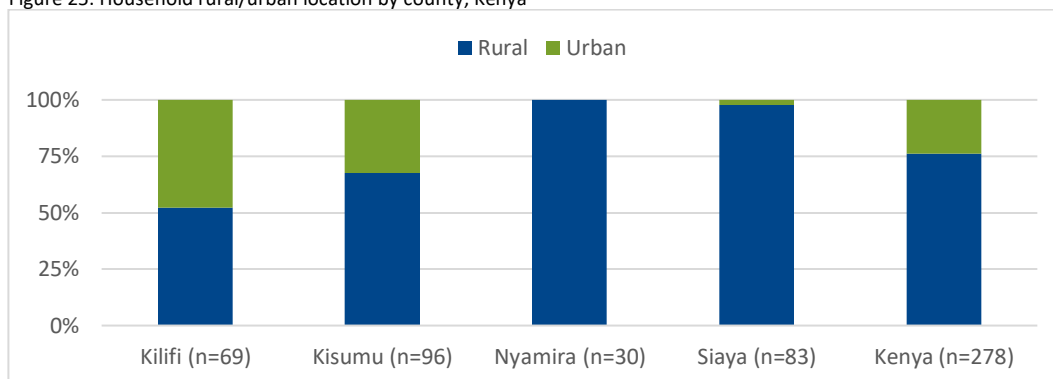
Caregiver demographics

A majority (84%) of the 278 caregiver respondents were female. The mean age of the caregiver respondent was 46 years (SD: 13.34, min: 20, max: 85), with 8% of caregivers under the age of 30 and 22% over 60 years of age (Figure 27). According to the WG-SS, 18% of primary caregivers who responded to the survey had a disability (Figure 28). In Kisumu County, one quarter of caregivers had a disability compared to around 21% in Siaya County and 12% in Kilifi County. None of the 30 caregivers from Nyamira were classified as having a disability using the WG-SS. Individuals could have difficulties in more than one domain; the most common across Kenya was difficulties with cognition (24 caregivers) and mobility (21), followed by vision (16), self-care (4), hearing and communication (3 each).

About 80% of caregivers had only completed primary school (Figure 29). Notably, in Kilifi County, more than half (52%) had not completed their primary education.

In terms of caregiver marital status, it was most common for the primary caregiver to be widowed (46%) or married (41%) (Figure 30). Widowhood was most common in Kisumu County with almost 60% of caregivers in this category. However, in Siaya, two-thirds of caregivers were married or living together.

Figure 26: Caregiver age, Kenya
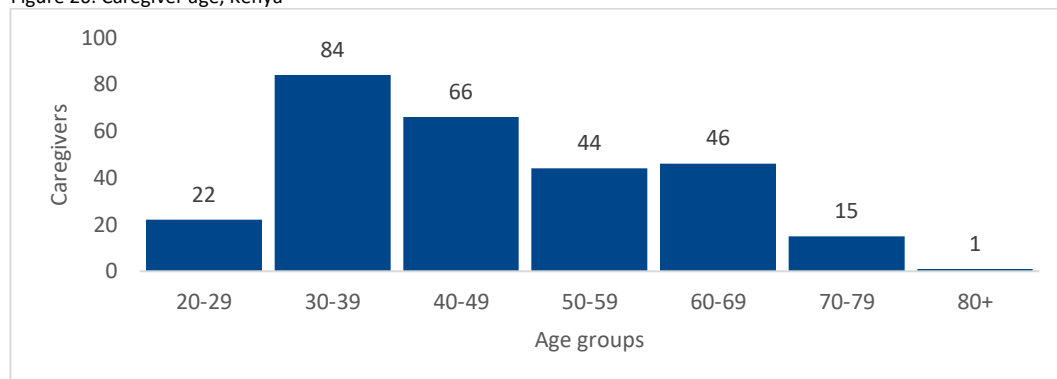
Figure 27: Caregiver disability prevalence, by county, Kenya
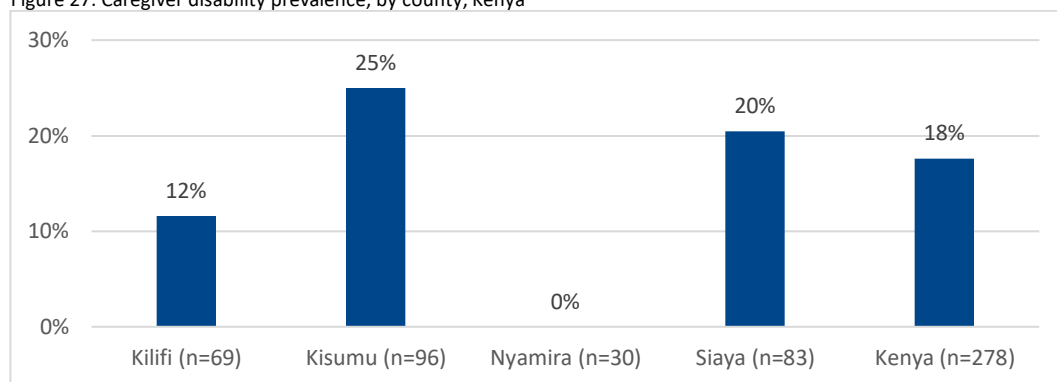
Figure 28: Caregiver education, by county, Kenya
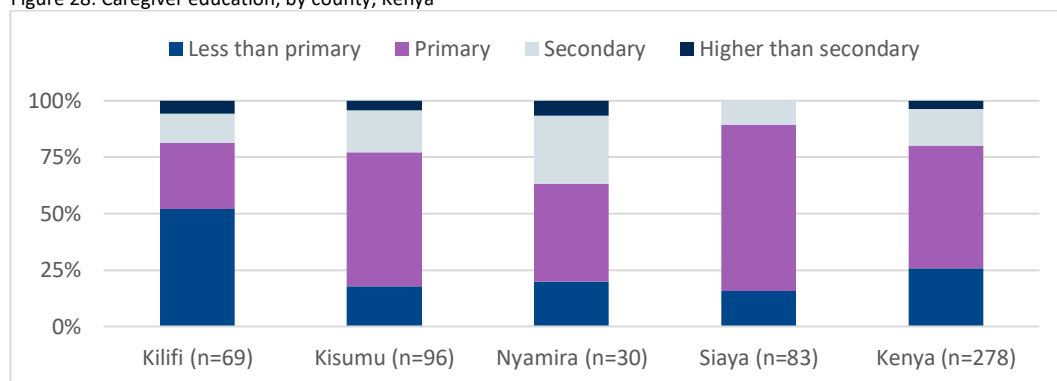
Figure 29: Caregiver marital status, by county, Kenya
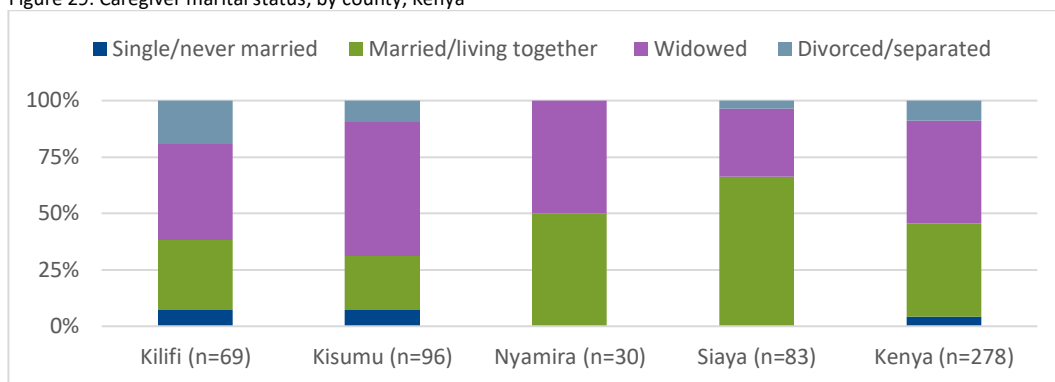
Child demographics

The survey collected information about 358 children, 232 (65%) were children reintegrating from residential care and 126 (35%) were an index child in households at risk of separation (Figure 31). Siaya County only included children in households at risk of separation, in contrast to Kilifi and Nyamira Counties where most children had reunified from residential care. Kisumu County was more split, including 77% of children who had been reunified.

Across all children, 58% were female while 42% were male (Figure 32), with quite some variation between counties, especially in Siaya where 91% of children in the sample were female. The mean age of children was 13 years (SD: 3.6, min: 1, max: 18), with little variation between counties. The highest proportion of children were aged 16 (15.6%), with almost two-thirds of the total being teenagers (Figure 33). Comparatively fewer children were of pre-school age, with less than 4% being aged 5 years or younger.

In terms of disability, no children aged 2–4 years had a functional limitation, whilst amongst children aged 5 years and above, 11% had functional limitations, with some variation between the counties (Figure 34). The main domains of limitations were: anxiety, depression, managing behavior, accepting change and concentrating.

Figure 30: Children who are reunified vs. in at-risk households, by county, Kenya
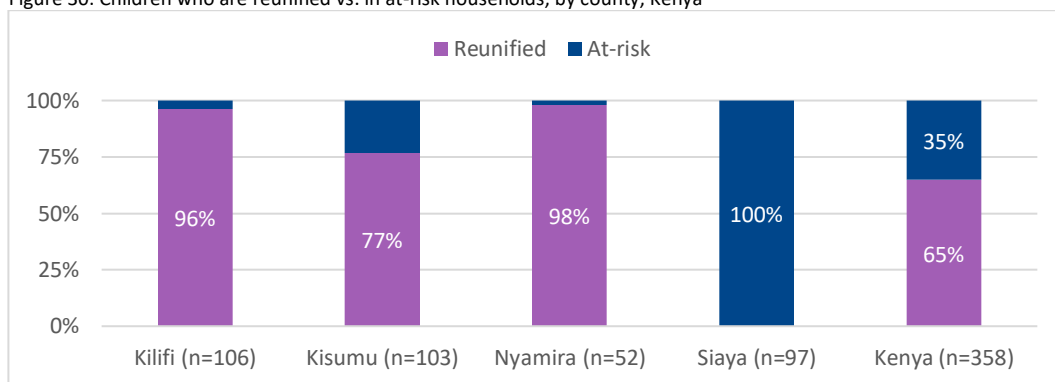
Figure 31: Sex of children, by county, Kenya
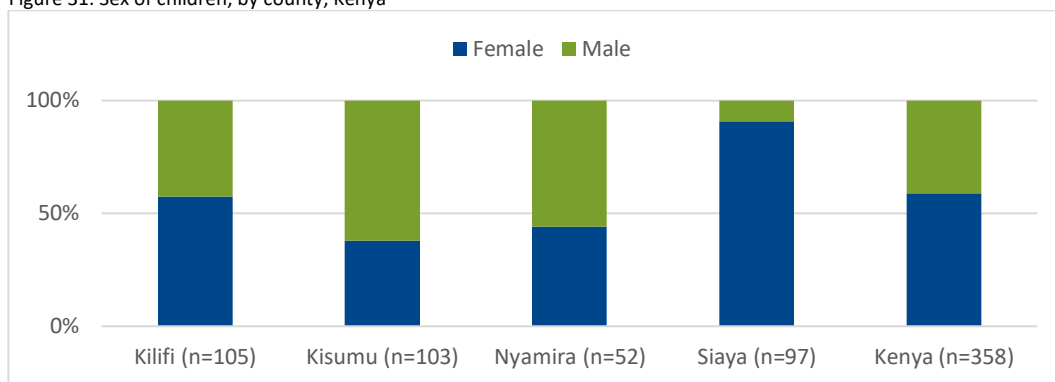
Figure 32: Child age, Kenya
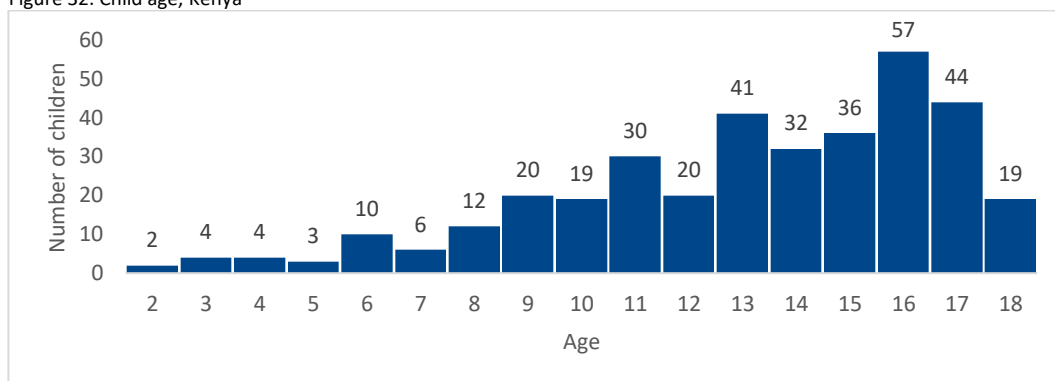
Figure 33: Child disability prevalence, 5+ years, by county, Kenya
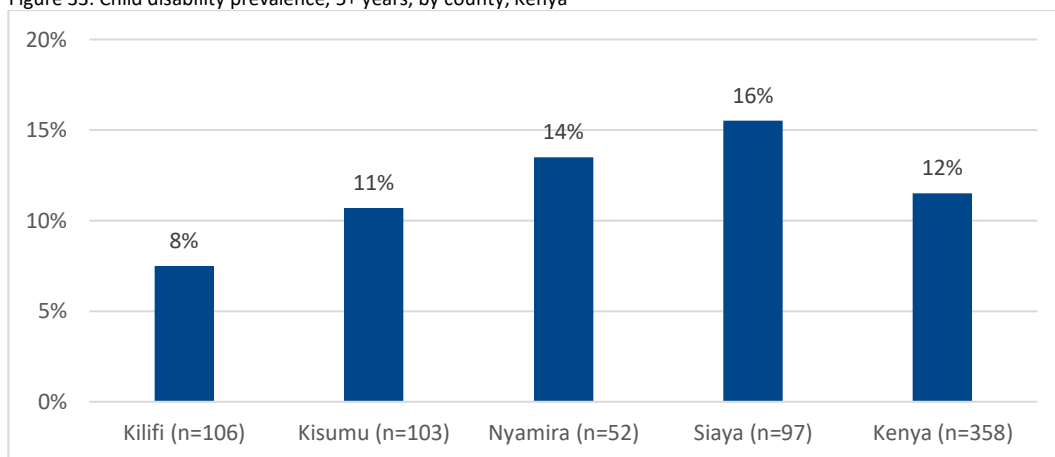
Child's relationship to household

More than half (51%) of the caregivers who responded to the survey were the biological mother of the reintegrating or index child. This was followed by grandparents (18%), aunts/uncles (11%), other relatives and non-relatives (4–5% each) (Figure 35). While it was common for children to live with at least one biological sibling (69% of children), many also lived with other children (Table 22).

It was common in Kenya for children to have lost a parent: 53% were either a single or double orphan (Figure 36). However, orphanhood status of every child was not known given that, in some cases, the respondent did not know whether a child's parents were alive, hence the orphanhood status of 11% of the children was unknown. The situations in Nyamira and Siaya were different

from the trend for the entire sample. In Nyamira, 63% of children were orphaned, but in Siaya, only 29% were orphaned (Table 23).

If a child's parent was alive, but they did not live with them, the caregiver was asked about the child's frequency of contact with the parent. Out of the 49 children not living with a mother who was alive, 42% of them were never in contact while 6% were in contact every day or nearly every day (Table 24). Out of the 78 not living with a living father, 74% never contacted him while only 5% were in contact every day or nearly every day (Table 25).

Figure 34: Caregiver relationship to child, Kenya
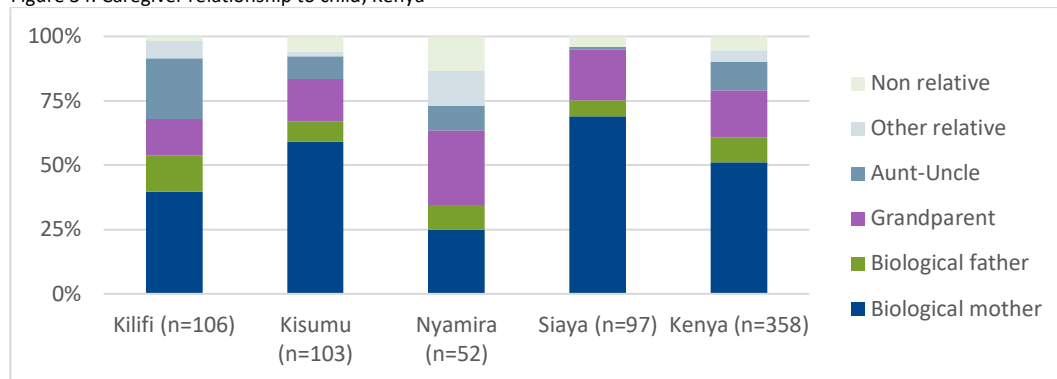
Table 22: Child's relationship to children in the same household, Kenya

	Kilifi (n=106)	Kisumu (n=103)	Nyamira (n=52)	Siaya (n=97)	Kenya (n=358)
Biological sibling (same parents)	64%	69%	52%	84%	69%
Biological half sibling (one parent the same)	19%	9%	17%	3%	11%
Biological cousins (children of a relative)	15%	17%	21%	20%	18%
Not related	2%	6%	4%	0%	3%
Other relative	5%	15%	15%	2%	8%

Figure 35: Orphanhood status, Kenya
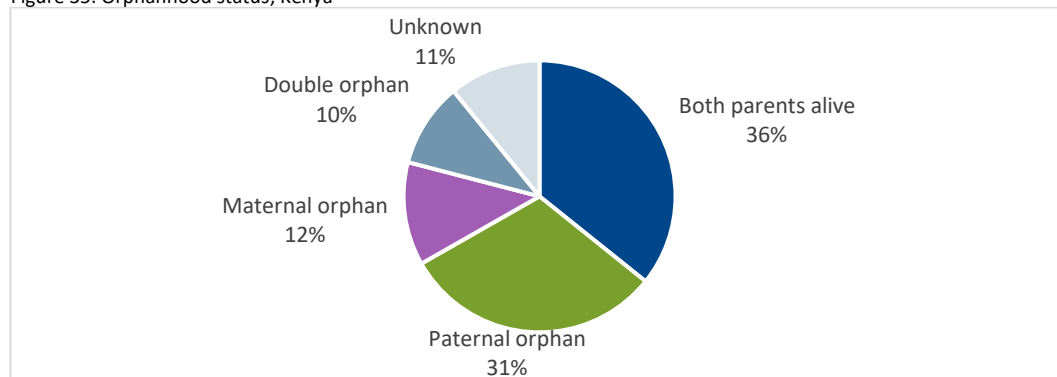
Table 23: Child orphan status by county, Kenya

	Kilifi (n=106)	Kisumu (n=103)	Nyamira (n=52)	Siaya (n=97)	Kenya (n=358)
Both parents alive	30 (28%)	30 (29%)	4 (8%)	64 (66%)	128 (36%)
Paternal orphan	34 (32%)	42 (41%)	13 (25%)	22 (23%)	111 (31%)
Maternal orphan	20 (19%)	12 (12%)	7 (13%)	5 (5%)	44 (12%)
Double orphan	14 (13%)	8 (8%)	13 (25%)	1 (1%)	36 (10%)
Unknown	8 (8%)	11 (11%)	15 (29%)	5 (5%)	39 (11%)

Table 24: Frequency of contact with non-resident mother by county, Kenya

Contact with mother	Kilifi	Kisumu	Nyamira	Siaya	Kenya
Never	5 (29%)	6(38%)	2 (100%)	7 (54%)	20 (42%)
Less than once a month	3 (18%)	4 (25%)	0 (0%)	1 (8%)	8 (17%)
At least once a month	6 (35%)	5 (31%)	0 (0%)	1 (8%)	12 (25%)
At least once a week	1 (6%)	1 (6%)	0 (0%)	3 (23%)	5 (10%)
Every day or almost every day	2 (12%)	0 (0%)	0 (0%)	1 (8%)	3 (6%)

Table 25: Frequency of contact with non-resident father by county, Kenya

Contact with Father	Kilifi	Kisumu	Nyamira	Siaya	Kenya
Never	27 (84%)	16 (70%)	4 (80%)	9 (56%)	56 (74%)
Less than once a month	0 (0%)	3 (13%)	0 (0%)	0 (0%)	3 (4%)
At least once a month	2 (6%)	2 (9%)	0 (0%)	4 (25%)	8 (11%)
At least once a week	2 (6%)	1 (4%)	0 (0%)	2 (13%)	5 (7%)
Every day or almost every day	1 (3%)	1 (4%)	1 (20%)	1 (6%)	4 (5%)

Children's care history

For children reintegrating from residential care, their caregiver was asked how old the child was the first time they entered the residential care institution as well as how old they were when they most recently came to live with them permanently. The mean age at which children entered care in Kenya was 7 years (SD3.8), and the mean age at their most recent placement in family care was 11 years (SD3.6). Taking the difference of these two ages, children in Kenya spent an average of 4.3 years in care. This pattern was similar in Kisumu and Nyamira, but children in Kilifi entered residential care younger (5 years) and stayed for longer by comparison (5.8 years) (Table 26).

Nearly a quarter (24%) of the reunified children had lived with someone other than their current primary caregiver before they entered residential care (Table 27). Children had lived in a variety of settings before entering residential care, including with their biological parents (66% of children) and other relatives' homes (29%) (Table 27). There were 126 (57%) children who lived in residential care with one or more of their siblings (Table 28). Out of these, the majority (89%) came with at least one sibling to live in their current caregiver's home.

When asked if the child was in contact with anyone from their residential care institution, most (67%) respondents said yes.

Finally, the survey sought to determine whether children moved in and out of care during the period of time they were in residential care. The primary caregivers of children who had been reunified were presented with the following question: "Think back to the whole period of time [child] lived in the residential care institution (between ages [age of entrance] to [age of reunification]). Did [child] ever leave the residential care institution to live with you or another family member, but then return to the residential care institution again?" Across the Kenya sample, this was true of 34% of children who had been reunified (Table 29), although there was a slightly lower rate in Kisumu county (17%) compared to Kilifi and Nyamira (43%). When asked how often this happened, most caregivers (77%) said a few times a year (Table 29). Asked if this movement in and out of care happened due to the COVID-19 pandemic, 44 caregivers (59%) said yes.

Table 26: Age at entrance to and exit from, and years spent in residential care, by county, Kenya

	Kilifi (n=82)	Kisumu (n=69)	Nyamira (n=31)	Kenya (n=182)
Age at entrance to residential care	5	8	8	7
Age most recently exited residential care	11	11	10	11
Years in residential care	5.8	3.0	3.0	4.3

Table 27: Who children lived with prior to entering residential care, by county, Kenya

Before entering residential care, the child…	Kilifi (n=101)	Kisumu (n=74)	Nyamira (n=41)	Kenya (n=216)
Lived with respondent	75 (74%)	60 (81%)	30 (73%)	165 (76%)
Lived with someone else	26 (26%)	14 (20%)	11 (27%)	51 (24%)
Before entering the most recent residential care, the child lived in…				
Another institution	0 (0%)	1 (1%)	1 (3%)	2 (1%)
Biological parents' home	76 (75%)	52 (70%)	30 (75%)	158 (74%)
Other relatives' home	20 (20%)	15 (20%)	8 (20%)	43 (20%)
Non-relatives' home	1 (1%)	0 (1%)	1 (3%)	2 (1%)
Other non-relatives' home	4 (4%)	6 (8%)	0 (0%)	10 (5%)

Table 28: Children's living arrangements with siblings during and after residential care, by county, Kenya

The child and their siblings…	Kilifi	Kisumu	Nyamira	Kenya
Lived together in residential care	75 (73%)	31 (41%)	20 (47%)	126 (57%)
Then came together from residential care to current family	70 (93%)	25 (81%)	17 (85%)	112 (89%)

Table 29: How often children moved between residential care and family/current placement, by county, Kenya

The child moved between residential care and family…	Kilifi	Kisumu	Nyamira	Kenya
Yes	44 (43%)	13 (17%)	18 (43%)	75 (34%)
How often did they move…				
Once a month or more	5 (11%)	0 (0%)	2 (11%)	7 (9%)
A few times per year	34 (77%)	11 (85%)	13 (72%)	58 (77%)
About once a year	4 (9%)	1 (8%)	2 (11%)	7 (9%)
Less than once a year	1 (2%)	1 (8%)	1 (6%)	3 (4%)
Movement was due to COVID pandemic…				
Yes	28 (64%)	8 (62%)	8 (44%)	44 (59%)

6.2.2. Kenya CTWWC support

All caregivers (n=278) were asked if their household had received support from CTWWC. Most (93%) caregivers reported that they had received home visits followed by parenting training (89%), training to manage finances (81%), cash transfers (75%) and kitchen garden training (71%) (Table 30).

If the caregiver reported that they received a service, they were also asked to rate how helpful the service was for taking care of their children. A score of 0 corresponded to "didn't help at all," 1 meant "helped a little," and 2 was "helped a lot." All interventions were rated as being helpful, receiving average ratings between 1.62 and 1.85 (Figure 37). Caregivers rated parenting training as the most helpful service (1.85). Cash transfers were rated as the second most helpful (1.76), closely followed by home visits and training on managing finances (1.75 each), gifts in kind (1.70)

and kitchen gardens (1.69). There was some variation between the different counties, with caregivers in Kilifi giving the lowest average scores across all the services.

Based on CTWWC monitoring data, 174 (63%) cases have been closed. Over 40% of caregivers reported not being well prepared for case closure, while 34% felt partially prepared and 25% felt fully prepared (Figure 38).

Table 30: CTWWC services received, by county, Kenya

Received service	Kilifi	Kisumu	Nyamira	Siaya	Kenya
Home visits	67 (97%)	90 (94%)	26 (87%)	76 (97%)	259 (93%)
Parenting training	54 (78%)	85 (89%)	25 (83%)	82 (99%)	246 (89%)
Training on finances (COFE)	44 (64%)	79 (82%)	23 (77%)	78 (94%)	224 (81%)
Cash transfers	62 (90%)	88 (92%)	22 (73%)	37 (45%)	209 (75%)
Kitchen garden training	26 (38%)	71 (74%)	26 87%)	74 (89%)	197 (71%)
Savings and loans group (SILC)	36 (52%)	62 (65%)	20 (67%)	75 (90%)	193 (69%)
Training on agricultural business skills (SMART skills)	25 (36%)	72 (75%)	24 (80%)	71 (86%)	192 (69%)
Referrals to other services providers	51 (74%)	65 (68%)	22 (73%)	53 (64%)	191 (69%)
Gifts in kind	54 (78%)	57 (59%)	20 (67%)	42 (51%)	173 (62%)

Figure 36: Caregivers' average rating of the helpfulness of family strengthening interventions received (scale of 0–2, with 2 representing most helpful), Kenya
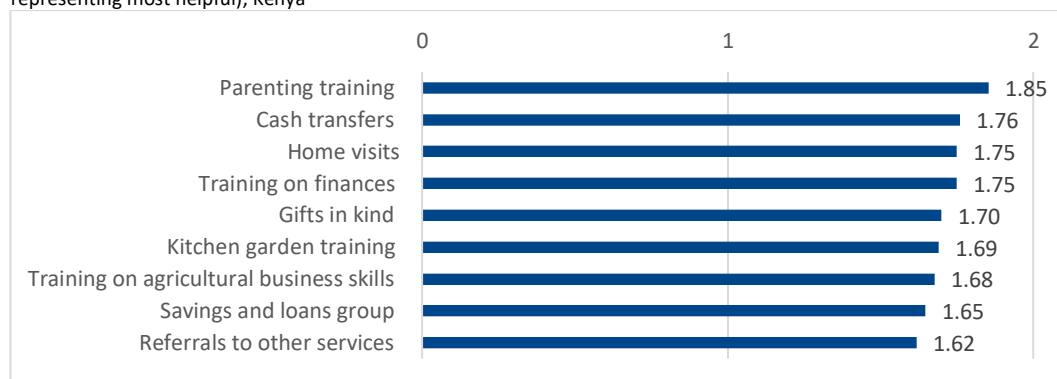
Table 31: Caregivers' average rating of the helpfulness of family strengthening interventions, by county, Kenya (scale of 0–2, with 2 representing most helpful), by county, Kenya

Service	Kilifi	Kisumu	Nyamira	Siaya	Kenya
Parenting training	1.67	1.93	1.80	1.91	1.85
Cash transfers	1.55	1.86	1.82	1.83	1.76
Home visits	1.54	1.89	1.73	1.76	1.75
Training on managing your finances	1.50	1.85	1.70	1.81	1.75
Gifts in kind	1.52	1.88	1.70	1.69	1.70
Kitchen garden training	1.19	1.83	1.77	1.70	1.69
Training on agricultural business skills	1.20	1.79	1.63	1.75	1.68
Savings and loans group	1.31	1.69	1.65	1.77	1.65
Referrals to other services	1.41	1.68	1.77	1.68	1.62

Figure 37: Preparedness for case closure, by county, Kenya
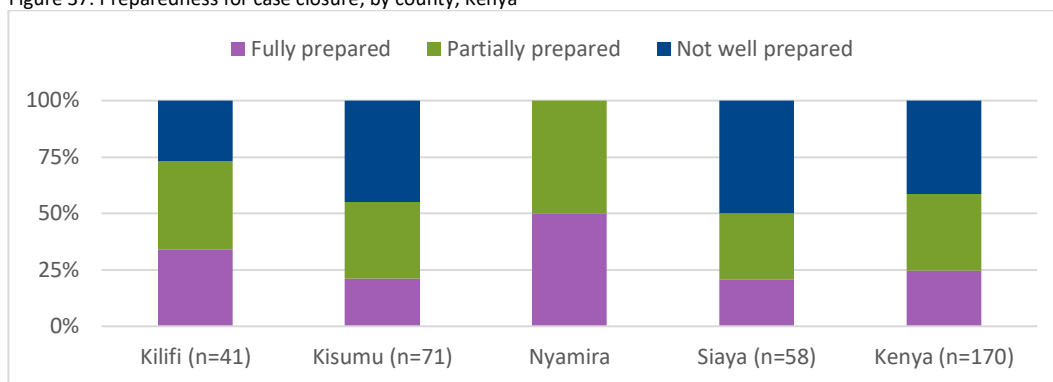
6.2.3. Kenya caregiver protective factors

Caregiver protective factors, which strengthen a caregiver's ability to be resilient and care for their children, are examined in the household survey through three sets of measures as presented below: four types of protective factors measured in the PFI, three different parenting practices and a set of measures linked to economic stability.

Protective factors index

Figure 38: Caregiver protective factor definitions

Parental resilience: Managing stress and functioning well when faced with challenges, adversity and trauma.
Social and emotional competence: Interacting with children in a way that helps them develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships.
Social support and connections: Positive relationships that provide emotional, informational, instrumental and spiritual support.
Access to concrete support in times of need: Access to concrete support and services that address a family's needs and help minimize stress caused by challenges.

A score for each of the four protective factors was calculated (Table 32), and an overall PFI score resulted. This was based on a scale of 0–4, where 4 represents higher protective factors. There are no set cut offs that indicate whether a score should be considered high, medium or low. The text of each of the survey questions that make up these scales are included in the appendix.

The overall average PFI score for Kenya was 2.79. The two external-facing factors scored lower on average: 2.27 for social support and connections and 2.62 for access to concrete support. The more internal factors of resilience and social and emotional competence scored higher on average: 3.10 and 3.19, respectively. There was little difference between the counties.

When looking across differences in household and caregiver factors, some interesting results arise. The more children in the household, the lower the caregiver's social connection score (r=-.124, p<.05). Female caregivers had slightly higher social emotional scores compared to male caregivers (female 3.23, male 3.02, p<.05). Caregivers without a disability had slightly higher social connection scores compared to those with a disability (without a disability 2.33, with a disability 2.00, p=.05), as did caregivers who had not been widowed compared to those are widows (non-widows 2.38, widows 2.13, p<.05). Households with children at risk of separation had lower parental resilience and overall PFI scores compared to those with a reintegrating child (resilience: at-risk 3.01, reunified 3.15, p<.05; PFI: at-risk 2.71, reunified 2.84, p<.05). There were no significant correlations when considering caregiver age, education or number of adults in the house and no significant differences between urban and rural households.

When comparing results from the caregivers who were involved in this round of the survey as well as in 2021/Y3 (n=156), no statistically significant changes on protective factor scores between Y3 and Y5 were found (Table 33). At the county level, there was some improvement in Kisumu on internal factors of resilience and emotional competence. However, there was a decline in Nyamira in three areas of concrete support, resilience and social and emotional competence. There was no significant change in Kilifi (Table 34).

Table 32: Protective Factors Index mean scores, by county, Kenya

	Kilifi	Kisumu	Nyamira	Siaya	Kenya
Caregiver resilience	3.05	3.14	3.02	3.03	3.10
Social and emotional competence	2.99	3.21	2.90	3.22	3.19
Social support and connections	2.21	2.07	2.56	2.31	2.27
Access to concrete support	2.40	2.74	2.61	2.62	2.62
Protective Factors Index	**2.69**	**2.83**	**2.80**	**2.83**	**2.79**

Table 33: Caregiver protective factors change over time, Kenya

	Y3	Y5	p value
Caregiver resilience	2.61	2.62	.99
Social and emotional competence	3.16	3.17	.79
Social support and connections	3.09	3.11	.75
Access to concrete support	2.15	2.25	.28
Protective Factors Index	**2.75**	**2.78**	**.63**

Table 34: Caregiver protective factors change over time by county, Kenya

	Kisumu (n=74)			Kilifi (n=56)			Nyamira (n=26)		
	Y3	Y5	p-value	Y3	Y5	p-value	Y3	Y5	p-value
Caregiver resilience	3.02	3.20	.04*	3.04	3.04	0.95	3.39	3.00	.004**
Social and emotional competence	3.10	3.34	.005**	3.10	3.07	0.82	3.44	2.9	.02*
Social support and connections	2.17	2.10	0.6	1.99	2.26	0.08	2.43	2.63	.30
Access to concrete support	2.69	2.77	0.47	2.37	2.44	0.51	2.97	2.57	.005**
Protective Factors Index	**2.74**	**2.83**	**0.28**	**2.62**	**2.70**	**0.37**	**3.05**	**2.78**	**.03***

Significance levels: *** p<.001, ** p<.01, * p<.05.

Parenting practices

The survey assessed parenting practices focusing on how caregivers are involved with their children and the extent to which they practice positive parenting. Six questions were asked on parental involvement and six on positive parenting practices, using a scale of 0–4, with 0 being never, 2 sometimes and 4 being always. The totals across the six statements were summed, giving a maximum score of 24, with higher scores indicating a greater degree of involvement or positive parenting practice. On average, caregivers had a mean total score of 15.35 for parental involvement and 16.60 for positive parenting practices. There were little variations in parenting practices across counties (Table 35). Amongst the items presented in each scale, those that were about the caregiver talking with the child or verbally praising or complimenting them scored the highest (all over 3, on average). The items related to doing an activity with the child (e.g., games or homework), rewarding or hugging/kissing scored much lower, closer to 2, on average.

The survey also asked three questions about the use of corporal punishment, using the same 0–4 scale from never to always. Across all caregiver respondents, 70% said they never or almost never spank their children with their hand, 85% said they never or almost never slap their children on the face and 66% said they never or almost never hit their children with an object (such as a belt or cane) (Figure 41). This varied little between the four counties (Figure 42).

When looking at differences in parenting practices between groups of caregivers or households, it was clear that the older the caregiver, the less frequently they used any of the forms of corporal punishment (spank r=-.226, slap r=-.243, hit with object r=-.155, p<.01). The more children in the household, the more frequently the caregiver used spanking (r=.124, p<.05), and the higher a caregiver's education level, the more likely they were to be involved with their children (r=.190, p<.01). Comparisons show that female caregivers practiced positive parenting more frequently compared to male caregivers (female 16.81, male 15.54, p<.05), but female caregivers also hit with an object more frequently than male caregivers (1.00, male 0.57, p=<.01). Caregivers without a disability were more frequently involved with their children compared to those with a disability (without a disability 15.66, with a disability 13.86, p<.05). Caregivers in households with reintegrating children were also more involved with their children compared to those in households at risk of separation (reunified:16.07, at-risk 14.25, p<.01). Parenting practices were not correlated with the number of adults in a household and did not significantly differ between households in urban and rural locations.

The survey assessed change over time for respondents in both rounds of the survey (Table 36). The results showed no statistically significant changes in parental involvement or positive parenting practices between Y3 and Y5. In addition, there were no statistically significant changes in slapping and hitting, but on average, caregivers spanked their children more in Y5 compared to Y3. By county, there were no significant changes in Kisumu in relation to parental involvement or positive parenting practices, but there were improvements in parental involvement in Kilifi and a decline in parental involvement in Nyamira. For corporal punishment, there was an increase in the use of spanking in Kisumu (Table 37).

Table 35: Parenting practice total scores (0–24, with higher score meaning more frequent practice), by county, Kenya

	Kilifi	Kisumu	Nyamira	Siaya	Kenya total
Parental involvement	16.20	14.81	15.37	15.27	15.35
Positive parenting	16.17	16.33	17.27	17.01	16.60

Figure 39: How often parental involvement and positive parenting are practiced, mean scores per statement (0=never, 2=sometimes, 4=always), Kenya
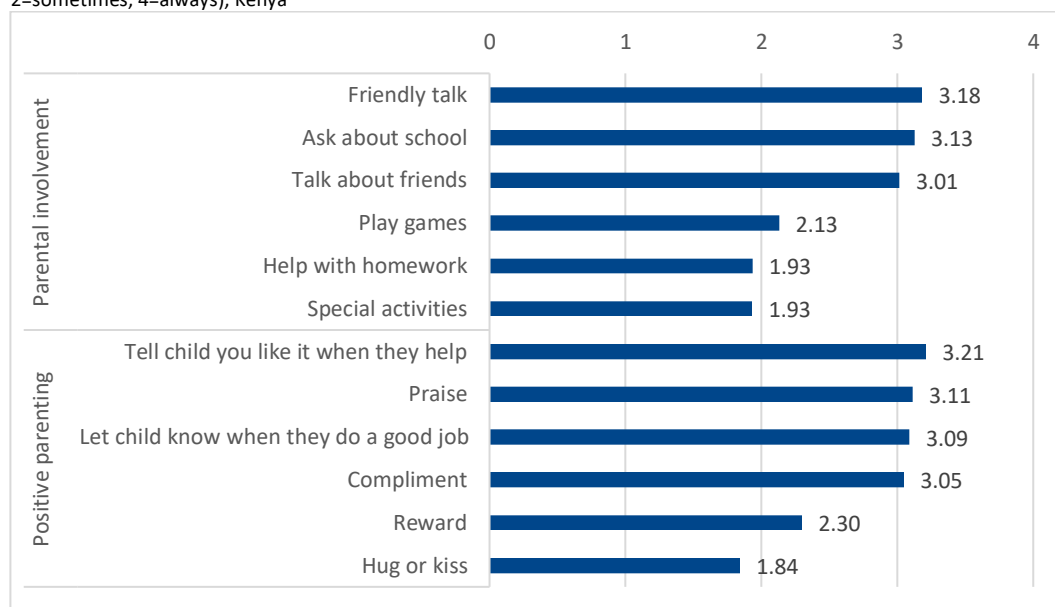
Figure 40: Corporal punishment percentage response options, Kenya
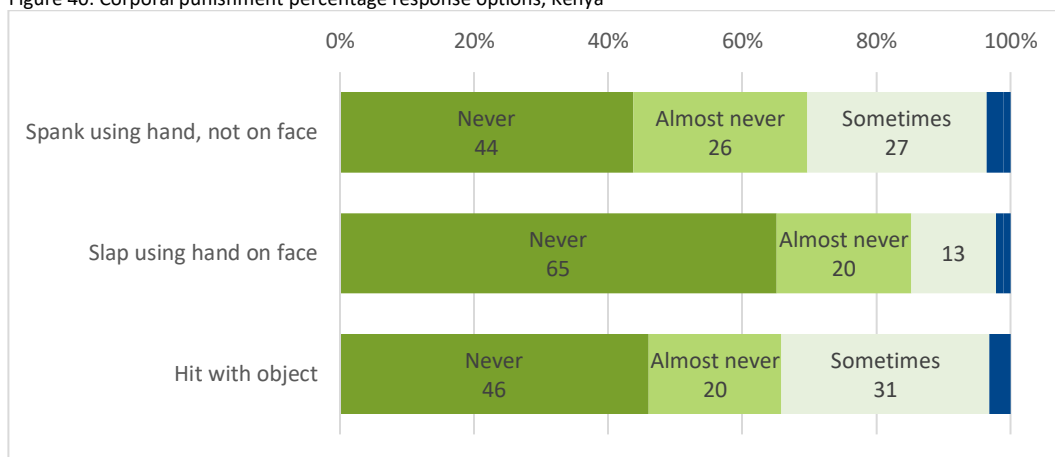
Figure 41: Corporal punishment percentage response options by county, Kenya
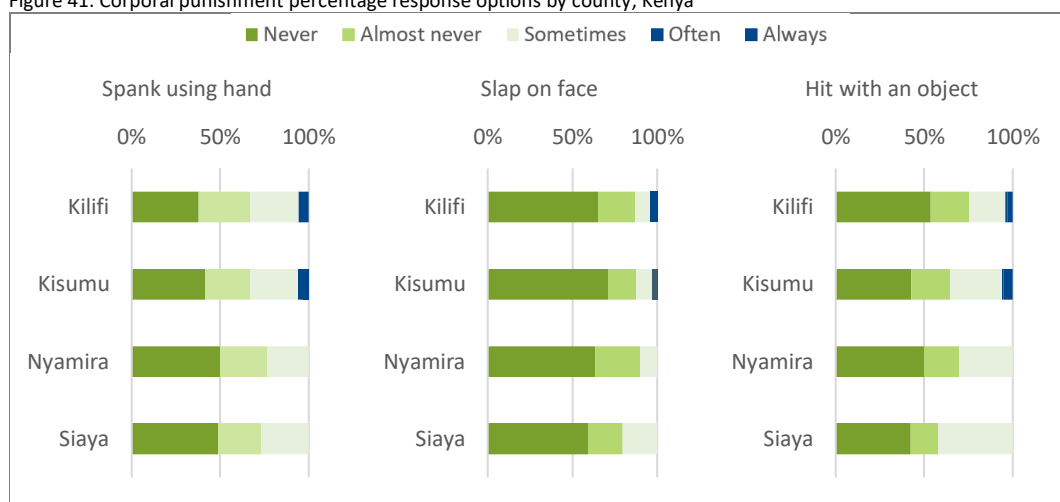
Table 36: Parenting practice, total scores (0–24, higher scores indicate more positive parenting practice), and corporal punishment, average scores (0–4, higher scores indicate more frequent use of punishment), Y3 and Y5, Kenya

Parenting practice (total of six statements)	Y3	Y5	p value
Positive parenting	16.07	16.43	0.42
Parental involvement	15.67	15.42	0.62
Corporal punishment (average for each statement)	Y3	Y5	p value
Spank with hand, not on face	0.77	0.99	.03*
Slap with hand on face	0.42	0.52	0.24
Hit with an object	0.78	0.94	0.15

Significance levels: *** p<.001, ** p<.01, * p<.05.

Table 37: Parenting practice, total scores (0–24, higher scores indicate more positive parenting practice), and corporal punishment, average scores (0–4, higher scores indicate more frequent use of punishment), Y3 and Y5, by county, Kenya

Parenting practices	Kisumu (n=74)			Kilifi (n=56)			Nyamira (n=26)		
	Y3	Y5	p-value	Y3	Y5	p-value	Y3	Y5	p-value
Positive parenting	15.51	16.30	0.227	15.35	16.22	0.23	19.24	17.28	0.095
Parental involvement	16.02	15.14	0.21	13.98	15.84	.02*	18.33	15.29	.04*
Corporal punishment									
Spank with hand, not on face	0.70	1.04	.03*	0.86	1.05	0.19	0.77	0.69	0.78
Slap with hand on face	0.36	0.54	0.12	0.34	0.54	0.16	0.77	0.42	0.11
Hit with an object	0.81	1.07	0.13	0.71	0.88	0.31	0.85	0.69	0.56

Significance levels: *** p<.001, ** p<.01, * p<.05.

CTWWC indicator results: Positive Parenting

The parenting practices results, as presented above, were used to calculate results for the CTWWC outcome indicator on the percentage of caregivers who completed training in positive parenting and were subsequently assessed as practicing positive parenting with the targeted level of frequency (a total score of 15+ for positive and involved parenting and little corporal punishment).

About one fifth (19%) of caregivers who had received positive parenting met all of the criteria to meet this indicator, a similar level to the results in Y3 when 21% met all of the criteria (Table 38). In Y5, almost three-quarters (73%) of caregivers were frequently involved with their children and 61% were frequently practicing positive parenting techniques, but only one third had reached the minimal level of corporal punished, which the indicator was aiming for (Figure 43).

Table 38. Indicator 8: Positive parenting, Kenya

Percentage of caregivers who completed training in positive parenting who are subsequently assessed as practicing positive parenting skills	Y3 N	Y3 %	Y5 N	Y5 %
Kenya	41	21%	44	19%
Household type: *at risk*	8	24%	15	15%
reintegrating	33	21%	29	23%
Sex: *male*	9	29%	8	24%
female	32	20%	36	18%

Figure 42: Indicator 8: Positive parenting, positive responses to each item, Kenya
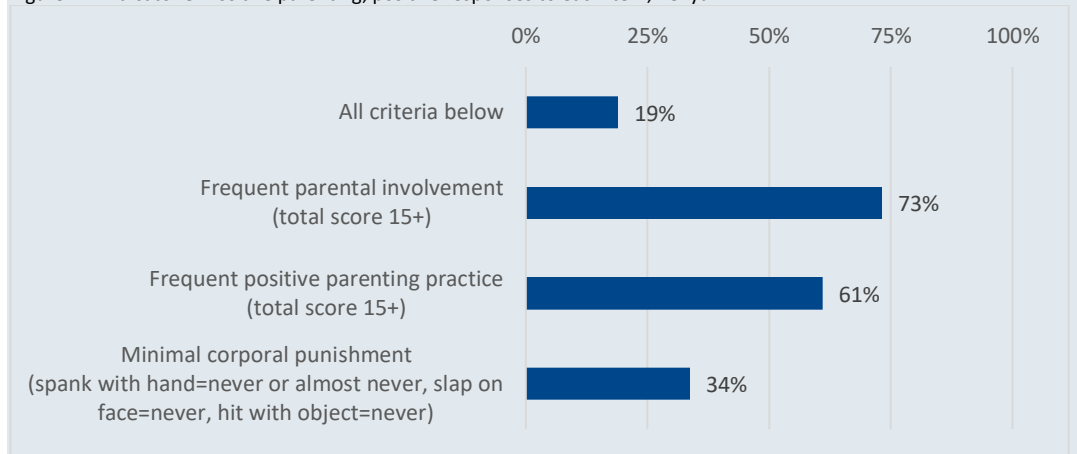
Couple functionality: communication

The survey includes, for the first time, the communication subscale from the CFAT to understand how well caregivers who are married or living together communicate when a problem arises in their relationship. The tool uses a scale of 0–4 where 0 was very unlikely and 4 very likely, so that a higher score indicates a greater likelihood to communicate positively when problems arise. Responses to seven statements were totaled, yielding a maximum score of 28. The average score for all Kenyan respondents was 20.32 (Figure 44).

CFAT scores varied significantly depending on location, with caregivers in rural areas scoring more positively compared to those in urban areas (rural 20.95, urban:17.68, p<.05). There was no significant variation when considering caregiver age, education, sex or disability, nor when looking at the number of adults or children in the household or whether the household was reintegrating a child or was at risk of separation.

Figure 43: Couple functionality, communication, Kenya
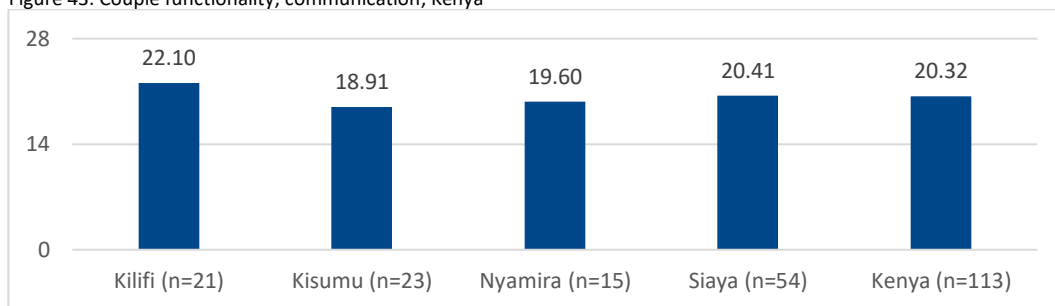
Household economic stability

To gauge the economic stability of households, respondents were asked about financial practices in their households:

■ Over 95% of caregivers reported often or sometimes having worried about money in the four weeks preceding the survey (Figure 45).
■ 35% of respondents reported that they had managed to save money in the past month (Figure 46). Kilifi had the lowest percentage (26%) of caregivers who reported having saved money, with the Kisumu and Nyamira counties having 30% caregivers saving. In Siaya, almost half of all caregivers reported being able to save.
■ About one third of caregivers could get 7,500 Kenyan shillings (KES) during emergencies (both "easy" and "possible but hard" responses) and about one quarter could KES 9,600 for an emergency (Figure 47). This varied between counties with more Kisumu and Siaya caregivers reporting a difficulty in raising money in an emergency.

Using the Household Hunger Scale, 59% of households were found to have moderate levels of hunger and 41% had no or little hunger (Figure 48). However, at the county level, moderate hunger was more common in Nyamira (70%) and Siaya (75%).

The survey also assessed what households can pay for when necessary:

Overall, just 15% of caregivers were able to fully pay all educational costs for their children with this rate varying considerably across counties from 23% in Kilifi to 7% in Nyamira (Table 39). As a result, three quarters of households reported that children in their household had to miss some school because of inability to cover costs.

Across all locations, 78% of caregivers reported that a child in their household was sick or needed health services, and 92% of those sought health care services (Table 40). Of those seeking health care services, 63% were able to pay for their children's health care expenses.

In total, 71% of households reported having unexpected household costs in the three months preceding the survey, of whom 68% said these expenses had not been paid (Table 41).

When looking at variations between groups or across characteristics of households and caregivers/respondents regarding their economic stability, there were several notable results.

- Widows worried more about money than those who were not widowed (widow 2.71, non-widow 2.55, p<.05).
- Caregivers who were able to save were slightly younger on average than those not saving (mean age of savers 43.88 years, non-savers 47.81 years, p<.05). Fewer caregivers with a disability were able to save compared to those without a disability (disability: 20.4%, no disability: 38.0%, p<.05). Fewer caregivers in urban households were able to save compared to those in rural households (urban 22.7%, rural 38.7%, p<.05).
- Female caregivers were less likely to be able to obtain funds in an emergency compared to male caregivers (female 0.32, male 0.52, p<.05) as were caregivers in households with children at-risk of separation compared to those with reintegrating children (at-risk 0.27, reunified 0.41, p<.05).
- The more children in a household, the more severe the level of hunger. Levels of hunger were also higher in households with a caregiver with a disability compared to those without (disability 2.82, no disability 1.79, p<.01) and in households with a caregiver who is a widow compared to those who are not (widow 2.26, non-widow 1.74, p<.01).
- There were no significant correlations between economic stability measures and caregiver education or number of adults in a household.

When reviewing change over time between the surveys in Y3 and Y5, findings show that, on average, caregivers expressed significantly greater worry about their financial situation at Y5 compared to Y3 (p<.05) (Table 42) and significantly higher levels of hunger at Y5 compared to Y3 (p<.001). Caregivers in Kilifi reported an improvement in their ability to cover emergency expenses (p<.05). In contrast, there was a small but significant increase in hunger in Kisumu (p<.01) and a more substantial increase in hunger in Nyamira (p<.01) between Y3 and Y5. These findings highlight the economic struggles faced by families across Kenya in recent years, especially during the COVID-19 pandemic.

Figure 44: How often worried about money in past month, by county, Kenya
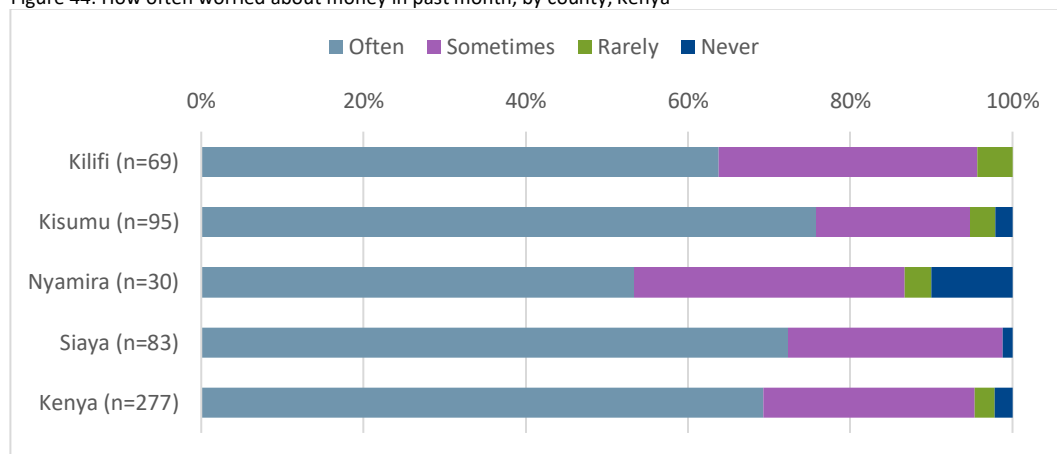
Figure 45: Ability to save money in the past month, by county, Kenya
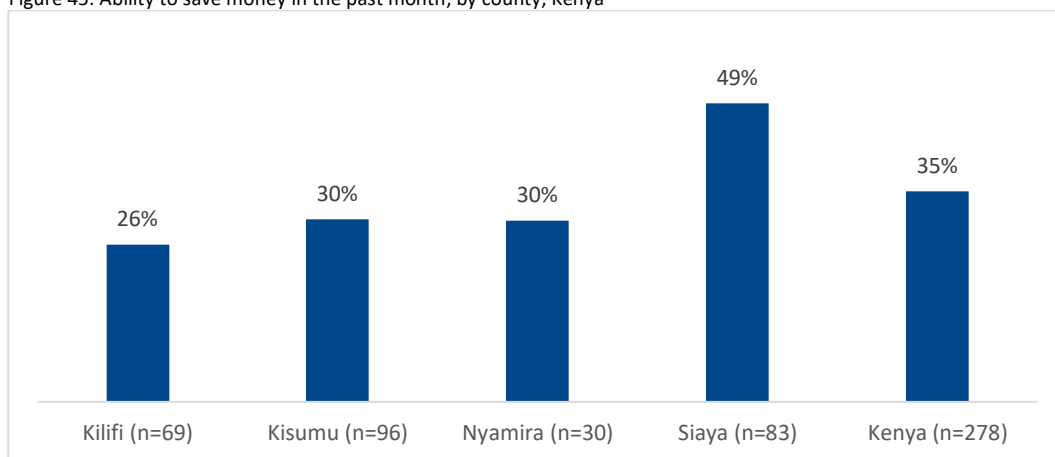
Figure 46: Ability to get KES 7,500 and KES 9,600 in an emergency (both "easy" and "possible but hard" responses), by county, Kenya
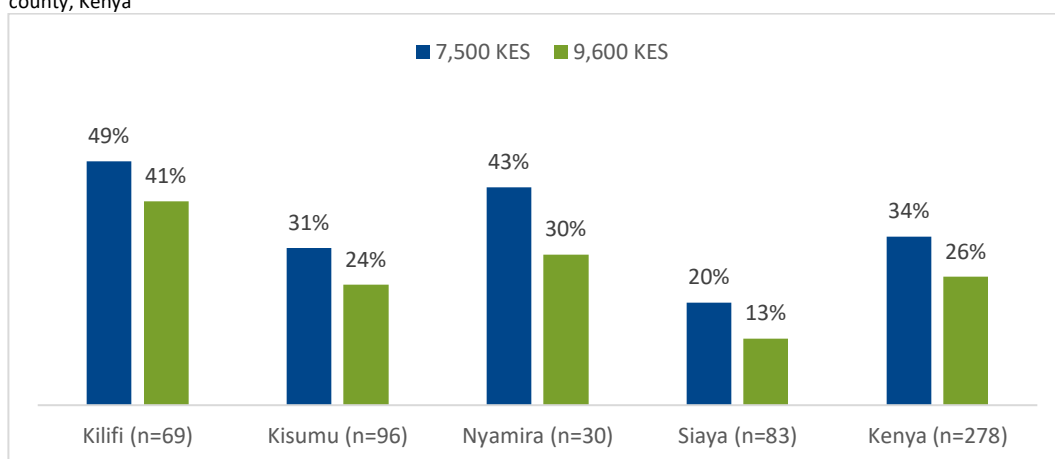
Figure 47: Household hunger, Kenya
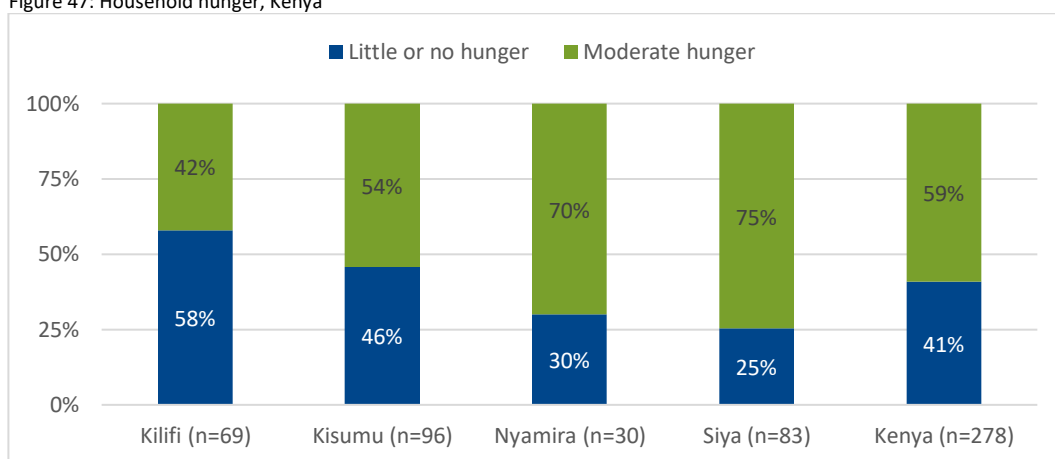
Figure 48: Ability to pay for household expenses when needed, Kenya
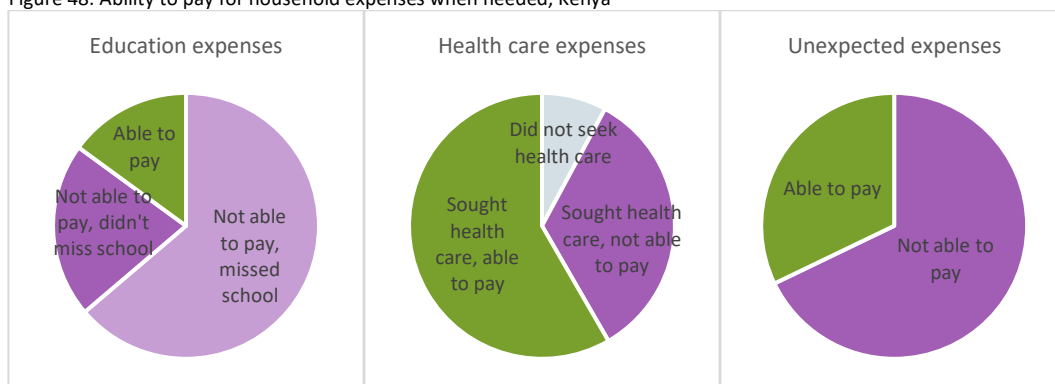
Table 39: Ability to pay for education expenses for children enrolled at school, by county, Kenya

	Kilifi (n=60)	Kisumu (n=90)	Nyamira (n=28)	Siaya (n=77)	Kenya (n=255)
Able to pay all education expenses	14 (23%)	14 (16%)	2 (7%)	8 (10%)	38 (15%)
Unable to pay all education expenses	46 (71%)	76 (83%)	26 (90%)	69 (87%)	217 (82%)
Child missed school as a result of not paying	37 (80%)	52 (69%)	19 (73%)	54 (78%)	162 (75%)
Child did not miss school as a result of not paying	9 (20%)	23 (31%)	7 (27%)	15 (22%)	54 (25%)

Table 40: Ability to pay for health care expenses when child was sick or needed health care, by county, Kenya

	Kilifi (n=55)	Kisumu (n=68)	Nyamira (n=20)	Siaya (n=73)	Kenya (n=216)
Did not seek health care	5 (9%)	7 (10%)	2 (10%)	3 (4%)	17 (8%)
Sought health care	50 (91%)	61 (90%)	18 (90%)	70 (96%)	199 (92%)
Able to pay for health care	35 (70%)	40 (66%)	13 (72%)	38 (54%)	126 (63%)
Unable to pay for health care	15 (30%)	21 (34%)	5 (28%)	32 (46%)	73 (37%)

Table 41: Ability to pay unexpected costs, by county, Kenya

	Kilifi (n=69)	Kisumu (n=96)	Nyamira (n=30)	Siaya (n=82)	Kenya (n=277)
No unexpected expenses	24 (35%)	26 (27%)	11 (37%)	19 (23%)	80 (29%)
Unexpected expenses	45 (65%)	70 (73%)	19 (63%)	63 (77%)	197 (71%)
Able to pay unexpected costs	19 (42%)	18 (26%)	6 (31%)	20 (32%)	63 (32%)
Unable to pay unexpected costs	26 (58%)	52 (74%)	13 (68%)	42 (68%)	133 (68%)

Table 42: Caregiver economic stability change over time, Kenya

	Y3	Y5	p value
Worried about money (scale of 0=never worried to 3= often worried)	2.43	2.59	.02*
Able to cover emergency (scale of 0=impossible to 2=easy)	0.41	0.44	.58
Household Hunger Score (scale of 0–6, higher score=more hunger)	1.24	1.96	<.001 ***

Significance levels: *** p<.001, ** p<.01, * p<.05.

Table 43: Caregiver economic stability change over time by county, Kenya

	Kisumu (n=74)			Kilifi (n=56)			Nyamira (n=26)		
	Y3	Y5	p value	Y3	Y5	p value	Y3	Y5	p value
Worried about money (scale of 0=never worried to 3= often worried)	2.56	2.68	0.15	2.38	2.59	0.1	2.15	2.35	.38
Able to cover emergency (scale of 0=impossible to 2=easy)	0.46	0.34	0.15	0.37	0.57	.04*	0.35	0.46	.42
Household Hunger Score (scale of 0–6, higher score=more hunger)	1.22	1.91	.001**	1.16	1.63	0.07	1.46	2.80	.003**

Significance levels: *** p<.001, ** p<.01, * p<.05.

CTWWC indicator results: Economic Stability

The economic stability results, as presented above, were used to calculate results for the CTWWC outcome indicator on the percentage of caregivers who received economic support who were subsequently assessed as being economically stable within the targeted factors (not worried about money, able to save, could meet emergency costs, little or no hunger).

Only 1% (two out of 273) of caregivers who had received economic support (cash transfer/gift cards) met all of the criteria to meet this indicator, a small decrease on results from Y3 when only 4% met all of the criteria (Table 44). In Y5, around one third of caregivers were able to save and could meet emergency costs, and their households faced minimal hunger, but just 4% were not worried about money (Figure 50).

Table 4444. Indicator 7: Economic stability, Kenya

Percentage of caregivers who received economic support who are subsequently assessed as being economically stable	Y3 N	Y3 %	Y5 N	Y5 %
Kenya	**10**	**4%**	**2**	**1%**
Household type: *at risk*	0	0%	0	0%
reintegrating	10	5%	2	1%
Sex: *male*	1	2%	0	0%
female	9	4%	2	1%

Figure 49: Indicator 7: Economic stability, positive responses to each item, Kenya
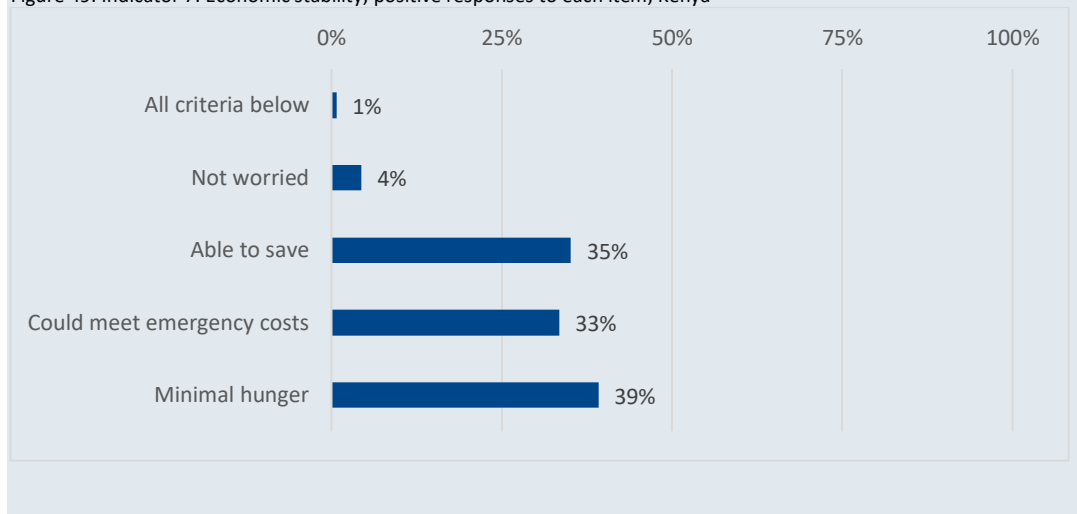
6.2.4. Kenya child well-being

Health

The survey assessed the overall health of children aged 2–10 years (n=80) and 11–18 years (n=163). The assessment of overall health was conducted using a scale ranging from 0 to 4, with 0 representing poor health, 2 indicating good health and 4 excellent health. Caregivers responded on behalf of children aged 2–10 years, giving an average score of 2.56, indicating good health. Children aged 11–18 years were asked directly about their health and provided an average score of 2.48.

When looking at different child characteristics and their reported health, if was found that amongst children aged 2–10 years, boys had better health than girls (male 2.92, female 2.41, p<.05), children without a disability had better health than those with a disability (without a functional difficulty 2.56, with a functional difficulty 1.40, p<.01) and reintegrating children had better health than those at risk of separation (reunified 3.09, at risk 2.17, p<.001). There were no significant differences by parental care or orphanhood status and no difference when looking at age at the time of the survey, entry to or exit from residential care, nor length of stay in residential care. Amongst children aged 11+ years, health scores also varied significantly by placement type with children reintegrating again having better health than those at risk of separation (reunified 2.68, at risk 2.11, p<.001) and orphaned children having better health than those with both living parents (orphan 2.77, non-orphan 2.12, p<.001). There were no significant differences by sex, disability status or parental care, nor when correlated with age at the time of the survey when considering all children aged 11+ years. Specifically amongst children who were reintegrating who were aged 11+ years, there was a significant correlation with age at the time of entrance to care, so that the older a child was entering residential care the poorer they reported their health at the time of the survey. There was also a significant difference by disability status with children without a functional difficulty having better health compared to those with a functional difficulty (without a functional difficulty 2.77, with a functional difficulty 2.08, p<.05). Amongst reintegrating children aged 11+ years, there were no significant differences by sex, parental care or orphanhood status and no difference when looking at age at the time of the survey, at time of entry to care or length of stay in residential care.

Education

Caregivers of 2–4-year-olds were asked if their child was enrolled in any sort of ECE program. Half of children aged 2–4 were enrolled in ECE (n=10) and 80% of them were receiving at least two types of stimulation.

In addition, 90% of children aged 5+ years were enrolled in school (n=348), which was consistent across the four counties. Of the 10% who were not enrolled, it was due mostly to not wanting to enroll (30%, preferring to be at home, on the streets or working), costs (23%) and marriage/pregnancy (13%). Of those who were enrolled, 38% had missed four or more days in the last month due to costs (70%) or illness (25%). Missing days of school varied considerably between counties with almost 60% missing four or more days in the last month in Siaya, but only 22% missing the same amount of days in Kilifi (Table 45).

ECE enrollment and stimulation could not be compared between Y3 and Y5 because there were no children who were eligible for the relevant questions at both time points. However, for school enrollment, there was a significant drop in the proportion of children aged 5+ years enrolled in school, 95% to 88%, between Y3 and Y5 amongst the same children (Table 46).

Table 45: School enrollment and days missed, by county, Kenya

	Kilifi (n=105)	Kisumu (n=102)	Nyamira (n=47)	Siaya (n=88)	Kenya (n=342)
School enrollment	93%	89%	79%	95%	91%
Missed 4 or more days of school in last month	22%	34%	43%	59%	38%

Table 46: School enrollment over time, Kenya

	Y3	Y5	p value
School enrollment	95.3%	88.4%	.001**

Significance levels: *** p<.001, ** p<.01, * p<.05.

Child well-being, 2–10 years old

With regards to the well-being of children aged 2 to 10 years, using a scale of 0–2 with 0 being none of the time and 2 being all of the time, caregivers reported an average score across 10 statements of 1.61, which was consistent across the four counties. Most items were scored very positively, but some concern was evident around children's educational materials, food and support from relatives (Figure 51).

When comparing across groups of children aged 2–10 years aligned with health (see above section), boys had better well-being than girls (male 1.80, female 1.63, p<.05), children without a disability had better well-being than those with a disability (without a functional difficulty 1.71, with a functional difficulty 1.42, p<.05) and children reintegrating had better well-being than those in families at risk of separation (reunified 1.81, at-risk 1.60, p<.001). There were no significant differences by parental care or orphanhood status and no difference when looking at age at the time of the survey, entry to or exit from residential care, or length of stay in residential care.

Looking at children who were between the ages of 2–10 years at both time points (Y3 and Y5), there were no significant changes in their average wellbeing scores.

Figure 50: Child well-being (2–10 yrs) means scores per item, caregiver reported (scale of 0–2, 2=greater well-being), Kenya
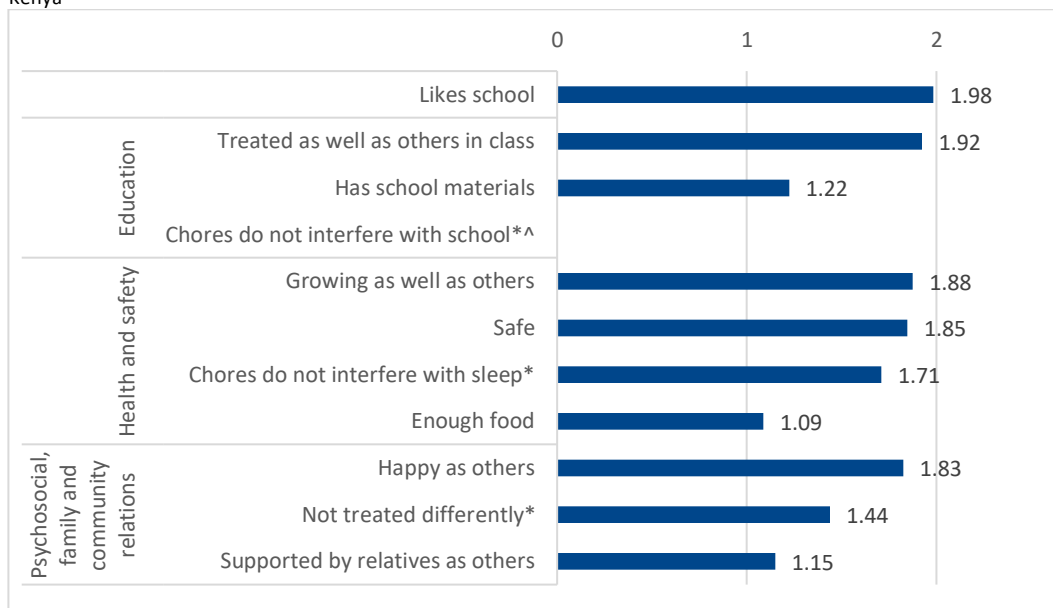
* Item asked in negative and results reverse coded for comparison with other items. ^ Error in data collection, data not collected

Table 47: Child well-being (2–10yrs) change over time, self-reported (scale of 0–2, 2=greater well-being), Kenya

	Y3	Y5	p-value
Child well-being 2–10 years	1.76	1.73	.59

Child well-being, 11+ years old

Children aged 11 years and above self-reported on their well-being using a scale of 0–2 with 0 being none of the time and 2 being all of the time. The average score across all factors was 1.49, with subscale average scores of 1.66 for leisure and freedom, 1.63 for care and safety and 1.28 for basic needs (Table 48). There was some variation in the overall average score between counties, from 1.35 in Nyamira to 1.57 in Kisumu. Similarly, the basic needs average score was the lowest subscale score in all four counties, ranging from 1.06 in Nyamira to 1.40 in Kisumu (Table 48).

When comparing across groups of children aged 11+ years, the only significant difference in well-being levels was between children with a disability and those without. Children with a disability reported lower levels of well-being (with functional limitations 1.35, without functional limitations 1.50, p<.01). There were no other significant differences or correlations when looking at well-being by age, sex, reunified vs. at-risk, parental care status, orphanhood, years in care or age at the time of the survey, entry to residential care or reunification.

Looking at all children who were aged 11+ who participated in the two surveys (Y3 and Y5), there was a statistically significant drop in overall well-being scores, from 1.56 to 1.45 (p<.05), as well as in the basic needs subscale, from 1.38 to 1.25 (p<.05) (Table 49). This drop in basic needs mirrors the household economic stability findings.

Table 47: Child (11+ yrs) well-being average scores, case management households, Kenya

	Kilifi (n=38)	Kisumu (n=55)	Nyamira (n=26)	Siaya (n=44)	Kenya (n=163)
Average score of all items	1.52	1.57	1.35	1.45	1.49
Care and safety subscale average score	1.69	1.69	1.52	1.58	1.63
Basic needs subscale average score	1.29	1.40	1.06	1.26	1.28
Leisure and freedom subscale average score	1.68	1.74	1.50	1.66	1.66

Table 48: Change over time child well-being self-report, aged 11+ (n=54), (scale of 0=none of the time to 2=all the time), Kenya

	Y3	Y5	p-value
Average of all items	1.56	1.45	.04*
Care and safety subscale	1.70	1.59	ns
Basic needs subscale	1.38	1.25	.03*
Leisure and freedom subscale	1.69	1.68	ns

Significance levels: *** p<.001, ** p<.01, * p<.05. ns = not significant.

Table 50: Change over time child well-being self-report, aged 11+ (n=54), (scale of 0=none of the time to 2=all the time), county breakdown, Kenya

	Kisumu (n=21)			Kilifi (n=19)			Nyamira (n=6)		
	Y3	Y5	p-value	Y3	Y5	p-value	Y3	Y5	p-value
Average of all items	1.57	1.49	ns	1.55	1.50	ns	1.52	1.26	ns
Care and safety subscale	1.66	1.61	ns	1.75	1.60	ns	1.75	1.4	ns
Basic needs subscale	1.46	1.3	.04*	1.32	1.30	ns	1.2	0.88	ns
Leisure and freedom subscale	1.74	1.73	ns	1.60	1.70	ns	1.67	1.40	ns

Significance levels: *** p<.001, ** p<.01, * p<.05. ns = not significant.

Figure 51: Child well-being (11+ yrs) mean scores per item, self-reported (scale of 0–2, 2=greater well-being), Kenya

Food, clothing, bedding
- Like the food I eat: 1.56
- Comfortable place to sleep: 1.56
- Two meals a day: 1.47
- Eat until satisfied: 1.45
- Happy with clothing: 1.39
- Balanced diet: 1.04
- Choose what/when to eat: .50

Education
- Like teachers: 1.92
- Teachers respect me: 1.91
- Time to study: 1.75
- Home is good for study: 1.61
- Have school materials: 1.12
- Chores don't impact study*: 1.08
- Worry about money for education: 0.92

Health
- Health is good: 1.53
- Get medicine when needed: 1.44
- Taken to health provider when needed: 1.40
- I can keep clean: 1.25

Community relations
- Adults teach me to be successful: 1.66
- Adults who understand me: 1.62
- Treated same in community*: 1.58
- People to talk to about problems: 1.50
- Someone to turn to for advice: 1.43
- Others who would help me: .63

Family relations
- Caregivers love and care for me: 1.88
- Caregivers respect me: 1.86
- Part of my family: 1.85
- Happy with family time: 1.82
- Caregivers help me improve: 1.77
- Treated the same in family*: 1.65
- Caregivers consider my wants: 1.51
- Supported by relatives: .99
- Not afraid of caregivers*: 0.69

Psychosocial
- Time to rest and sleep: 1.83
- Happy as others: 1.77
- Happy with friends: 1.76
- Get along with friends: 1.74
- Play: 1.71
- Have fun with friends: 1.64
- Pursue hobbies: 1.56

Safety
- Feel safe: 1.73
- Peaceful home: 1.70
- Freedom to go out: 1.41
- Someone to ask for help if unsafe: 1.37

* Item asked in negative and results reverse coded for comparison with other items.

Family and community acceptance

Children aged 11+ years also reported on their sense of family and community acceptance. The assessment used a scale from 0 to 2 with 0 being not accepted and 2 being very accepted. Overall, children reported that they felt well accepted by families, with a mean score of 1.85, and reasonably well accepted by the community, with a mean score of 1.50 (Figure 53). In terms of family acceptance across the counties, overall, Kisumu and Siaya had the highest mean scores (1.91 and 1.88) indicating very high levels of family acceptance (Table 51). All of the counties had lower community acceptance mean scores compared to family acceptance, with the mean score particularly low in Siaya at 1.27.

When comparing across groups of children aged 11+, there were no significant differences or correlations in family acceptance scores for any of the variables considered. For community acceptance, children with a disability reported lower levels of acceptance compared to those with no disabilities (with functional difficulties 1.31, without functional difficulties 1.55, $p<.05$) as did children at risk of separation compared to those who had been reunified from residential care (at-risk 1.27, reunified 1.62, $p<.001$), children in parental care compared to those in the care of other caregivers (parental care 1.43, non-parental care 1.62, $p<.05$), and children who have two living parents compared to those who are single or double orphans (non-orphans 1.38, orphans 1.59, $p<.05$). There were no significant correlations when looking at years in care or age at the time of the survey, entry to residential care or reunification.

In terms of comparisons between Y3 and Y5, there were no statistically significant changes in a child's sense of acceptance from family or community between Y3 and Y5 (Table 52 and 53).

Figure 52: Family and community acceptance, mean score (scale 0 to 2, 2=greater sense of acceptance), Kenya
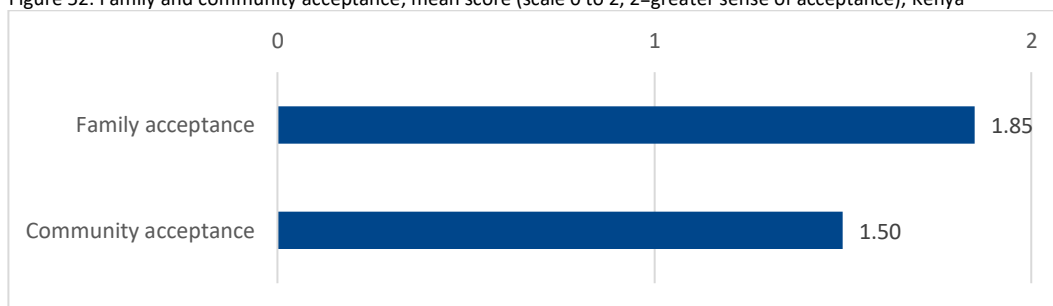
Table 49: Family and community acceptance, mean score (scale 0 to 2, 2=greater sense of acceptance), by county, Kenya

	Kilifi (n=38)	Kisumu (n=55)	Nyamira (n=26)	Siaya (n=44)	Kenya (n=163)
Family acceptance	1.80	1.91	1.75	1.88	1.85
Community acceptance	1.67	1.57	1.50	1.27	1.50

Table 50: Family and community acceptance over time, mean score (scale 0 to 2, 2=greater sense of acceptance), Kenya

	Y3	Y5	p-value
Family acceptance	1.68	1.70	.81
Community acceptance	1.87	1.81	.40

Table 51: Family and community acceptance over time, mean score (scale 0 to 2, 2=greater sense of acceptance), by county, Kenya

	Kisumu (n=29)			Kilifi (n=18)			Nyamira (n=5)		
	Y3	Y5	p-value	Y3	Y5	p-value	Y3	Y5	p-value
Family acceptance	1.9	1.9	ns	1.87	1.72	ns	1.73	1.97	ns
Community acceptance	1.54	1.71	ns	1.8	1.7	ns	1.73	1.57	ns

School belonging

Children aged 11+ years responded to a series of six statements about their sense of school belonging indicating the degree to which they agreed or disagreed on a scale from 0 to 4 with zero being strongly disagree while 4 was strongly agree. Overall, children had a good sense of school belonging with an overall mean score of 3.11 (Table 54). There was very little variation between the counties (Table 55).

When comparing across groups of children aged 11+, there were no significant differences or correlations with school belonging.

Table 54: School belonging means scores (scale 0 to 4, 4=greater sense of belonging), Kenya

	N	Mean	Std. Deviation
I feel like I belong at school	163	3.41	.941
I make friends easily at school	163	2.91	1.127
Other students seem to like me	163	2.98	.987
Most of the students in my class(es) are kind and helpful	163	2.95	1.011
If I have a problem at school my teachers will help me	163	3.18	.983
My teachers care about me	163	3.21	.952
Overall mean score	**163**	**3.11**	**.736**

Table 55: School belonging means scores (scale 0 to 4, 4=greater sense of belonging), by county, Kenya

	Kilifi (n=38)	Kisumu (n=55)	Nyamira (n=26)	Siaya (n=44)	Kenya (n=163)
School belonging	3.07	3.11	3.12	3.13	3.11

Overall life satisfaction

The survey asked children aged 11+ years about their sense of OLS on a scale from 0–10 with 0 being not at all satisfied and 10 being completely satisfied. On average, children reported feeling somewhat satisfied with their life with a mean score of 6.46 (Figure 54). The average score varied between counties from 5.81 in Nyamira to 7.22 in Kisumu (Table 56).

Amongst children who had been reunified, the average score at the time of the survey was 6.55, and when they reflected back to their time in residential care, they felt their OLS at that time was higher, with an average score of 7.41, a difference of -0.86 (Table 56). In two of the three counties where reunifications had been supported, children reported their life satisfaction to be better in residential care (difference in Kilifi -1.86 and Nyamira -1.28). In Kisumu, there was little difference (0.16) between the two average scores (Table 56).

When comparing between different groups of children aged 11+ years, OLS was lower for children with a disability compared to those without (with functional difficulties 1.35, without functional difficulties 1.50, p<.01), but was not significantly different based on any other variable.

Children aged 11+ who participated in both surveys had a significant drop in their OLS average scores from 7.30 in Y3 to 5.91 in Y5 (p<.01) (Table 57). At the county level, the change over time between Y3 and Y5 was only significant in Kilifi where the average score dropped from 8.05 in Y3 to 5.42 in Y5 (p<.01) (Table 58). Amongst children who had been reunified and participated in both rounds of the survey, there was no significant difference in their average score when reflecting back on their life satisfaction in residential care, but the change in satisfaction at the time of the survey in family care between Y3 (7.41) and Y5 (5.98) was significant (p<.05) (Table 56). At the county level, these changes over time were only significant in Kilifi County (Table 58).

Figure 53: Children aged 11+ overall life satisfaction, mean score (scale 0–10, 10=greater satisfaction), Kenya
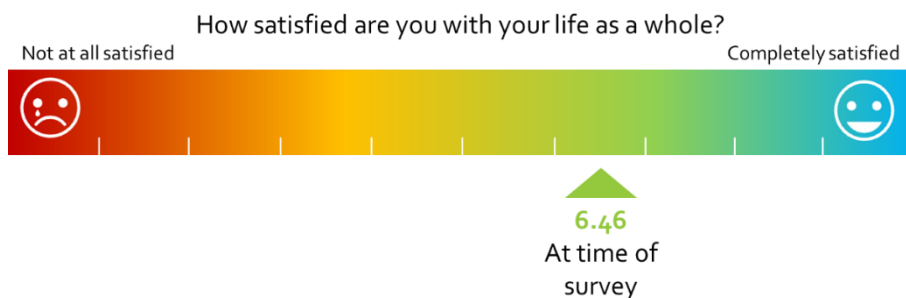
Figure 54: Children aged 11+ who had reunified from residential care overall life satisfaction at time of survey and thinking back to time in residential care, mean score (scale 0–10, 10=greater satisfaction), Kenya
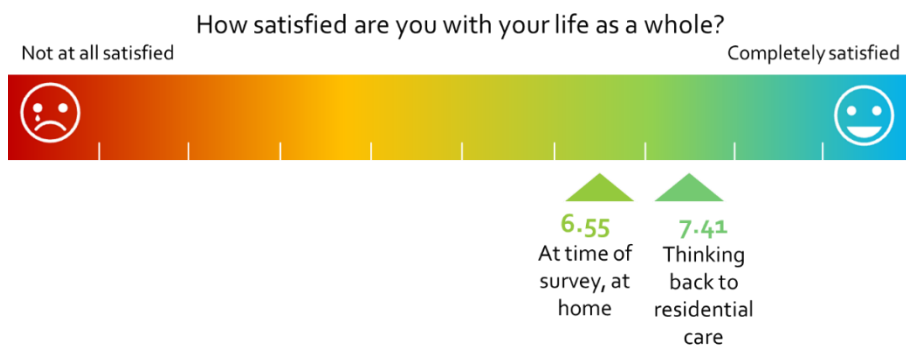
Table 52: Children aged 11+ overall life satisfaction, mean score (scale 0–10, 10=greater satisfaction), by county, Kenya

	Kilifi	Kisumu	Nyamira	Siaya	Kenya
OLS at time of survey (all children, n=163)	5.89	7.22	5.81	6.39	6.46
OLS at time of survey (children reunified from residential care only, n=107)	5.89	7.46	5.84	n/a	6.55
OLS in residential care (children reunified from residential care only, n=105)	7.75	7.30	7.12	n/a	7.41
Change in OLS between time of survey and in residential care (n=105)	-1.86	0.16	-1.28	n/a	-0.86

Note: No children in the sample had been reunified in Siaya so the question on OLS when in residential care was not applicable.

Table 53: Change over time in overall life satisfaction, mean score (scale 0–10, 10=greater satisfaction), Kenya

	Y3	Y5	p-value
OLS at time of survey (all children, n=54)	7.30	5.91	.003 **
OLS at time of survey (children reunified from residential care only, n=44)	7.41	5.98	.005 **
OLS in residential care (children reunified from residential care only, n=42)	7.36	7.86	ns
Change in OLS between time of survey and in residential care (n=44)	0.10	-1.83	.02 *

Change statistically significant at *p<.05, **p<.01, ***p<.001, ns = not significant.

Table 54: Change over time in *overall life satisfaction, mean score* (scale 0–10, 10=greater satisfaction), by county, Kenya

	Kisumu (n=29)			Kilifi (n=19)			Nyamira (n=6)		
	Y3	Y5	p-value	Y3	Y5	p-value	Y3	Y5	p-value
OLS at time of survey (all children)	7.1	6.4	ns	8.05	5.42	.001 **	6.0	5.17	ns
OLS at time of survey (children reunified from residential care only)	7.0	6.6	ns	8.28	5.44	<.001 ***	6.0	5.2	ns
OLS in residential care (children reunified from residential care only)	8.1	7.8	ns	7.33	8.61	ns	4.8	5.4	ns
Change in OLS between time of survey and in residential care	-1.0	-1.0	ns	0.94	-3.17	.003 **	1.2	-0.2	ns

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

The child well-being results, as presented above for children aged 11 years and above, were used to calculate results for the CTWWC outcome indicator on the percentage of children, either reintegrating or at risk of separation, who feel safe and nurtured in their family (based on 12 items from the child well-being section about safety and family relationships).

Amongst children aged 11+ years who responded to the survey 20% of children at risk of separation and 31% of children reintegrating from residential care felt safe and nurtured in their family, a slight decrease on the results from Y3 (Table 59). In Y5, all but three of the items used to calculate this indicator had close to 90%+ positive responses. The three items with lower results were: having someone to ask for help if they feel unsafe and someone to ask for support, as well as children being afraid of what will happen if they do not listen to their caregivers (Figure 56).

Table 59. Indicator 3 & 11: Children who feel safe and nurtured, Kenya

Percentage of targeted at-risk children (aged 11+ years) in vulnerable families who feel safe and nurtured in their family	Y3 N	Y3 %	Y5 N	Y5 %
Kenya	**6**	**38%**	**11**	**20%**
Age: 11–14	5	42%	5	24%
15–17	1	25%	3	12%
18+	0	n/a	2	40%
Sex: Male	4	57%	3	38%
Female	2	22%	8	17%
Disability: Disabled	1	25%	0	0%
Not Disabled	5	45%	11	24%
Percentage of children (aged 11+ years) who have been reunified, placed in family-based care or in independent living who feel safe and nurtured in their placement				
Kenya	**44**	**34%**	**33**	**31%**
Age: 11–14	28	36%	18	34%
15–17	12	28%	14	27%
18+	4	40%	1	33%
Sex: Male	22	41%	18	27%
Female	22	41%	15	37%
Disability: Disabled	2	11%	2	20%
Not Disabled	41	38%	31	32%

Figure 55: Indicator 3 & 11: Children who feel safe and nurtured, positive responses to each item, Kenya
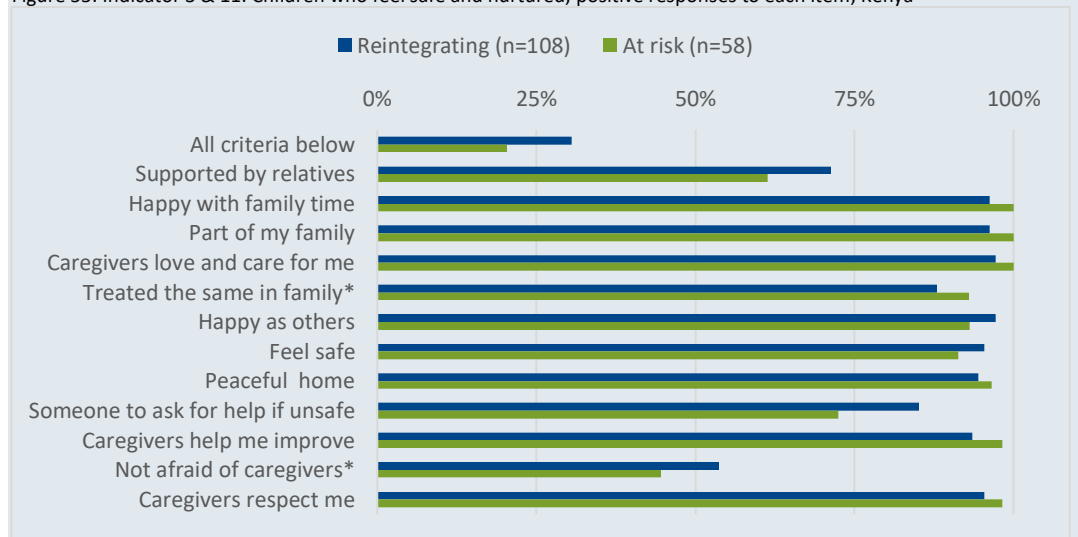
* Statements posed in reverse and results reverse coded for analysis.

6.2.5. Kenya relationships between caregiver protective factors and child well-being

The following analyses examine whether caregiver protective factors are related to child well-being. This table presents correlation coefficients between different caregiver and child variables. Statistically significant correlations are denoted by asterisks.

Child well-being, as reported by children aged 11+, is significantly correlated with most variables. Children experience higher levels of wellbeing when their caregivers report high levels of resilience, access to concrete assistance, social and emotional competences and the overall Protective Factors Index (PFI). Children's well-being is also higher when their caregivers practice positive and involved parenting more frequently and when their households have lower levels of hunger.

Children's OLS is higher when caregivers' social and emotional competencies are higher, and reunified children report a more positive change in their OLS (comparing the time of the survey with being in residential care) when their caregivers report higher levels of resilience and social and emotional competencies, as well as when their caregivers practice positive and involved parenting more frequently. More unusually, there is also a positive correlation between higher levels of worry about money and change in OLS.

Table 60: Pearson's r correlations coefficients for caregiver protective variables with child (11+ years) well-being variables, Kenya

		All children ages 11+				Reunified children 11+
		Overall well-being	*Current OLS*	*Family acceptance*	*Community acceptance*	*Change in OLS*
Protective factors Index	Resilience	0.34***	0.19*	0.29***	0.29***	0.25**
	Social connections	0.15	0.01	0.07	0.17*	-0.03
	Concrete assistance	0.25**	0.06	0.15	0.12	0.07
	Social and emotional	0.39***	0.16*	0.37***	0.22**	0.29**
	Overall PFI	0.33***	0.11	0.2**	0.25**	0.17
Parenting practices	Positive parenting	0.31***	0.06	0.30***	0.28***	0.24*
	Parental involvement	0.22**	-0.08	0.26**	0.19*	0.21*
Economic stability	Household Hunger Score	-0.37***	-0.10	-0.09	-0.24**	-0.12
	Ability to obtain funds in emergency	0.03	0.02	-0.13	0.07	-0.07
	Worried about money	0.07	0.11	0.08	-0.08	0.24*

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

6.3.   Moldova results

6.3.1. Moldova participant characteristics

Household characteristics

A total of 42 households were included in the survey in Moldova, all of which had been supported by CTWWC partners as the household included a child who had been placed there from residential care. The households were widely dispersed across the raions (Moldova's geographic subdivisions), with the largest proportion of survey participants coming from Anenii Noi (19%), Nisporeni (10%), and Cantemir, Criuleni and Ialoveni (7% each) (Table 61).

Three-quarters of the households were from rural locations (Table 62).

The mean number of adults per participating household was two (SD: 1.2, min: 1 max:7), and the mean number of children was four (SD: 2.35, min: 1 max: 12). It was most common for households to have at least two adults and three children (Figures 57 & 58).

Table 61: Number of participating households per raion, Moldova

Raion	N	%
Anenii Noi	8	19
Bălți	2	5
Briceni	1	2
Călărași	2	5
Cantemir	3	7
Căușeni	2	5
Chișinău	1	2
Cimișlia	1	2
Criuleni	3	7
Drochia	1	2
Dubăsari	1	2
Florești	1	2
Hîncești	2	5
Ialoveni	3	7
Leova	2	5
Nisporeni	4	10
Ștefan Vodă	2	5
Strășeni	2	5
Taraclia	1	2
Total	**42**	**100**

Table 62: Urban/rural location of households, Moldova

	N	%
Rural	32	76
Urban	10	24
Total	**42**	**100**

Figure 57: Number of adults (18+ years) per household, Moldova
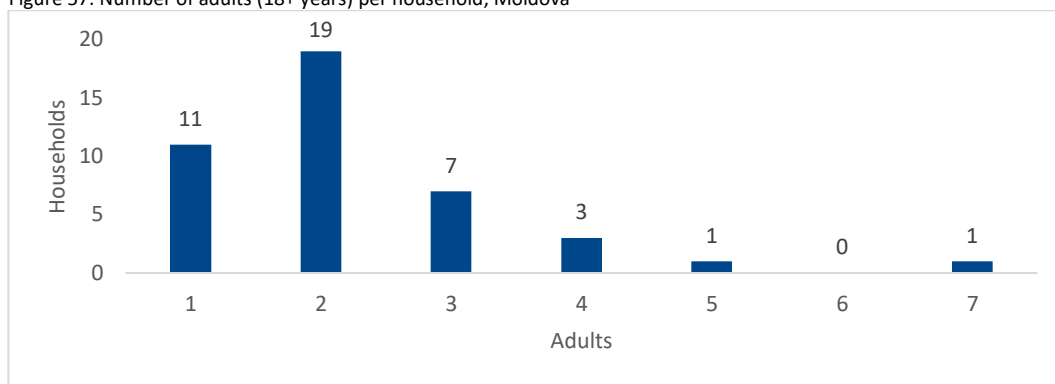
Figure 58: Number of children (0–17 years) per household, Moldova
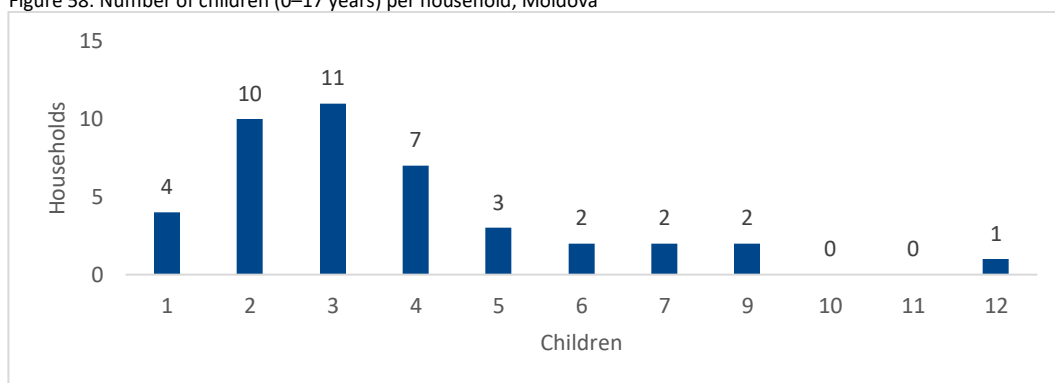
Caregiver demographics

Of the 42 caregivers who participated, all but one were female (98%). Their average age was 43 years, with the largest proportion (38%) aged between 30–39 years and 31% between 40–49 years (Figure 59). Four caregivers were aged over 60 years. A total of 12% of respondents were identified as having a disability using the WG-SS. The domains of disability included mobility, cognitive, hearing, communication and self-care.

In terms of educational status of the caregivers, 52% had completed primary education, 40% had completed secondary education and 7% had progressed higher than secondary level (Figure 60). When asked about their marital status, the largest proportion indicated they were married or living together (64%), with 14% widowed, 14% divorced or separated and 7% single (never married) (Figure 61).

Figure 59: Number of caregivers per age group, Moldova
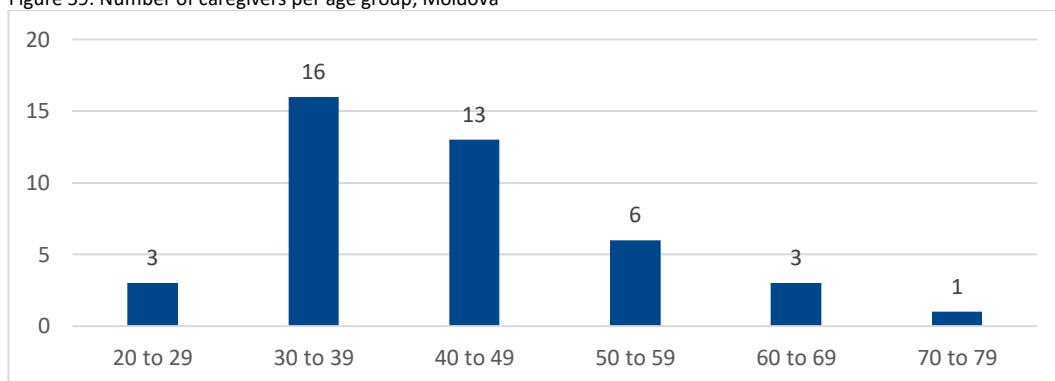
Figure 60: Caregiver education status, Moldova
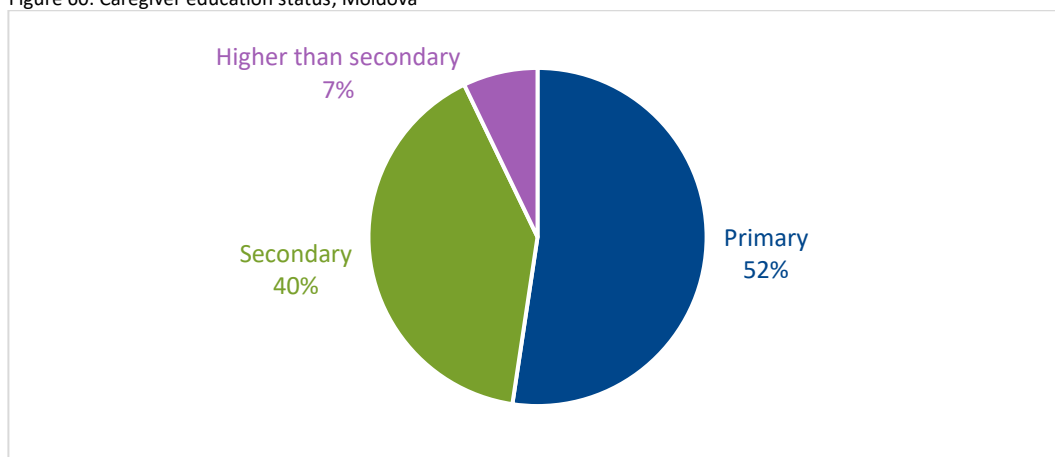
Figure 61: Caregiver marital status, Moldova
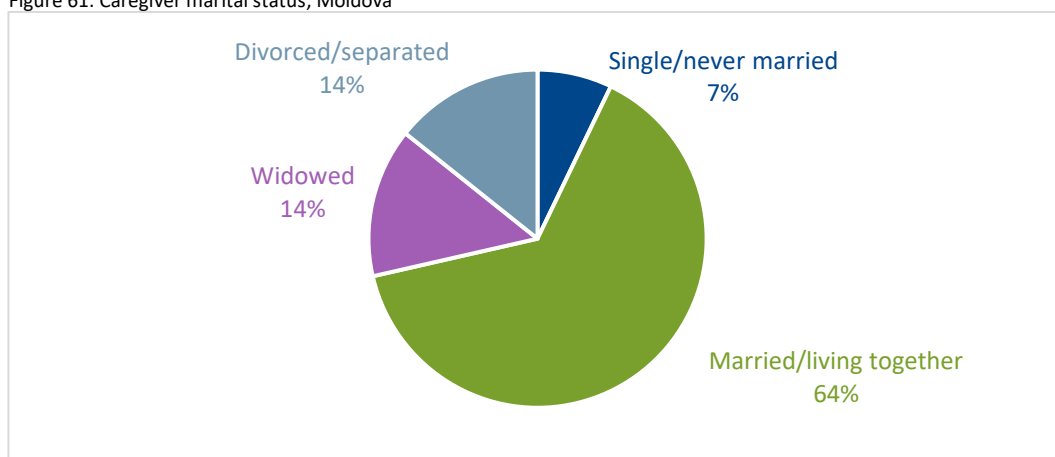
Child demographics

Each caregiver provided information on each child who had been placed with them from residential care. In total, data was provided for 70 children. Of these children, 46% were female and 54% were male. Children's ages ranged from less than 1 to 18 years, with 50% of children aged 6 years or younger (Figure 62).

Based on the CFM, 55% of the children aged 2–4 years and 57% of children aged 5–17 years have a functional limitation.[46] In both age groups there were children with functional limitations in all of the domains considered by the CFM, apart from hearing. Amongst children aged 2–4 years, just over half of the children with a functional limitation had only one type of limitation while the rest had limitations within two to six domains. Amongst children aged 5+ years, 27% with a limitation had only one type of limitation while just over a third had limitations in two to four domains and another third had limitations in five to 11 domains. This shows the complexity of disability amongst children in care in Moldova.

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[46] This may be different from formal assessments undertaken in Moldova, but the CFM data is used for analysis of the survey results.

Figure 62: Child age, Moldova
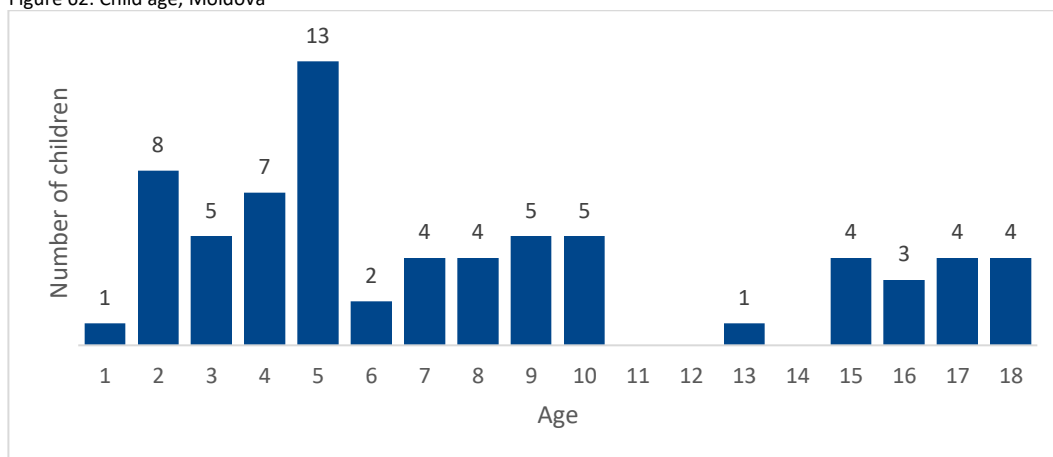
Child's relationship to household

The primary caregiver (i.e., the survey respondent) was most frequently the child's biological mother (31 children, 44%), followed by foster carers (26 children, 37%) (Figure 63). A further 10 children were cared for by another relative (grandparents, aunts or siblings) and three were cared for by a non-relative.

It was common for children to live with at least one biological or half sibling (87%), including children in foster care.

The majority of children in Moldova had both parents still living (58%), with 19% being either a single or double orphan (Figure 64). However, not all of the children's orphanhood status was known, especially amongst those in foster care, hence, the orphanhood status of 23% of the children was unknown. This includes more than half of the children in foster care whose caregiver didn't know if their parents were alive or not.

If a child's parent was known to be alive, but they did not live with them, the caregiver was asked about the child's frequency of contact with the parent. Of the 24 children not living with a mother who was known to be alive, two-thirds were never in contact with her. Of the 33 not living with a father who was known to be alive, 76% never contacted him. Rates of no contact were higher amongst children in foster care than amongst those living with a family member or other non-relative.

Figure 63: Caregiver relationship to child, Moldova
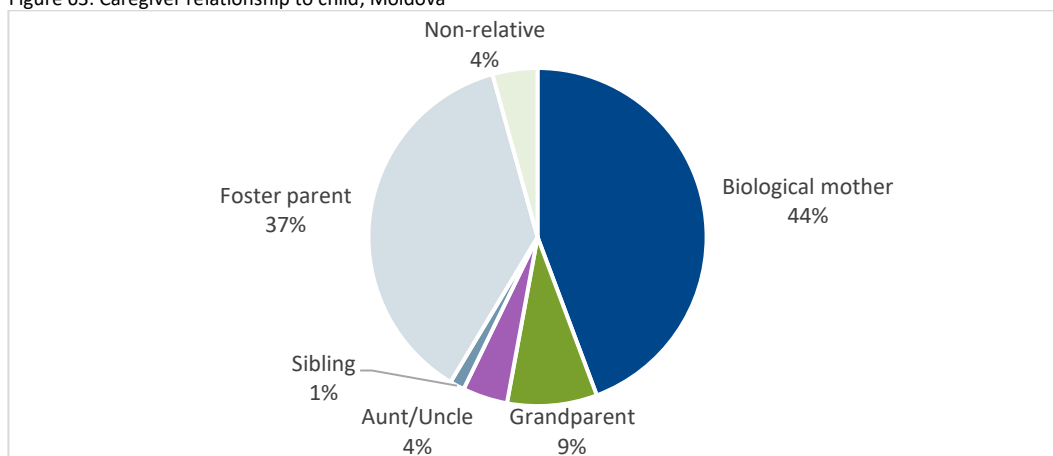
Figure 64: Orphanhood status, Moldova

Unknown
23%

Double orphan
1%

Maternal orphan
9%

Both parents alive
58%

Paternal orphan
9%
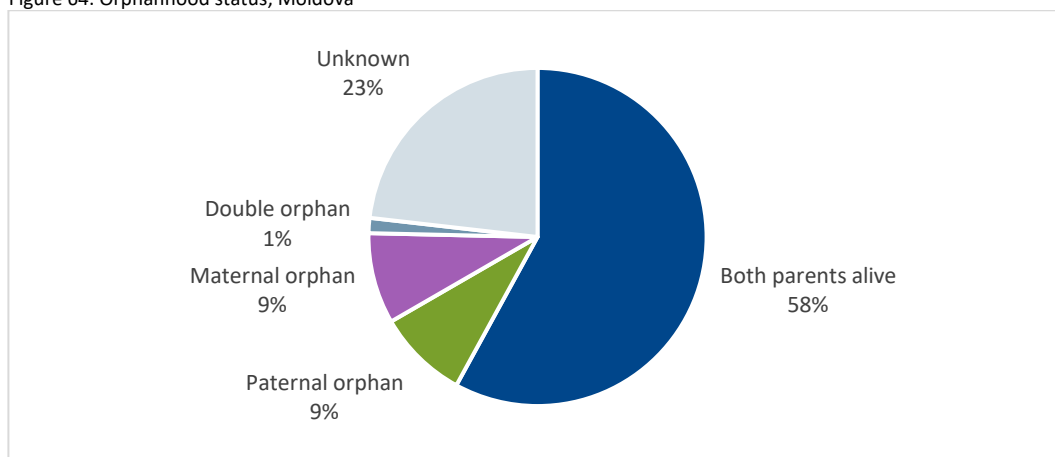
Care histories of children who have been reunified

Due to a programming error, this portion of the survey was not included.

6.3.2. Moldova CTWWC support

Caregivers reported receiving home visits (74%), referrals (69%) and cash transfers (69%).

Caregivers were asked their perceptions of the usefulness of the support they reported receiving. This was assessed using a scale from 0 to 2, with 0 being "didn't help at all" and 2 being "helped a lot." All received services were reported as being useful. Cash transfers had the highest mean score (1.62; SD 0.677) in terms of usefulness, followed by referrals (1.52; SD 0.688) and home visits (1.48; SD 0.769).

Table 63: Households that received CTWWC support services

	N	%
Home visits	31	74%
Referrals	29	69%
Cash transfers	29	69%

Figure 65: CTWWC support mean helpfulness score (scale 0–2, 0=didn't help, 2= helped a lot), Moldova

	0	1	2
Cash transfers			1.62
Referrals			1.52
Home visits			1.48

6.3.3. Moldova caregiver protective factors

Caregiver protective factors, which strengthen a caregiver's ability to be resilient and care for their children, are examined in the household survey through three sets of measures as presented

below: four types of protective factors measured in the PFI, three different parenting practices and a set of measures linked to economic stability.

Protective factors index

Figure 66: Caregiver protective factor definitions

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

Social and emotional competence: Interacting with children in a way that helps them develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships.

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

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

A score for each of the four areas of protective factors was calculated, and an overall protective factors index score resulted. This was based on a scale of 0–4, where 4 represents higher protective factors. There are no set cut offs that indicate whether a score should be considered high, medium or low. The text of each of the survey questions that make up these scales are included in the appendix.

The overall average PFI score in Moldova was 3.07 (Table 64). Both external-facing factors scored lower, on average, at 2.82 for both social support and connections and access to concrete support. The more internal factors of resilience and social and emotional competence scored higher, on average: 3.30 and 3.34, respectively.

Correlational analyses showed that the older the caregiver, the lower their overall PFI (r=-.340, p<.05) and their access to concrete support scores (r=-.352, p<.05). High levels of education amongst caregivers was correlated with lower social and emotional competencies (r=-.407, p<.01), but the larger the number of children in a household, the higher a caregiver's social connections (r=.327, p<.05). The number of adults in a household did not significantly correlate with any protective factor scores, and there were no significant differences when looking at caregiver disability, widow status or urban/rural location. Caregiver sex was not included in the analysis as there was only one male caregiver.

Table 64: Caregiver protective factors, Moldova

	Mean score
Caregiver resilience	3.30
Social and emotional competence of children	3.34
Social support and connections	2.82
Access to concrete support	2.82
Protective Factors Index	**3.07**

Positive parenting practice

Assessment of parenting practices focused on how caregivers were involved in the day-to-day life of their child and the extent to which they practiced positive parenting and corporal punishment. The survey used a scale of 0–4 with 0 being never, 2 sometimes and 4 always. For parental involvement and positive parenting practice, the scores across six items were summed. There are no set cut offs that indicate whether a score should be considered high, medium or low, but higher scores represented more parental involvement and more positive parenting. Corporal punishment considered three methods: spanking with hand, slapping a child's face and hitting with an object. Results used a scale from zero, indicating never, to four, indicating always. Results are presented showing the frequency of responses to each of the three types of punishment considered.

Caregivers reported an average total score of 19.00 for involvement and a positive parenting mean score of 20.67 (Table 65). The mean score was above three, indicating often, for all individual items within the positive parenting scale, and above three for four of the six items on the involvement scale (Figure 67).

The extent to which caregivers use corporal punishment revealed that caregivers report very little use of corporal punishment with 64% of caregivers never spanking their children with their hand, 95% never slapping their children on the face and 91% never hitting their children with an object (Figure 68).

When looking at different caregiver characteristics, analyses revealed no significant differences or correlations on parental practices and just two for corporal punishment. Caregivers with a disability more frequently used spanking as a form of punishment than those without a disability (disability 1.40, no disability 0.49, $p<.05$), and caregivers in urban locations more frequently used hitting, although still very infrequently (urban 0.20, rural 0.00, $p<.05$). There were no differences based on caregiver age, education or widow status, nor on the number of adults or children in the household.

Table 65: Frequency of practice of parental involvement and positive parenting, mean scores (min=0, max=24, higher score indicates more frequent involvement or positive parenting), Moldova

	All caregivers (n=42)
Parental involvement	19.00
Positive parenting	20.66

Figure 67: Frequency of practice of parental involvement and positive parenting, mean scores per item (scale of 0–4 with 0 being never and 4 always), Moldova
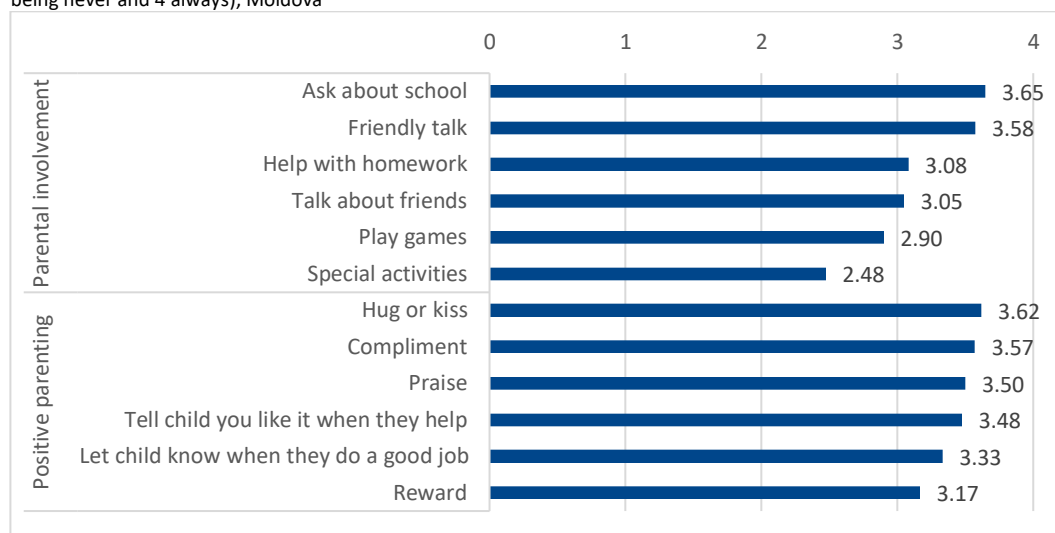
Figure 68: Frequency of practice of corporal punishment (possible options never, almost never, sometimes, always), Moldova
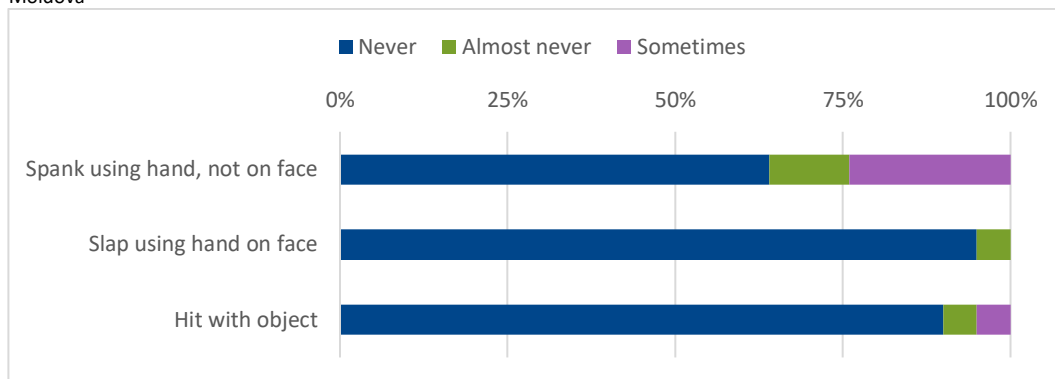
Couple Functionality Assessment Tool: Communication

The communication subscale from the CFAT was used to understand how well caregivers who are married or living together communicate when a problem arises in their relationship. The tool using a scale of 0–4 where 0 was very unlikely and 4 very likely, so that a higher score indicates a greater likelihood to communicate positively when problems arise. Responses to seven statements were totaled, yielding a maximum score of 28.

Amongst caregivers who were married or living with a partner, there was an average score of 22.78 (Table 66).

There were no significant correlations or differences based on caregiver age, education or disability, nor on location or number of adults or children in the household.

Table 66: Couples' communication average score (maximum 28, higher score=more likely to communicate positively), Moldova

	All Moldova caregivers who are married or living together
Average total score	22.78

Figure 69: Couples' communication average score per item (scale of 0–4, 0=very unlikely and 4=very likely), Moldova
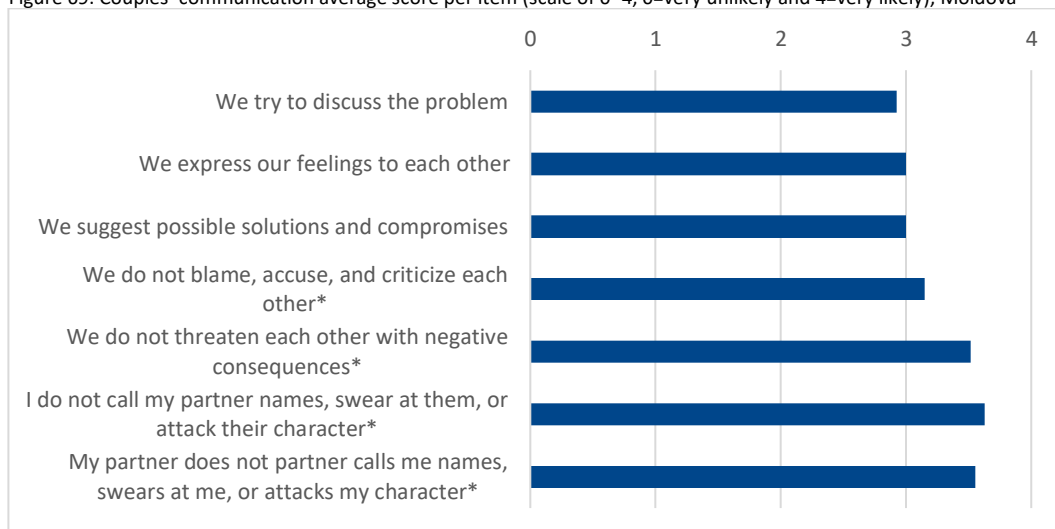
Statements posed in reverse and results reverse coded for analysis.

Economic Stability

To gauge the economic stability of households, respondents were asked about financial practices in their households:

- The majority (81%) of caregivers reported often or sometimes having worried about money in the four weeks preceding the survey (Figure 70).
- Just 17% of caregivers reported that they had managed to save money in the past month.
- The majority (81%) of caregivers could get 1,200 lei (MDL) during emergencies (both "easy" and "possible but hard" responses) (Figure 71).

Using the Household Hunger Scale, the survey revealed that nearly all households faced little or no hunger (90%).

The survey also assessed what households can pay for when necessary:

- Just over 50% of household were able to fully pay all educational costs for their children.[47]

Just over 70% of caregivers reported that a child in their household was sick or needed health services in the past three months. Of those who needed health care, 93% sought such services, and of these, 68% were able to pay for their children's health care expenses (Table 67).

Three-quarters of households reported having unexpected household costs in the three months preceding the survey, of those, just under 50% could meet these expenses (Table 67).

When looking at variations between groups or across characteristics of households and caregivers/respondents regarding their economic stability, there were several notable results.

Caregivers with higher levels of education worried less about money (r-.348, p<.05) and were more likely to obtain funds in an emergency (for MDL 1,200 r=.404, p<.001 ; for MDL 4,200 r=.368, p<.05). Caregivers who were widows worried less about money than those who were not widowed (widow 0.67, non-widow 2.39, p<.001).

Caregivers who were able to save were slightly younger, on average, than those not saving (mean age of savers 43.88 years, non-savers 47.81 years, p<.05). Fewer caregivers with a disability were able to save compared to those without a disability (disability 20.4%, no disability 38.0%, p<.05). Fewer caregivers in urban households were able to save compared to those in rural households (urban 22.7%, rural 38.7%, p<.05).

There were no significant differences or correlations in relation to ability to save or household hunger, and none for the characteristics of caregiver age or disability, location, or number of adults or children in a household.

Figure 70: How often worried about money in past month, Moldova

| Never 19% | Sometimes 29% | Often 52% |

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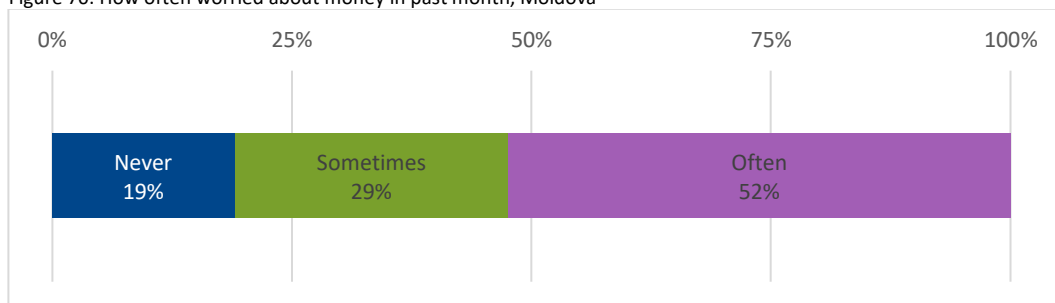
[47] Since education is free in Moldova, this question was phrased differently than for other countries in order to focus on additional necessities or costs: *In the last three months, have you or anyone in your household paid for all school necessities for children to attend school regularly? This includes all costs needed to go to school, including transportation costs, uniforms, other school supplies, etc.*

Figure 71: Ability to get MDL 1,200 in an urgent situation, Moldova

0%	25%	50%	75%	100%

Easy 14% | Hard, but possible 67% | Impossible 19%
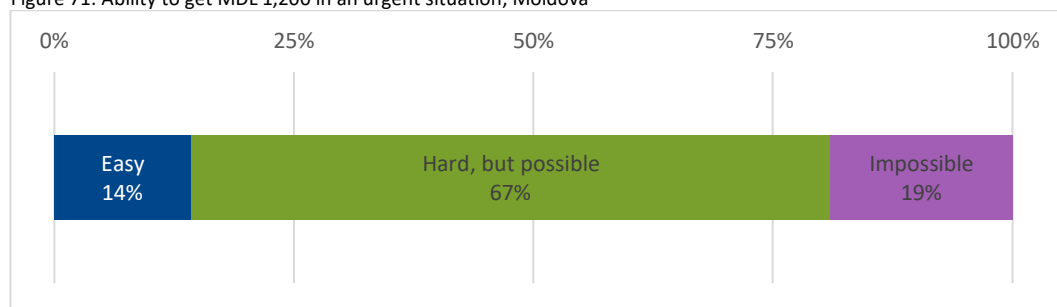
Table 67: Ability to pay for household expenses when needed, Moldova

Education expenses	All Moldova caregivers
Able to pay all education expenses	19 (51%)
Unable to pay all education expenses	18 (49%)
Health care expenses	
Did not seek health care	2 (7%)
Sought health care	28 (93%)
Able to pay for health care	19 (68%)
Unable to pay for health care	9 (32%)
Unexpected expenses	
No unexpected expenses	14 (34%)
Unexpected expenses	27 (66%)
Able to pay unexpected costs	13 (48%)
Unable to pay unexpected costs	14 (52%)

The economic stability results, as presented above, were used to calculate results for the CTWWC outcome indicator on the percentage of caregivers who received economic support who were subsequently assessed as being economically stable within the targeted factors (not worried about money, able to save, could meet emergency costs, little or no hunger).

Only three caregivers who had received economic support met all of the criteria to meet this indicator (Table 68). When considering the breakdown in the items used to calculate the indicator, the majority of caregivers could meet emergency costs and their households were not facing hunger, however, just under a quarter (24%) were able to save and 21% were not worried about money (Figure 72).

Table 68: Indicator 7: Economic stability, Moldova

Percentage of caregivers who received economic support who are subsequently assessed as being economically stable	Y5 N	Y5 %
Moldova	**3**	**10%**
Household type: *reintegrating*	1	6%
foster care	2	18%
Sex: *male*	0	n/a
female	3	10%

Figure 72: Indicator 7: Economic stability, positive responses to each item, Moldova
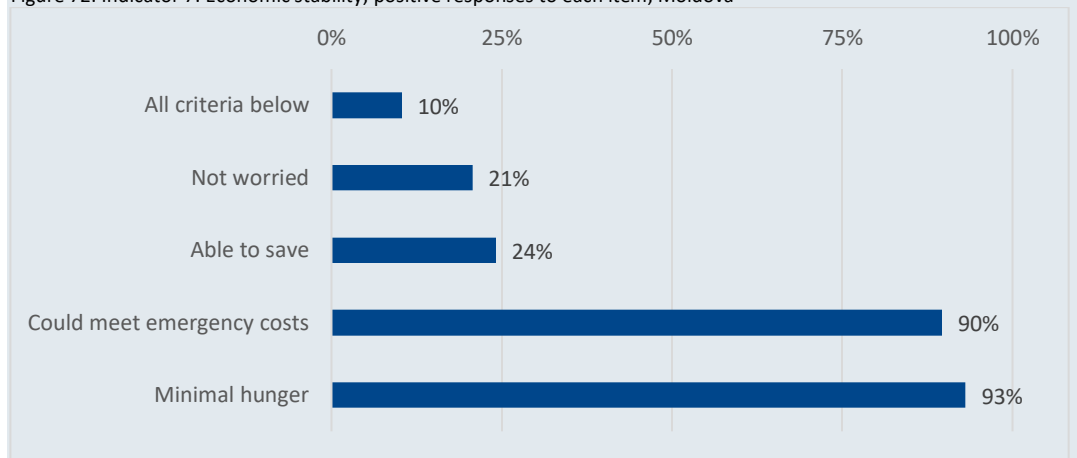
6.3.4. Moldova child well-being

Information about child well-being was gathered on all children who had participated in a case management process to be placed into family care.

Health

The survey sought to understand the overall health status of children using a scale ranging from 0 to 4, with 0 representing poor health, 2 indicating good health and 4 excellent health.

Caregivers responded on behalf of children aged 2–10 years (n=51), giving an average score of two (Figure 73), indicating good health. Children in the care of their biological families had a higher score than those in foster care (Figure 73). There was, however, a range of responses: one third of caregivers classified their child's health as poor (13%) or fair (20%), another third said their child's health was good, and the final third said their child's heath was very good (19%) or excellent (15%).

Children aged 11–18 years were asked directly about their health and provided an average score of 1.57 (n=14), with a small difference between those in foster care (1.50) and those in the care of their biological family (1.58) (Figure 74).

Child health scores for those aged 2–10 years varied significantly based on disability: children with a disability had much lower scores than those without a disability (with functioning difficulties 1.20, without functioning difficulties 2.71, $p<.01$). Health scores did not correlate significantly with age nor did they differ significantly when looking at sex, parental or orphanhood status. When looking at differences by care type (as shown in Figure 73), the significance level was 0.05 exactly, which doesn't qualify as a significant difference (below 0.05), but was clearly very close.

For children aged 11+ years, there were no significant correlations or differences. This is not surprising as there were only 14 children in this group, which is simply not a big enough sample to make significant judgements.

Figure 73: Overall health, children aged 2–10 years (scale of 0–4, 0=poor and 4=excellent), by care type, Moldova
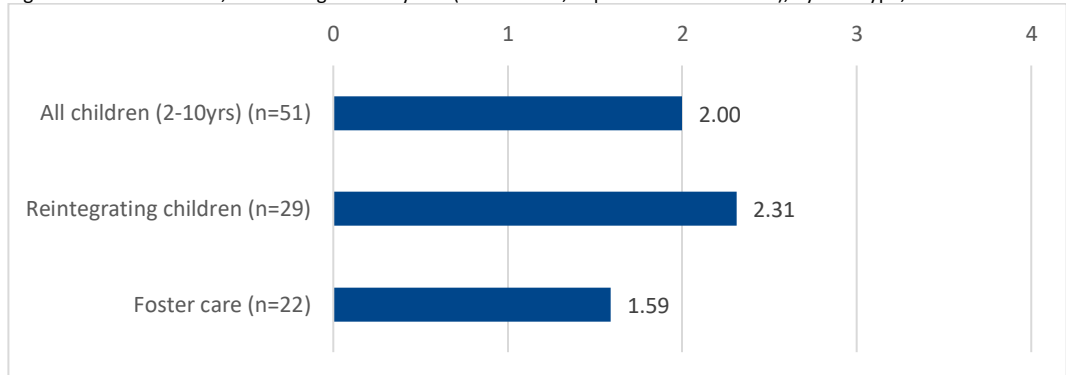
Figure 74: Overall health, children aged 11+ years (scale of 0–4, 0=poor and 4=excellent), by care type, Moldova

All children 11yrs+ (n=14)	1.57
Biological family care (n=12)	1.58
Foster care (n=2)	1.50
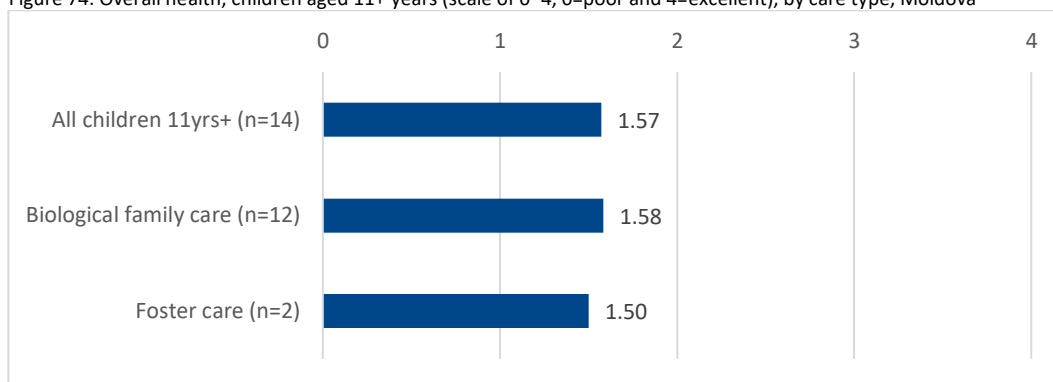
Education

Overall, 71% of children aged 2–4 years were enrolled in ECE (n=21). In addition, 71% were receiving at least two types of stimulation.

A further 63% of children age 5+ years were enrolled in school (n=46) with some variation between children reintegrated with family (71%) and those in foster care (47%). Of the 17 children not enrolled, seven were only 5 years old and two were 6 years old. These children have not reached the age for compulsory schooling. The enrollment rate for children aged 6–17 years is 72% (77% for children in family reintegration and 50% for children in foster care, which could reflect more children with disability in foster care).

Other reasons for not being enrolled were: the child was too old/young (although aged 9, 10 and 15), too sick, has to work, doesn't have capacity to learn, married and one no response. The survey found that 10% had missed four or more days in the last month and all were due to sickness or treatment/rehabilitation.

Child well-being, children 2–10 years old

Caregivers of children aged 2–10 years answered 10 questions about various aspects of their children's well-being. These questions were on a scale of 0 to 2, where 2 represents greater well-being. In Moldova, caregivers were generally positive about their child's well-being with average scores for all children of 1.51, with little difference between children in biological family care (1.49) and those in foster care (1.53). The breakdown by individual items is shown in Figure 75.

The 10 items were averaged to create an overall well-being score for children aged 2–10, allowing analysis by child characteristics. As with health, this revealed a significant difference based on disability: children with a disability had lower scores than those without a disability (with functioning difficulties 1.43, without functioning difficulties 1.70, $p < .01$). There were no other significant correlations or differences when looking at children's age, sex, care type, parental care or orphanhood status.

Figure 75: Child well-being (2–10 yrs) means scores per item, caregiver reported (scale of 0–2, 2=greater well-being), Moldova
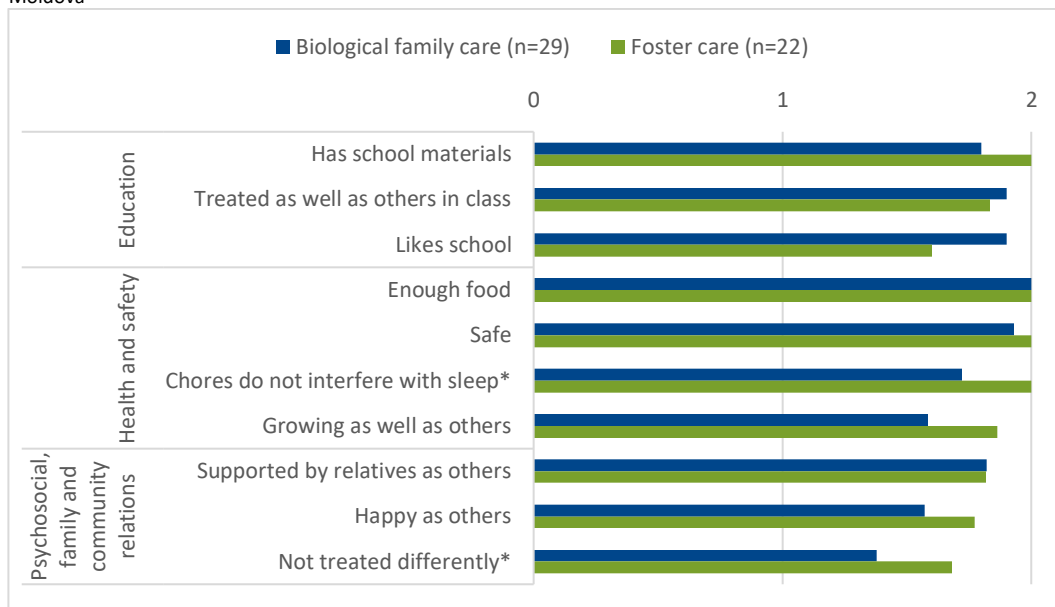
Statements posed in reverse and results reverse coded for analysis.

Child well-being, 11+ year olds

Children aged 11+ years were invited to respond to the child self-report survey. In Moldova, all of the children who participated were in fact aged 13–18 (n=14). They were asked a series of questions developed via focus group discussions with young people who have lived in residential care. The questions were on a scale of 0 to 2, where 2 represents greater well-being. When combined, the average score across all items was 1.61. Most of the individual items received a high average score. The only items to score less than 1, on average, were linked to wider community belonging and support: "I am not treated differently from other children in my community" (average score of 0.93) and "If I needed something that my parents or caregivers cannot provide, there are others who would help" (average score of 0.71). In addition, items that scored below 1.50 reflect concerns across a few different domains, including: diet (1.43), chores impacting school (1.25), money for education (1.08), health (1.29), fear of caregivers if the child doesn't listen (1.15), being treated differently from the others in family (1.14), happy with friends (1.43), fun with friends (1.36) and freedom to go out (1.29).

The subscale mean scores were:

- Care and safety: 1.78
- Basic needs: 1.67
- Leisure and freedom: 1.50

All of the items were averaged into an overall well-being score, allowing comparisons by child characteristics. However, it was not significantly correlated with child age and there were no significant differences when looking at children's sex, disability status, placement type, or parental care or orphanhood status. Again, this is likely due to the small sample size for self-reporting children aged 11+.

Figure 76: Child well-being (11+ yrs) mean scores per item, self-reported (scale of 0–2, 2=greater well-being), Moldova
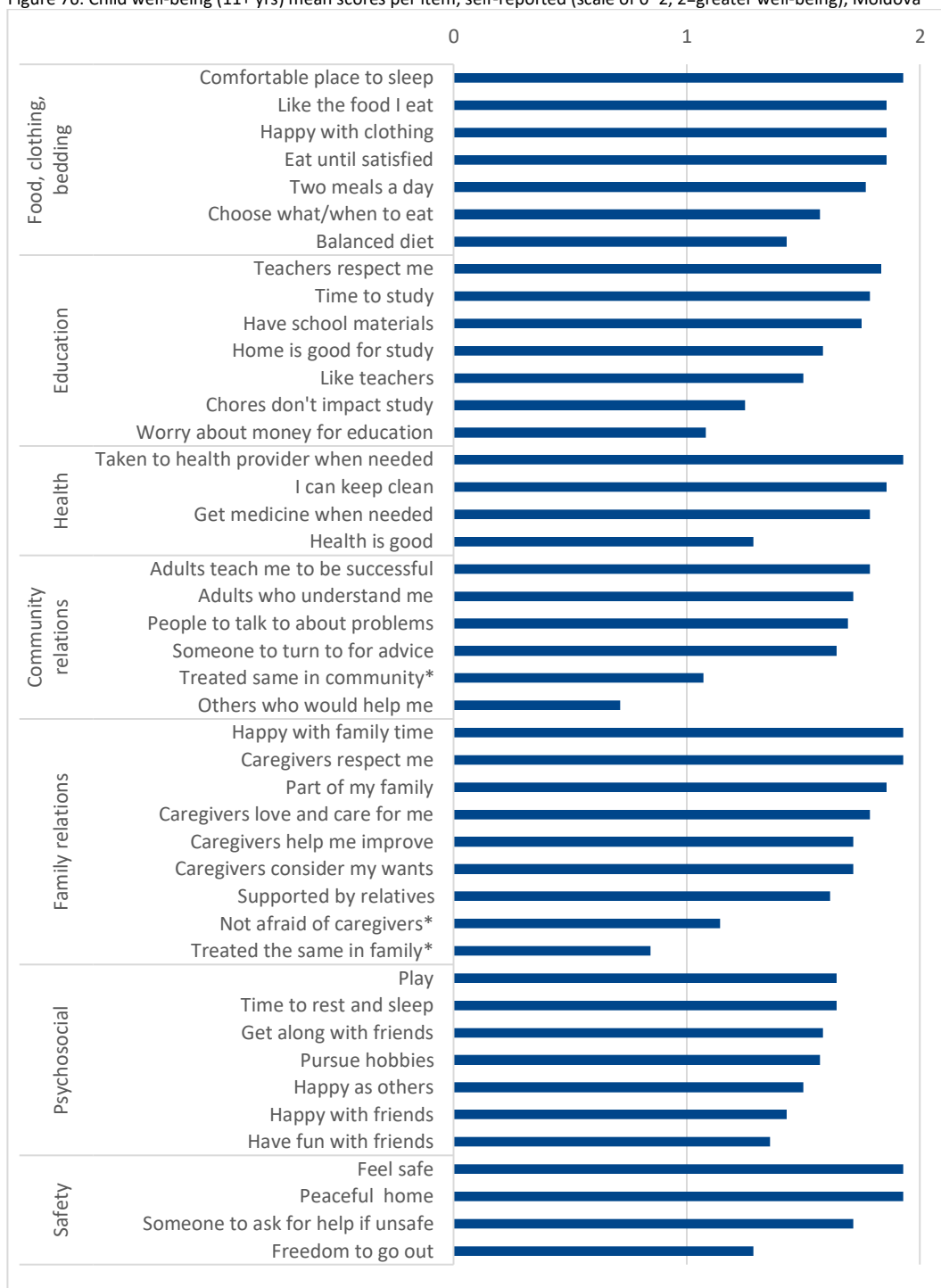
* Item asked in negative and results reverse coded for comparison with other items.

Family and community acceptance

The same child respondents (aged 13–18 years) were asked about how accepted they felt in their family and community. The average family acceptance score in Moldova was 1.86 on a scale of 0–2, with 2 representing higher acceptance. The average community acceptance score was 1.17.[48]

When comparing mean scores by child characteristics there were no significant correlations or differences in family acceptance, but looking at community acceptance scores through the lens of disability revealed a significant difference: children with a disability had much lower scores than those without a disability (with functioning difficulties 1.03, without functioning difficulties 2.00, $p<.05$). There were no other significant correlations or differences in community acceptance.

Figure 78: Family and community acceptance, mean scores (scale of 0–2, with 2 = higher acceptance), Moldova
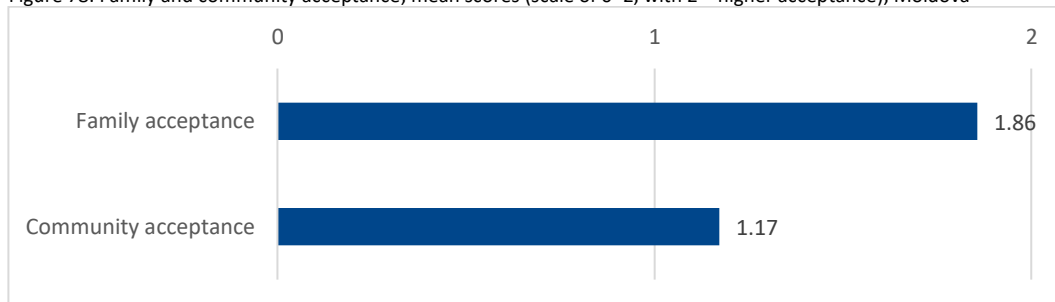
School belonging

Child respondents who were enrolled in school were asked a series of questions to understand their sense of belonging at school, using a scale of 0–4, with 0 being strongly disagree and 4 being strongly agree. The average overall score was 2.13, indicating a neutral sense of belonging.

Again, likely due to sample size, there was no significant difference or correlation for school belonging scores and children's age, sex, disability, care type, or parental care or orphanhood status.

Figure 79: School belonging (scale 0–4, with 4=greater sense of belonging), Moldova

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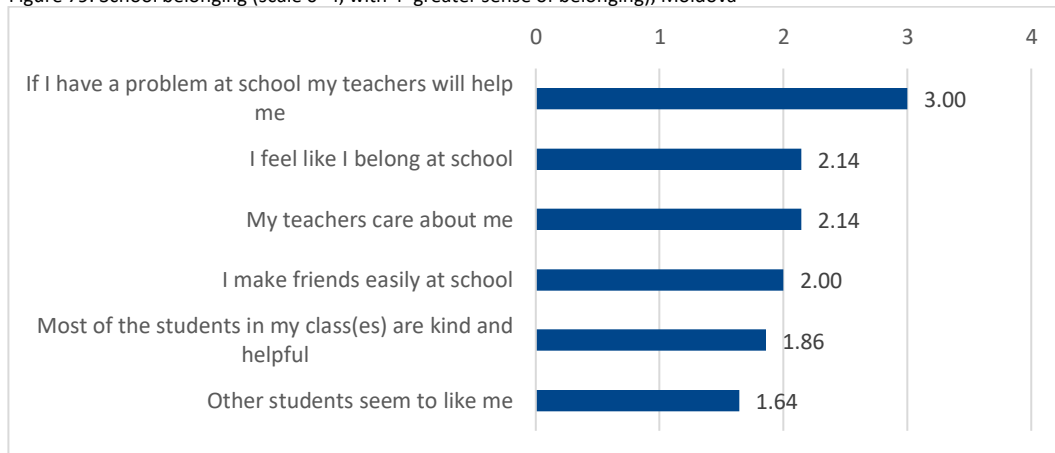
[48] One item from the family acceptance scale and two items from the community acceptance scale were missed in the survey programming.

Overall life satisfaction

Child respondents (aged 13–18 years) were asked about their OLS at the time of the survey, on a scale from 0 to 10, with 10 meaning greater satisfaction. Across the 14 child respondents there was a mean score of 8.36 (SD 2.061).

Again, likely due to sample size, there were no significant differences or correlations for OLS and children's age, sex, disability, care type, or parental care or orphanhood status.

However, it should be noted that all children without a functional limitation gave a response of 10, indicating complete satisfaction, while children with a functional limitation gave a range of scores from four to nine.

Figure 80: Overall life satisfaction at time of survey (on a scale from 0 to 10, 10=greater satisfaction), Moldova
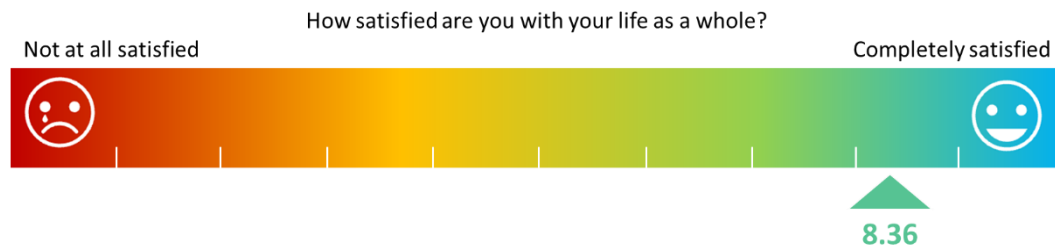
How satisfied are you with your life as a whole?

Not at all satisfied — Completely satisfied

8.36

The child well-being results, as presented above for children aged 11 years and above, were used to calculate results for the CTWWC outcome indicator on the percentage of children, either reintegrating or at risk of separation, who feel safe and nurtured in their family (based on 12 items from the child well-being section about safety and family relationships).

Amongst children aged 11+ years who have been reunified with family or placed in foster care, 21% felt safe and nurtured in their family (Table 69). All but two of the items used to calculate this indicator had close to 100% positive responses. The two items scoring lower were about not feeling they were treated differently from other children and being afraid of what will happen if they do not listen to their caregivers (Figure 77).

Table 69: Indicator 11: Children who feel safe and nurtured, Moldova

Percentage of children (aged 11+ years) who have been reunified, placed in family-based care or in independent living who feel safe and nurtured in their placement	Y5 N	Y5 %
Moldova	3	21%
Age: 11–14	0	0%
15–17	3	33%
18+	0	0%
Sex: Male	2	22%
Female	1	20%
Disability: Disabled	3	25%
Not Disabled	0	0%
Care type: Reintegration	1	8%
Foster care	2	100%

Figure 77: Indicator 11: Children who feel safe and nurtured, positive responses to each item, Moldova
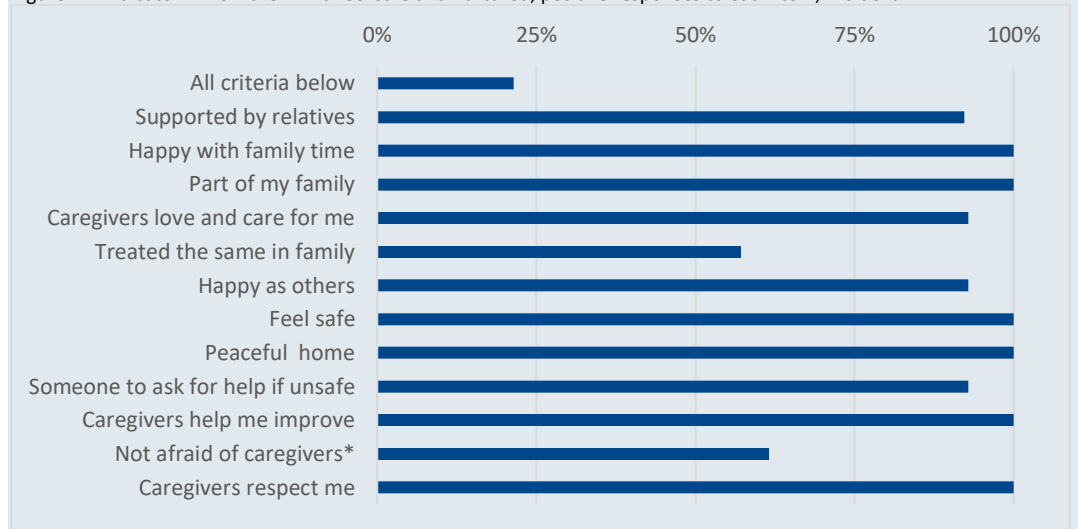
* Statements posed in reverse and results reverse coded for analysis.

6.3.5. Moldova relationships between caregiver protective factors and child well-being

The following analyses examine whether caregiver protective factors are related to child well-being. This table presents correlation coefficients between different variables. Statistically significant correlations are denoted by an asterisk, however, most likely due to the sample size of children aged 11+, there are no significant correlations.

Figure 81: Pearson's r correlations coefficients for caregiver protective variables with child (11+ years) well-being variables, Kenya

		All children ages 11+			
		Overall well-being	*Current OLS*	*Family acceptance*	*Community acceptance*
Protective factors index	Resilience	0.26	0.40	-0.02	-0.01
	Social connections	0.08	0.01	-0.06	0.26
	Concrete assistance	0.29	0.21	0.08	0.01
	Social and emotional	0.19	0.42	0.01	-0.02
	Overall PFI	0.23	0.24	-0.01	0.11
Parenting practices	Positive parenting	0.32	0.45	0.18	0.07
	Parental involvement	0.06	0.26	-0.01	-0.09
Economic stability	Household Hunger Score	-0.29	0.19	-0.30	-0.48
	Ability to obtain funds in emergency	0.21	-0.34	-0.01	-0.17
	Worried about money	-0.23	-0.04	-0.10	-0.34

7. CONCLUSIONS

7.1.   Country conclusions

The overarching aim of the household survey is to help CTWWC better understand their programming and its impact on children and families. In particular, the three main research questions are:

- What aspects of **family strengthening support** do caregivers think have affected their ability to care and provide for their children?
- What proportion of caregivers report selected **protective factors** in their life?
- What proportion of children are experiencing positive **well-being**?

7.1.1. Guatemala

Caregivers in Guatemala were very positive about the services they received, with nearly all caregivers saying that they were helpful in the care of their children. Those caregivers who have received case management reported feeling well prepared for case closure, which had happened a year earlier.

Protective factors within the households were generally high. For instance:

- Caregivers reported a high sense of resilience and social and emotional competency. They also reported high levels of social connections and the ability to procure concrete assistance. However, amongst those who have received case management, these levels reduced slightly over the past two years (i.e., from Y3 to Y5), which includes the time when their cases were closed and direct support and home visits had ceased.
- Overall, there was a high frequency of practicing positive parenting techniques and of being involved with their children, however, it is possible that some barriers exist to caregivers participating in activities with their children. For instance, caregivers' education levels could affect their ability or confidence in supporting homework, and economic limitations may reduce the likelihood of doing special activities. These reasons need further exploration. Corporal punishment is always likely to be underreported, especially if there is a fear of a child being removed from a family if they admit to using physical discipline. There was very limited reported use of slapping a child's face as a form of punishment, but some caregivers do spank with their hands (not on the face) or hit with an object to punish their children. Since some caregivers are practicing both positive parenting techniques to encourage their children and using corporal punishment, this should be addressed in parenting training curriculums. These curriculums should also reflect the findings that caregivers are more likely to use corporal punishment if they are younger, more educated, in urban areas and male.
- In terms of economic stability, families in Guatemala were able to meet their needs even when emergencies arose, however, there is limited savings and a high degree of worry about money. This reflects the Guatemalan context of high levels of poverty and the fact that the only economic strengthening intervention provided by CTWWC were cash transfers, which would be unlikely to impact savings or anxiety about money. Interventions to encourage savings and financial education to aide better planning might be useful additional interventions for similar families. It was also noteworthy that 30% of case management households did not seek health care when their child was sick. Further investigation should be undertaken to understand the reason. For instance, was it just that the child was not sick enough to need health care or were there other barriers that might need to be addressed, such as financial hardship or accessibility (i.e., location).

In general, children's health, education and well-being were reported to be positive. Children over 11 years of age rated their care and safety especially highly, and those who had spent time in residential care reported a higher sense of overall life satisfaction being with family than when they were in care. There has been some improvement or a general maintenance of levels of well-being between Y3 and Y5, even as cases were closed and families received less support. This is another indication that case

closure was well-timed and families were able to progress well together, even if caregivers felt an impact in terms of lower levels of support.

Some findings could be further investigated to ensure they are well understood. Both caregivers on behalf of children aged 2–10 and children themselves (aged 11+) highlighted a concern about having all of their education materials and chores sometimes impacting their schooling. Children not living with their parents or whose parents had died reported lower levels of well-being, family and community acceptance and OLS. There could be room to explore more qualitatively how families fare after case closure and to explore issues related to education and the impact of living away from parents, even when in a family setting. The survey chose not to include young adults over the age of 18 who had participated in the Y3 survey, but a qualitative engagement with these young people could also bring forward insights into their transition into adulthood.

7.1.2. Kenya

Caregivers in Kenya were very positive about the services they received, including parenting training and home visits. CTWWC Kenya also provided a wide range of household economic strengthening support, especially in Kisumu, Nyamira and Siaya counties, where all forms of economic support were well received, especially cash transfers and financial education via the Child Optimized Financial Education curriculum. At the time of the survey, case closure in Kenya was an ongoing process. Caregivers who had recently had their cases closed reported mixed feelings about how well prepared they were for case closure.

Protective factors within the households were generally high. For instance:

- Caregivers reported a high sense of internal resiliency and social and emotional competency, as well as the more external-facing social connections and ability to receive concrete assistance. The internal factors were stronger for women compared to men, whilst the social connections were weaker in urban areas and amongst widows. While this bodes well for the internal resilience of Kenyan families, given that it is important for all protective factors to be strong, family strengthening support and services should pay attention to how to increase social connections and concrete support for all families.
- Positive parenting was sometimes being practiced by caregivers, more frequently amongst women, whilst widows and caregivers with a disability were less frequently involved with their children. Practices that involve talking with children were most frequently utilized, whilst others linked to hugging, rewarding, helping with homework and playing games were less frequently practiced. Given the age profile of children in the sample, it is possible that some of these parenting practices are felt to be less appropriate for adolescents. This needs further investigation. Corporal punishment is still used regularly by a third of caregivers. This needs continued emphasis in parenting training, especially to support caregivers in larger households, those who are female, and those who are young, as they are more frequently using corporal punishment.
- In terms of economic stability, nearly all caregivers are worried about their financial situation, which had worsened between Y3 and Y5 of the survey. This reflects the overall economic situation in Kenya during this period. Nonetheless, a third of caregivers are able to save money (a practiced encouraged by the local savings and loans groups set up by CTWWC Kenya) and could meet costs in an emergency. Two-thirds of the households experience moderate hunger as a result of their financial constraints and over 80% cannot meet school costs resulting in many children missing days of school.

Children's health, education and well-being were reported to be generally positive, with some elements of concern, often linked to the provision of basic needs and education. Overall, school enrollment dropped between Y3 and Y5 of the survey, although it is still at a high level (88%). Amongst both children aged 2–10 and those aged over 11 years, school was a positive experience, but concerns were raised about having enough food to eat and adequate materials for school, mirroring caregiver-level findings. Children aged over 11 rated their care, safety, leisure and

freedom highly, but felt they were missing out in terms of their basic needs. For children reintegrating from residential care, this is likely to be reflected in them reporting a sense that their OLS had not changed much between being in residential care and being at home. On average, their sense of satisfaction at home declined between Y3 and Y5 of the survey, which highlights the importance of continued support for families where a child is reintegrating, especially to meet basic needs and ensure access to quality education. It is likely that children had access to more regular and diverse meals, school supplies, clothing and other basic needs in residential care. Residential care providers should be supported to transition their programming to services that help the children in families and communities in the same material ways, bringing basic needs and promoting community belonging together. Since the survey also revealed that many families remain in contact with residential care providers, this could provide an opportunity for transition since there is already a good understanding of the communities' needs and dynamics. It also suggests the importance of multisectoral approaches to children and families at risk of separation, so that social protection, education and child protection efforts are aligned to fully meet their needs.

Strengthening protective factors in poor economic situation

Until the COVID-19 pandemic, Kenya was one of the fastest growing economies on the African continent and had reached lower-middle income status as a country.[49] However, significant challenges to sustainable and inclusive economic growth were exacerbated by economic disruptions caused by the pandemic, ongoing corruption and economic inequality. Two-thirds of Kenyans live in poverty; 70% of families are chronically vulnerable due to poor nutrition, food insecurity and preventable diseases; and many Kenyans suffer from economic inequality. The fact that no Kenyan family escapes the impacts of this socio-economic climate makes a number of the survey findings remarkable. Over 95% of Kenyan caregivers reported often or sometimes having worried about money in the four weeks preceding the survey. At the same time, caregiver protective factors remained stable over more than two years when economic stress was likely high. There were no statistical differences in parental involvement and positive parenting between Y3 and Y5. A remarkable 35% of caregivers reported being able to save money despite uncertainty. These findings could suggest that even in an economically strained context, when families have strengthened protective factors, they are buffered against stressors in their environment and can still keep their children safe and cared for.

7.1.3. Moldova

Caregivers in Moldova were positive about the support that CTWWC provided, alongside support received through government social assistance. CTWWC provided home visits, cash support and referrals to government services, all of which were reported to be helpful, especially cash support.

Protective factors were generally high amongst caregivers in Moldova.

- Caregivers reported a high sense of internal resiliency and social and emotional competency, with high, but slightly lower levels of the external-facing social connections and ability to get concrete assistance.
- There was a very high frequency of practicing positive parenting, both positive reinforcement and involvement. Undertaking special activities and playing games were the only aspects with room for improvement. Caregivers reported very little use of corporal punishment, although some occasional use of spanking with hand (not on face) was reported. Alternative discipline measures should be emphasized in interactions with families, and caregivers should be encouraged in their continued use of positive parenting strategies.

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[49] USAID. (2023). Kenya Economic Growth and Trade. Accessed at: https://www.usaid.gov/kenya/economic-growth-and-trade#:~:text=There%20is%20a%20large%20gap,labor%2C%20resources%2C%20and%20opportunities.

■ There is little hunger, and most families are able to meet the costs of children's school and health care and could most likely meet emergency costs. There is, however, a high level of worry about money and little ability to save. This could be addressed through offering financial education to caregivers and exploring easily accessible savings schemes with them, which would be a good completement to the cash transfers already offered by CTWWC to support the more immediate costs of a child's placement.

Most children are at school and have good health, but there are clearly some children struggling with health and education, especially children in foster care where the disability prevalence is higher. Additional support is needed for families caring for children with a disability.[50]

Children are experiencing generally positive well-being, whether reported by caregivers for younger children or when self-reported by teenagers. Children aged 11+ years reported the highest level of well-being around care and safety and basic needs, aligning with findings on positive parenting and economic stability. Children reported their well-being linked to leisure and freedom to be lower. This included reporting low well-being in relation to friendship and freedom to go out. Other areas of low well-being were in relation to support from the community. This is echoed in children reporting a high sense of family acceptance, but a much lower sense of community acceptance and a neutral sense of school belonging. Reintegration and foster care involve difficult transitions, and there is often stigma toward children who have been in the care system and/or those with disabilities. It is recommended that CTWWC strengthen efforts to prepare, sensitize and facilitate greater community acceptance as part of their family strengthening and foster care efforts. The families in Moldova are doing well providing children's basic needs, access to school and health care, and creating a stable and loving home, but there is a need to ensure that the wider community also welcomes these children home and provides accommodative spaces and support for children and caregivers alike. CTWWC is exploring ways to engage with civil society structures in Moldova, including faith-based organizations, to promote family strengthening and support for all families. It is important that this is inclusive of children with disabilities and those living in foster care.

7.2.   Program effectiveness

CTWWC's theory of change is based around demonstration locations and countries that provide examples and learning about the provision of family care and family strengthening in order to influence wider change within these countries, to their surrounding regions and eventually, to inform the global care sector. Therefore, CTWWC has invested in significant monitoring, evaluation and research processes, of which this household survey is a key part, to understand implementation of family care and family strengthening activities and the outcomes they contribute to for the children and caregivers who participate. This allows CTWWC to be reflective, adapt its programming and contribute to the wider evidence base.

Monitoring indicators

At the start of CTWWC, a comprehensive monitoring, evaluation, accountability and learning (MEAL) plan was developed to track implementation and change at different levels of the initiative. It was decided that a repeated household survey would best provide insights at the child and family level, allowing a look at change in outcomes over time and across different variables. A series of indicators were designed in the hope that they would provide a snapshot of progress amongst children who had been supported as part of their reintegration from residential care or because they were identified as at risk of family separation, and amongst their caregivers, with a focus on two key elements of support:

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[50] The role of disability is explored in: Insights from Moldova: Role of Targeted Economic Support in Reintegration of Children, available at: https://bettercarenetwork.org/library/principles-of-good-care-practices/leaving-alternative-care-and-reintegration/insights-from-moldova-role-of-targeted-economic-support-in-reintegration-of-children

economic stability and positive parenting. After the survey's design, but before any data was collected, a decision was made as to which items in the survey would contribute to these indicator results.

The results presented in this report (see blue boxes in Guatemala and Kenya sections), show a mixed set of results between the two rounds of the survey in Y3 and Y5 of the initiative. In Guatemala, children's sense of safety and nurture were at similar or slightly higher levels between the two rounds, and caregiver levels of economic stability and positive parenting practices slightly increased. In Kenya, children's sense of safety and nurture, and caregiver levels of economic stability and positive parenting practices, were at similar or slightly lower levels between the two rounds.

All of the indicators attempt to present a complex mix of factors in a simple metric. When the indicator results are broken down into their different elements, more can be learned about the effectiveness of the programming. For instance, in both countries (i.e., Guatemala and Kenya), the use of corporal punishment remains at higher levels than desired in the indicator definition, but as hoped for, positive parenting approaches are frequently practiced.

Furthermore, the complexity of the issues faced by children and families (i.e., the often tailored and multifaceted nature of interventions, the necessary flexibility in the timing of steps in processes such as case management, and the differing context in each country, as well as a global pandemic), make it hard to design and interpret indicators of this nature. This is often part of the challenge faced in monitoring and evaluating these kinds of interventions. The following section, therefore, seeks to focus on one part of the CTWWC intervention—reintegration supported by case management—to understand what the survey results highlight for Guatemala and Kenya.

Reintegration and case management

In the second round of the survey, it is possible to see how situations have changed for reintegrating families who participated in both rounds of the survey in Guatemala and Kenya. The results provide an indication of how their participation in case management processes may have contributed to child and caregiver outcomes.

The case management process, which CTWWC follows, is made up of multiple steps, beginning with assessing a child and their family for the possibility of reunification, planning for and undertaking the reunification placement, planning for and undertaking follow-up support, reviewing the progress of the child and family to determine if case closure is possible, and finally, closing the case.

The results in Guatemala are an endorsement of the case management process. The first round of the survey was conducted, on average, 18 months (March 2020 to September 2021) after children were returned home, during which time the COVID-19 pandemic had happened and much support to the families had been provided virtually. It was also, on average, only three months before cases were closed. The second round of the survey was conducted another 18 months after the cases had been closed, once families had met the benchmarks indicating they could progress independently. Meaning, at this point, the families had not had contact with CTWWC for a year and a half (Figure 82). Given this alignment of the survey and the case management process, it is significant that at both survey points caregivers highly endorsed the services they received from CTWWC and reported feeling well prepared for case closure. It is also important to note that protective factors amongst caregivers and well-being amongst children remained high between the survey rounds. There was a slight decline between the two survey rounds, this was not unexpected given that cases had been closed and no support had been given for a year. Indeed, this suggests that resilience had been built into the families to cope when facing challenges on their own.

Figure 82: Average dates of case management and dates of data collection processes, Guatemala
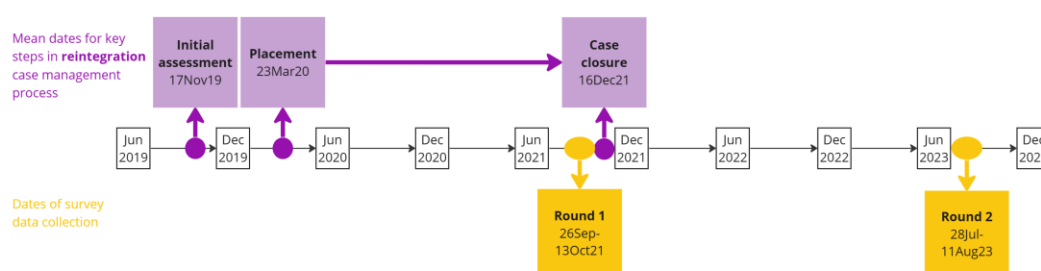
In Kenya, there was a much greater variation in the dates during which children and families went through the case management process for reintegration, partly due to the response to the COVID-19 pandemic and partly because of CTWWC operating across multiple locations and how residential care is provided (i.e., largely by private organizations, with often limited involvement of the formal child protection system) (Figure 83). Families in Kenya were also provided with a diverse range of family strengthening support. Similar to Guatemala, the first round of the survey happened roughly 18 months after many children had exited residential care, however, this was largely due to a government directive issued in March 2020 in the early phase of the COVID-19 pandemic, which required children to be sent home if at all possible. CTWWC had begun a process of child and family assessments, which was rolled out much more rapidly than planned, often once a child had already returned home, meaning much of the preparatory phase ahead of reunification could not happen. During the 18 months between round 1 and round 2 of the survey, follow-up visits to families and case reviews were undertaken with most families going through the process at some point in 2022, and with case closures beginning toward the end of 2022 and continuing into 2023. Amongst families who participated in round 2 with reintegrating children, 65% had already had their cases closed in the preceding six months. In addition, whilst individual family support was continuous from 2020, group interventions focused on savings began in 2022, and financial literacy[51] and positive parenting group trainings began in early 2023 and were not fully completed at the time of round 2 of the survey. Therefore, the results of the survey are a picture of how families fared during two to three years of support, much of which was rolled out during the complexities of the COVID-19 pandemic and following economic downturn. The results are not yet a measure of sustainability of the placements nor of the impact of group interventions on financial literacy and positive parenting practices. Keeping this in mind, we can tentatively conclude that the results show that caregivers maintained high levels of protective factors and children maintained high levels of well-being in the areas of care, safety, leisure and freedom. Participation in a case management process is likely to have supported this. Savings groups have encouraged high levels of savings, but this has not been enough to overcome the negative economic environment impacting the provision of basic needs for many families and access to education for many children. Another round of the survey 18 months from now would allow a better assessment of the support provided in 2022–23.

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[51] The financial literacy approach used with groups is called Child Optimized Financial Education (COFE) where the emphasis is on meeting the basic needs of children in a family's care (for more information see: www.crs.org/our-work-overseas/research-publications/child-optimized-financial-education-cofe-manuals)

Figure 83: Interquartile range (IQR) of dates of case management and dates of data collection processes, Kenya
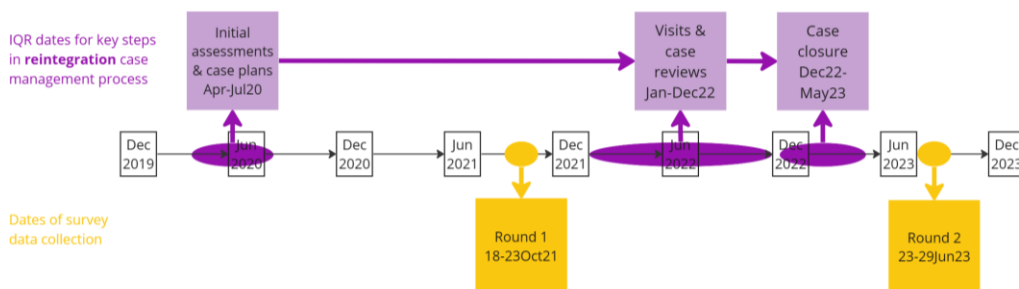
7.3.   Cross-country conclusions

When looking at the survey findings in the three countries, it is interesting to see the commonalities and differences that point to wider trends that should inform the provision of care and family strengthening, as well as when seeking care system reform.

Women hold the responsibility for child rearing
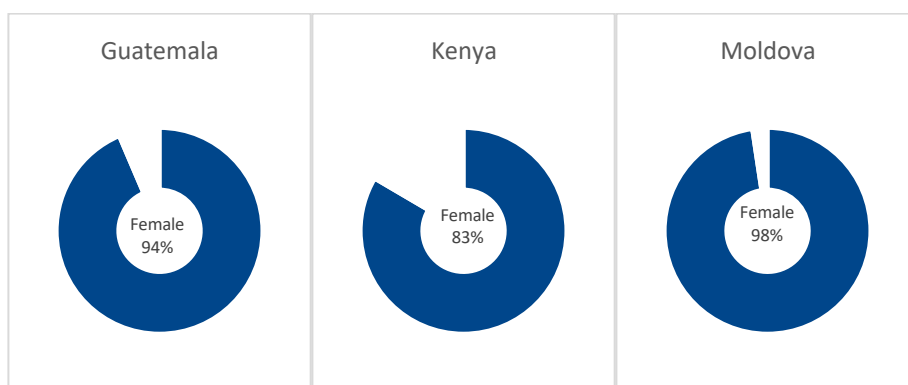
Across all country contexts, women were overwhelmingly identified as primary caregivers, and thus, the respondents to this survey. This suggests they hold the majority of responsibility for child rearing in both at-risk and reintegrating families (94% of caregiver respondents in Guatemala, 84% in Kenya and 98% in Moldova were women). Therefore it is important that programming and family strengthening approaches recognize sex dynamics in child rearing, such as evidence-based income generation approaches for women, as well as male-targeted family strengthening approaches to increase equity and male responsibility.

Caregiver education level is often low
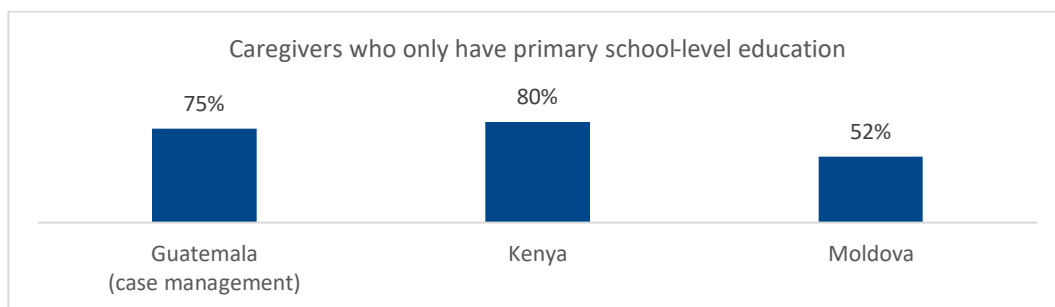
One interesting caregiver factor that warrants further research is the link between caregiver education as related to child separation/risk for placement in residential care. In Guatemala, 75%

of caregivers receiving case management had completed only primary school. This metric was 80% in Kenya and 52% in Moldova. These demographics could suggest several things related to supporting families. Parenting materials, for example, should be at basic education reading levels or presented in visual and oral formats. In Moldova, correlational analyses showed that the higher the education level of the caregiver, the less frequently they worried about money and the more able they were to obtain funds in an emergency.

Local context can make a difference to protective factors

The family's context seems to matter in relation to social connections and support. In Kenya, social isolation was felt more by caregivers in urban areas than rural areas, while in Moldova and Guatemala, scores for social connections were higher for caregivers in urban areas. Comparisons between Moldovan households showed that caregivers in rural locations were more likely to worry about money compared to those in urban areas. Rural Moldovan caregivers had lower mean scores in all protective factor domains than their urban counterparts. These comparisons suggest the importance of considering urban and rural nuances when planning and delivering family strengthening programming. The response of a "one size fits all" approach is unlikely to be effective even within one country context.

The role of disability

Disability prevalence in caregivers was not terribly different to the global average adult prevalence, which is estimated at 16%[52] (17% of the caregiver respondents had disabilities in Guatemala, 18% in Kenya and 12% in Moldova). UNICEF estimates the global child disability prevalence at 10% of children worldwide.[53] This fits with the estimate for disability prevalence in the study in Guatemala and Kenya (7% and 11%, respectively), however, in Moldova, well over 50% of the children were living with functional difficulties with only 29% of these children being cared for by their biological families. This reflects the stage of care reform in Moldova where many children remaining in residential care have a disability, and it highlights the importance of family-based alternative care for children with disabilities.

When looking at the different characteristics that make a significant difference to outcomes for caregivers and children, disability is prominent in all three countries. Caregivers with a disability in Guatemala and Kenya have lower levels of economic stability compared to caregivers without a disability, worrying more about money, being less able to save and meet emergency costs and experiencing more hunger. It is important that economic strengthening strategies work to overcome the additional barriers faced by caregivers with a disability. Caregivers with a disability in Kenya also experience greater isolation and struggle to be as involved with their children as caregivers without a disability. This should be further investigated to better understand what challenges these caregivers are facing, but it is likely that group interventions could help build up social connections.

Children with disabilities in all three countries report lower community acceptance compared to children without a disability. It is likely that they face stigma and struggle with social interactions. Children with disabilities also report lower levels of well-being in all three countries compared to children without a disability (Guatemala: lower levels of life satisfaction, Kenya and Moldova: lower levels of well-being and health). It is also notable that disability is a factor in lower attainment in education in Moldova. It is critical that the strengths and needs of these children are addressed during reintegration processes and family strengthening interventions so that they are not left behind.

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[52] World Health Organizations. (2023). Accessed at: https://www.who.int/news-room/fact-sheets/detail/disability-and-health
[53] UNICEF. (2022). Seen, Counted, Included: Using data to shed light on the well-being children with disabilities.

Navigating case closure for families following reunification or high risk factors

It is interesting to note the difference in results on case closure and the families' preparation for closure, suggesting the need for further attention and learning. In Guatemala, 78% of families reported that they felt fully prepared for the support to come to an end, while in Kenya, 40% felt ill-prepared and only 25% reported feeling fully prepared. While the Guatemala and Kenya contexts and programs are very different, as is the delivery of case management, there are still programmatic lessons that can be learned by looking closely at the practices around the closure step of case management across the contexts. Such questions might include: *Who is involved in decisions around case closure? When does preparation begin? What is involved in preparation for closure? How are family members involved in preparation for case closure? What changes need to be made to case worker training and supervision, caseloads, family participation in case management, tools and standard operating procedures (SOP) in order to improve case closure process?*

Comparisons between the groups of families included in the Guatemala survey must be done cautiously as the survey targeted all families who received case management and only a sample of those who received parenting education. How these families entered these services is also very different. Case management is used to support families in contact with the child protection system, whilst community members voluntarily enrolled in the parenting schools. Nonetheless, it would be interesting to explore these areas further to understand why caregivers in Guatemala who participated in a case management process had higher protective factor scores than the caregivers who only participated in parenting schools. Similarly, one third of caregivers who participated in a case management process reported that they had managed to save money in the past month, whilst just 15% of caregivers who had attended parenting schools reported being able to save. Further research could look to answer questions like: *What are protective factors and saving practices like in the general population? Is one-to-one individual household support making a significant difference to families in crisis?*

Drivers of separation and the continuum of care

Most children in Guatemala, Kenya and Moldova were placed in residential care from the care of their biological parents. Furthermore, in Guatemala, children spent an average of one year in residential care, suggesting the need for short-term alternatives when children temporarily cannot remain safely with their families. In Kenya, most children enter residential care at school age, suggesting access to education as a driver. These findings suggest a number of important things when considering programming:

- Residential care is still not a last resort option in Kenya or Guatemala. If it was, the figures would show more children entering residential care after failed placement in kinship or other forms of family-based alternative care. Programmatically, this suggests the importance of developing accessible family-based alternative care models.
- Early identification of biological parents at risk of separation and placement of children in residential care and early interventions is critically important to reducing the inflow of children. Prevention work needs to include addressing education access.

The data provides insights into the push and pull factors leading children to be separated from their families and placed into residential care across country contexts, and therefore, offers critical information for programming. In Kenya, two-thirds of children across reintegrating and at-risk families are teenagers, and most children who had entered residential care did so from their biological families around school age. In Moldova, a significant percent of reintegrated children have disabilities, strongly suggesting that programs and alternative care services addressing this risk factor are needed. Unlike Guatemala and Moldova, being a single or double orphan was a factor for separation in Kenya. This data helps programs to know what to consider when identifying families as at risk and designing responsive services.

Family strengthening approaches

The survey data also provides important information about family strengthening approaches, which were different in each country. Parenting approaches as part of the family strengthening package received high scores in terms of being helpful to families in Kenya and Guatemala, suggesting the value of investment in scaling these approaches. Unsurprisingly, families across all three countries found cash transfers helpful, even while many families still reported being worried about finances. In Kenya, training on managing finances and kitchen gardens were complementary economic strengthening interventions that also received "helped a lot" scores equitable to the appreciation for cash. In Guatemala, caregivers who received case management with the additional family strengthening intervention of referrals to services tended to score that intervention higher than the families who had parenting school. This could suggest that referring a family to a service and being able to support their access to the service and follow up as part of case management makes the service referral more helpful to the family.

Successes and challenges of research on children's care

Whilst this survey has provided some interesting insights into the situation of children and families supported by CTWWC, as highlighted above, it has also shown how hard it is to effectively measure the outcomes of care. This is especially challenging since the use of case management means that each child and family received a personalized care plan based on their strengths and needs, thus, no two families received the same interventions and care plans were followed on timelines reflecting the readiness of each child and family, further meaning, the surveys were undertaken at different points in the process for each family. Additional challenges come when undertaking a survey with limited resources alongside ongoing interventions and when the formation of comparison groups has ethical implications. Continued creativity, sharing of good practice and adequate resourcing is needed to address these challenges to ensure that children's care is informed by reliable evidence generated in relevant contexts.

This survey has uncovered some interesting dynamics in children's well-being by using a tool designed with children and young people with experience of alternative care, which has been psychometrically validated.[54] Whilst this was an additional step to take in the survey process, it is clear that by involving children and young people, the results of this report are more meaningful and have revealed insights that would not otherwise have been possible.

8. RECOMMENDATIONS

This section provides initial recommendations that have emerged through CTWWC team members engaging with the survey findings during various workshops and online sessions. It is anticipated that more recommendations will emerge along with more concrete next steps to inform CTWWC's practice and beyond.

8.1.   Initiative-wide

- **Case management**: Given the variation in results amongst groups of caregivers and children, it is important that case management processes continue to be a central pillar of the provision of alternative family-based care, reintegration and family strengthening for those at high risk of separation. The use of a case management approach allows social service workers to attend to the

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[54] Neville, S.E., Wakia, J., Hembling, J. et al. (2024) Development of a Child-Informed Measure of Subjective Well-Being for Research on Residential Care Institutions and Their Alternatives in Low- and Middle-Income Countries. Child Adolescent Social Work Journal. doi.org/10.1007/s10560-024-00968-x.

many differences that play a role in determining strengths and needs of children and their caregivers.

■ **Community engagement in reintegration and family strengthening support**: Paying particular attention to the finding that children in all three countries reported not feeling accepted in their community, by other children in school and/or by non-biological caregivers, there is a need to strengthen reintegration or family strengthening efforts using an ecological systems lens. This is especially needed for families with a child with a disability. This requires targeting actors outside the child's home, including neighbors, schools, faith leaders, etc., during the preparation work within a reintegration process, including finding ways to strengthen linkages, foster acceptance and engagement, and ideally, decrease stigma. There is also the potential that group interventions, such as parenting schools and savings groups, could provide forums to build social capital and connections for caregivers.

■ **Disability inclusion**: Disability is clearly a significant factor in determining outcomes for children, especially when exiting residential care in favor of family care. Additional effort must be encouraged when considering the design and implementation of alternative family-based care and family strengthening services and support in order to avoid leaving children with disabilities behind.

■ **Protective factors framework**: There continues to be a demonstrable link between caregiver protective factors and child well-being. Therefore, the strengths-based protective factors, family strengthening and case management approaches used by CTWWC should continue to be utilized, promoted and researched.

■ **Evidence building**: Given the complexities of this kind of survey, and the need for evidence to inform the practice and policies of care reform, it is important to direct funding toward and collaborate widely on good practices in evidence-generation and to seek ways to build care status of children into routine administrative data collection and nationally representative surveys.

8.2.   Country-specific

Guatemala

In addition to the above recommendations that apply across the initiative, for Guatemala specifically, it is recommend that further investigation be undertaken in the following areas:

■ Better understand the post-case closure experience for caregivers and children, especially for children not living with their biological parents and for young adult care leavers after they turn 18.

■ Explore how the positive parenting curricula can support parents with less education and reduce corporal punishment through encouraging the use of non-violent discipline and positive reinforcement.

■ Explore how families can access savings and financial education to aide better planning.

■ Why some families are not seeking medical care when their child is sick in order to understand if there is a barrier or another issue preventing care being sought.

Finally, a third round of the survey is recommended as it would provide a unique opportunity to look into the situation of families several years after case closure. There is a significant gap in the current evidence base globally, and especially in Latin America.

Kenya

In addition to the above recommendations that apply across the initiative, for Kenya specifically, the following is also recommended:

■ Given the impact of the current economic situation on child well-being and household economic stability, it is important to build capacity of local governments and other organizations in delivering economic strengthening interventions suitable for local contexts. Financial literacy, cash transfers, savings groups and agricultural training have all been well received. The current government's

commitment to expanding access to statutory cash transfer schemes and government agricultural schemes are key opportunities.

In addition, further investigation is recommended in the following areas:

- Linkages to education provision and its impact on child well-being as well as how support to families can address challenges in education and how CTWWC can advocate for improvements in the education system.
- Explore how the positive parenting curricula can support parenting of adolescents, especially their educational and mental health needs.

Finally, a third round of the survey is recommended to understand the situation of families post-case closure and to look at the impact of group interventions given that these interventions were still being rolled out at the time of this round of the survey.

Moldova

In addition to the above recommendations that apply across the initiative, for Moldova specifically, it is recommend that another round of the survey be undertaken to understand the situation of children and families further into their reintegration process in order to measure change in outcomes, as was possible in Guatemala and Kenya.

9. ANNEXES

Annex 1: Bivariate statistics tables

The following tables show the complete results for the bivariate analysis of caregiver protective factors and child well-being against selected variables. Significant results have been included in the relevant parts of the country results sections. The tables below are for reference and further detail.

The following items from the survey were used in the relevant analysis, where the data existed:

- **Caregiver protective factor items**: PFI domain and overall mean scores, positive parenting and parental involvement total scores, three corporal punishment scores, Household Hunger Score, degree of worry about money, ability to obtain funds in an emergency (lower amount, ability to obtain funds in emergency – higher amount, ability to save), couples communication scale.
- **Caregiver and household variables**:
    - Linear: age, education, number of adults in household, number of children in household.
    - Categories: sex, disability status, widow status, locale (rural/urban), placement type.
- **Child well-being items**:
    - Ages 2–10: health score, mean well-being score.
    - Ages 11–18: health score, mean well-being score, OLS score, family acceptance mean score, community acceptance mean score, school belonging.
    - Ages 11–18, reunified children: health score, mean well-being score, OLS score, change in OLS score (between residential care and time of survey), family acceptance mean score, community acceptance mean score, school belonging.
- **Child variables**:
    - Linear: age (at time of survey) and for reunified children: years in care, age at reunification/placement, age at entrance to residential care.
    - Categories: sex, disability status, case type (at-risk, reintegration, foster care), parental care status, orphanhood status.

Scales for each item can be found in the methodology section.

Guatemala

Protective factors and caregiver variables—<u>Case management</u> households

Table 70: Pearson's r correlations coefficients for caregiver protective factors and caregiver/household characteristics – <u>case management</u> households, Guatemala

	Parental resilience	Social connections	Concrete assistance	Social/ emotional	Overall PFI
Caregiver age	-.190	.002	.107	.226	.070
Caregiver education	-.036	-.189	-.052	-.244	-.134
No. of adults in household	-.117	.180	.229	.394**	.258
No. of children in household	.345*	.344*	.503***	.267	.464**

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

Table 71: T-tests comparing caregiver protective factor mean scores by caregiver groups – <u>case management</u> households, Guatemala

	Parental resilience	Social connections	Concrete assistance	Social/ emotional	Overall PFI
Caregiver sex					
Female	3.47	3.07	3.00	3.28	3.18
Male	3.28	2.80	2.96	3.31	3.09
Caregiver disability status					
Disability	3.38	3.67	3.13	3.54	3.22
No disability	3.46	2.93	2.97	3.23	3.15
Caregiver widow status					
Non-widows	3.51**	3.07	3.07	3.35	3.26**
Widows	2.89**	2.58	2.33	2.85	2.53**
Household locale					
Rural	3.41	2.87	2.82	3.19	3.04
Urban	3.50	3.29	3.28	3.46	3.38
Household placement type					
Has at-risk children only	3.55	2.88	2.97	2.94	3.02
Has reunified children	3.42	3.05	3.00	3.35	3.19

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

Table 72: Pearson's r correlations coefficients for parenting practices and caregiver/household characteristics – <u>case management</u> households, Guatemala

	Parental involvement	Positive parenting	Freq. of spanking	Freq. of slapping	Freq. of hitting
Caregiver age	-.295	-.038	-.178	-.073	-.072
Caregiver education	.125	-.100	.163	.180	-.035
No. of adults in household	.040	.038	-.006	.098	-.094
No. of children in household	.280	.125	.027	.132	.062

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

Table 73: T-tests comparing parenting practices by caregiver groups – <u>case management</u> households, Guatemala

	Parental involvement	Positive parenting	Freq. of spanking	Freq. of slapping	Freq. of hitting
Caregiver sex					
Female	18.97	21.07	0.61	0.05	0.27**
Male	18.50	18.67	1.17	0.00	1.17**
Caregiver disability status					
Disability	16.33	18.75	0.25	0.00	0.63
No disability	19.34	21.18	0.77	0.05	0.33
Caregiver widow status					
Non-widows	19.42	21.17	0.71	0.04	0.37
Widows	15.20	18.00	0.50	0.00	0.50
Household locale					
Rural	18.56	20.80	0.43*	0.03	0.33
Urban	19.44	20.71	1.12*	0.06	0.47
Household placement type					
Has at-risk children only	20.00	19.71	0.57	0.00	0.86
Has reunified children	18.68	20.95	0.70	0.05	0.30

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

Table 74: Pearson's r correlations coefficients for economic stability outcomes and caregiver/household characteristics – <u>case management</u> households, Guatemala

	Household Hunger Score	Degree of worry about money	Ability to obtain funds in emergency	Ability to obtain funds in emergency (higher amount)
Caregiver age	-.081	.025	.039	.008
Caregiver education	-.151	.015	-.131	-.092
No. of adults in household	.235	.146	.082	-.033
No. of children in household	-.076	-.204	-.132	.257

Correlations statistically significant at *p<.05, **p<.01, ***p<.001. a. Cannot be computed because at least one of the variables is constant.

Table 75: T-tests comparing economic stability outcomes by caregiver groups – case management households, Guatemala

	Household Hunger Score	Degree of worry about money	Ability to obtain funds in emergency
Caregiver sex			
Female	0.44	1.73	1.02
Male	0.00	1.33	1.00
Caregiver disability status			
Disability	1.00	2.63**	0.25***
No disability	0.26	1.49**	1.18***
Caregiver widow status			
Non-widows	0.34	1.59	1.05
Widows	0.67	2.33	0.83
Household locale			
Rural	0.33	1.77	0.93
Urban	0.47	1.53	1.18
Household placement type			
Has at-risk children only	1.00	2.29	1.00
Has reunified children	0.28	1.58	1.03

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

Table 76: Chi-squared tests of significance for distributions of caregivers who had been able to save any money – case management households, Guatemala

	% who saved	% who did not save
Caregiver sex		
Female	34.15	65.85
Male	50.00	50.00
Caregiver disability status		
Disability	12.50	87.50
No disability	41.03	58.97
Caregiver widow stats		
Non-widows	39.02	60.98
Widows	16.67	83.33
Household locale		
Rural	30.00	70.00
Urban	47.06	52.94
Household placement type		
Has at-risk children only	57.14	42.86
Has reunified children	32.50	67.50

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

Table 77: T-tests comparing means of caregivers who had been able to save any money- case management households, Guatemala

	Mean of those who saved	Mean of those who did not save
Caregiver age	42.52	42.73
Caregiver education^	0.41*	1.00*
No. of adults in household	2.82	3.07
No. of children in household	3.65	3.27

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

Protective factors and caregiver variables – <u>Parenting school</u> households

Table 78: Pearson's r correlations coefficients for caregiver protective factors and caregiver/household characteristics – parenting school households, Guatemala

	Parental resilience	Social connections	Concrete assistance	Social/ emotional	Overall PFI
Caregiver age	-.226	-.150	-.102	-.137	-.213
Caregiver education	.222	.210	-.037	.100	.101
No. of adults in household	.015	.005	.185	.299*	.180
No. of children in household	-.048	.053	-.350**	-.089	.144

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

Table 79: T-tests comparing caregiver protective factor mean scores by caregiver groups – parenting school households, Guatemala

	Parental resilience	Social connections	Concrete assistance	Social/ emotional	Overall PFI
Caregiver disability status					
Disability	3.43	3.08	2.73	3.25	3.14
No disability	3.36	2.83	2.82	3.09	3.05
Household locale					
Rural	3.36	2.84	2.89	3.14	3.11
Urban	3.35	2.89	2.71	3.08	3.01

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001. Note: For Guatemala parenting school households data, caregiver sex not used as a variable as only one caregiver was male, widow status not used as a variable as there was only one widow, and placement type not used as a variable as not relevant to this group.

Table : Pearson's r correlations coefficients for parenting practices and caregiver/household characteristics – parenting school households, Guatemala

	Parental involvement	Positive parenting	Freq. of spanking	Freq. of slapping	Freq. of hitting
Caregiver age	-.198	.019	-.220	[a]	.014
Caregiver education	.155	-.101	.279*	[a]	-.030
No. of adults in household	.111	.195	.052	[a]	.117
No. of children in household	-.107	-.102	.031	[a]	.225

Correlations statistically significant at *p<.05, **p<.01, ***p<.001. [a] Analysis not relevant as all respondents gave the same response (0=never) to this question.

Table 81: T-tests comparing parenting practices by caregiver groups – parenting school households, Guatemala

	Parental involvement	Positive parenting	Freq. of spanking	Freq. of slapping	Freq. of hitting
Caregiver disability status					
Disability	21.56	21.78	1.11	[a]	0.67
No disability	20.16	20.81	0.96	[a]	0.73
Household locale					
Rural	20.80	21.42	0.93	[a]	0.78
Urban	20.00	20.42	1.04	[a]	0.65

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001. [a] Analysis not relevant as all respondents gave the same response (0=never) to this question. Note: For Guatemala parenting school households data, caregiver sex not used as a variable as only one caregiver was male, widow status not used as a variable as there was only one widow, and placement type not used as a variable as not relevant to this group.

Table 82: Pearson's r correlations coefficients for economic stability outcomes and caregiver/household characteristics – parenting school households, Guatemala

	Household Hunger Score	Degree of worry about money	Ability to obtain funds in emergency	Ability to obtain funds in emergency (higher)
Caregiver age	-.222	.090	-.073	.122
Caregiver education	-.192	-.002	.125	.104
No. of adults in household	-.118	-.177	.207	.065
No. of children in household	-.028	.026	.069	.106

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

Table 83: T-tests comparing economic stability outcomes by caregiver groups – parenting school households, Guatemala

	Household Hunger Score	Degree of worry about money	Ability to obtain funds in emergency
Caregiver disability status			
Disability	1.00*	2.40	0.90
No disability	0.37*	2.08	0.94
Household locale			
Rural	0.53	2.21	0.94
Urban	0.41	2.04	0.92

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001. Note: For Guatemala parenting school households data, caregiver sex not used as a variable as only one caregiver was male, widow status not used as a variable as there was only one widow, and placement type not used as a variable as not relevant to this group.

Table 84: Chi-squared tests of significance for distributions of caregivers who had been able to save any money – parenting school households, Guatemala

	% who saved	% who did not save
Caregiver disability status		
Disability	10.00	90.00
No disability	13.73	86.27
Household locale		
Rural	14.71	85.29
Urban	11.11	88.89

Chi-squared test statistically significant at *p<.05, **p<.01, ***p<.001. Note: 118or Guatemala parenting school households data, caregiver sex not used as a variable as only one caregiver was male, widow status not used as a variable as there was only one widow, and placement type not used as a variable as not relevant to this group.

Table 85: T-tests comparing means of caregivers who had been able to save any money – parenting school households, Guatemala

	Mean of those who saved	Mean of those who did not save
Caregiver age	31.63	36.96
Caregiver education^	1.13	1.28
No. of adults in household	2.88	2.74
No. of children in household	1.75	2.08

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

Child well-being and child variables

Table 86: Pearson's r correlations coefficients for child well-being measures and child characteristics – children 2–10, Guatemala

	Overall well-being	Overall health
Child age	0.10	0.41*
Years in care	-0.32	-0.09
Age at reunification	0.19	0.54*
Age at entrance to care	0.32	0.57*

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

Table 87: T-tests comparing child well-being measures by child groups – children 2–10, Guatemala

	Overall well-being		Overall health
Child sex			
Female	2.02		2.94
Male	1.91		2.92
Child case type			
At-risk child	2.05		3.20
Reunified child	1.89		2.64
Child parental care status			
In non-parental care	1.97		3.00
In parental care	1.97		2.91
Child orphanhood status			
Non-orphan	2.06***		3.14
Orphan	1.67***		2.17

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001. Note: For children aged 2–10 in Guatemala, disability was not used as a variable as only one child had a functioning limitation.

Table 88: Pearson's r correlations coefficients for child well-being measures and child characteristics – children 11–18, Guatemala

	Overall well-being	Overall life satisfaction	Community acceptance	Family acceptance	School belonging	Overall health
Child age	-0.08	-0.29	-0.35	-0.18	-0.35*	-0.07

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

Table 89: T-tests comparing child well-being measures by child groups – children 11–18, Guatemala

	Overall well-being	Overall life satisfaction	Community acceptance	Family acceptance	School belonging	Overall health
Child sex						
Female	1.76	9.08	1.79	1.86	2.72	2.86
Male	1.75	8.80	1.75	1.83	3.14	2.56
Child disability status						
No difficulties	1.78	9.20*	1.85***	1.86	2.98	2.78
With difficulties	1.48	6.67*	1.00***	1.78	2.39	2.00
Child placement type						
At-risk child	1.70	8.43	1.64	1.94	2.85	2.57
Reunified child	1.77	9.10	1.80	1.82	2.96	2.74
Child parental care status						
In non-parental care	1.45	7.50	1.75	1.00**	2.42	1.50
In parental care	1.77	9.04	1.77	1.91**	2.96	2.79
Child orphanhood status						
Non-orphan	1.81**	9.26*	1.83*	1.91*	3.00	2.80
Orphan	1.46**	7.40*	1.45*	1.52*	2.53	2.20

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

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

	Overall well-being	Overall life satisfaction at survey	Change in life satisfaction	Community acceptance	Family acceptance	School belonging	Overall health
Child age	.019	-.304	-.028	-.183	-.189	-.426*	-.942
Years in care	-.013	-.116	.046	.020	.012	-.015	-.266
Age at reunification	-.178	-.411	-.049	-.309	-.310	-.501*	-.039
Age at entrance to care	-.143	-.326	-.062	-.271	-.268	-.415*	.109

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

Table 91: T-tests comparing child well-being measures by child groups – reunified children 11–18, Guatemala

	Overall well-being	Overall life satisfaction at survey	Change in life satisfaction	Community acceptance	Family acceptance	School belonging	Overall health
Child sex							
Female	1.80	9.09	5.00	1.79	1.88	2.86	3.00
Male	1.73	9.10	4.78	1.82	1.76	3.06	2.45
Child parental care status							
In non-parental care	1.45*	7.50	^	1.75	1.00**	2.42	1.50
In parental care	1.80*	9.26	^	1.81	1.90**	3.01	2.86
Child orphanhood status							
Non-orphan	1.80	9.28	4.83	1.80	1.89*	2.97	2.75
Orphan	1.54	8.00	5.50	1.83	1.33*	2.89	2.67

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001. Note: For Guatemala reunified child data, child disability/functioning was not used as a variable as only one child had a functioning limitation. ^Similarly, there was only one child with relevant data for non-parental care and change in OLS.

Kenya

Protective factors and caregiver variables

Table 92: Pearson's r correlations coefficients for caregiver protective factors and caregiver/household characteristics – Kenya

	Parental resilience	Social connections	Concrete assistance	Social/ emotional	Overall PFI
Caregiver age	-.081	.009	-.062	-.085	-.052
Caregiver education	.037	.086	.111	.067	.106
No. of adults in household	.028	.081	.080	-.072	.058
No. of children in household	-.055	-.124*	-.021	.073	-.063

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

Table 93: T-tests comparing caregiver protective factor mean scores by caregiver groups – Kenya

	Parental resilience	Social connections	Concrete assistance	Social/ emotional	Overall PFI
Caregiver sex					
Female	3.11	2.25	2.61	3.23*	2.79
Male	3.01	2.39	2.75	3.02*	2.79
Caregiver disability status					
Disability	2.96	2.00*	2.65	3.30	2.69
No disability	3.13	2.33*	2.51	3.17	2.82
Caregiver widow stats					
Non-widows	3.13	2.38*	2.65	3.16	2.83
Widows	3.06	2.13*	2.60	3.22	2.75
Household locale					
Rural	3.10	2.33	2.66	3.19	2.82
Urban	3.08	2.09	2.54	3.20	2.72
Household placement type					
Has at-risk children only	3.01*	2.12	2.57	3.17	2.71*
Has reunified children	3.15*	2.36	2.66	3.20	2.84*

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

Table 94: Pearson's r correlations coefficients for parenting practices and caregiver/household characteristics – Kenya

	Parental involvement	Positive parenting	Freq. of spanking	Freq. of slapping	Freq. of hitting
Caregiver age	-.052	-.054	-.226**	-.243**	-.155**
Caregiver education	.190**	.040	.093	.039	.069
No. of adults in household	.022	-.045	-.099	-.036	-.057
No. of children in household	-.015	-.030	.124*	.050	.086

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

Table 95: T-tests comparing parenting practices by caregiver groups – Kenya

	Parental involvement	Positive parenting	Freq. of spanking	Freq. of slapping	Freq. of hitting
Caregiver sex					
Female	15.33	16.81*	0.95	0.56	1.01**
Male	15.44	15.54*	0.74	0.39	0.57**
Caregiver disability status					
Disability	13.86*	15.80	1.06	0.51	1.14
No disability	15.66*	16.77	0.88	0.63	0.90
Caregiver widow stats					
Non-widows	15.74	16.70	0.94	0.58	0.87
Widows	14.89	16.32	0.88	0.47	1.02
Household locale					
Rural	15.22	16.75	0.89	0.56	0.99
Urban	15.77	16.09	0.98	0.44	0.79
Household placement type					
Has at-risk children only	14.25**	16.14	1.04	0.62	1.09
Has reunified children	16.07**	16.87	0.84	0.48	0.86

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

Table 96: Pearson's r correlations coefficients for couples communication (CFAT) and caregiver/household characteristics – Kenya

	CFAT Total
Caregiver age	.159
Caregiver education	.135
No. of adults in household	.131
No. of children in household	-.125

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

Table 97: T-tests comparing couples communication (CFAT) by caregiver groups – Kenya

	CFAT Total
Caregiver sex	
Female	19.70
Male	22.07
Caregiver disability status	
Disability	20.91
No disability	20.31
Household locale	
Rural	20.95*
Urban	17.68*
Household placement type	
Has at-risk children only	20.19
Has reunified children	20.49

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

Table 98: Pearson's r correlations coefficients for economic stability outcomes and caregiver/household characteristics – Kenya

	Household Hunger Score	Degree of worry about money	Ability to obtain funds (KES 7,500) in emergency	Ability to obtain funds (KES 9,600) in emergency
Caregiver age	.107	-.034	-.016	-0.004
Caregiver education	-.080	-.008	.103	0.04
No. of adults in household	-.023	-.074	.046	0.04
No. of children in household	.135*	.047	-.010	-0.03

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

Table 99: T-tests comparing economic stability outcomes by caregiver groups – Kenya

	Household Hunger Score	Degree of worry about money	Ability to obtain funds in emergency (KES 7,500)
Caregiver sex			
Female	2.02	2.64	0.32*
Male	1.74	2.54	0.52*
Caregiver disability status			
Disability	2.82**	2.69	0.27
No disability	1.79**	2.61	0.38
Caregiver widow stats			
Non-widows	1.74**	2.55*	0.39
Widows	2.26**	2.71*	0.32
Household locale			
Rural	2.05	2.59	0.35
Urban	1.72	2.74	0.37
Household placement type			
Has at-risk children only	1.94	2.67	0.27*
Has reunified children	2.01	2.59	0.41*

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

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

	% who saved	% who did not save
Caregiver sex		
Female	37.1	62.9
Male	23.9	76.1
Caregiver disability status		
Disability	20.4*	79.6*
No disability	38.0*	62.0*
Caregiver widow status		
Non-widows	36.8	63.2
Widows	32.5	67.5
Household locale		
Rural	38.7*	61.3*
Urban	22.7*	77.3*
Household placement type		
Has at-risk children only	37.1	62.9
Has reunified children	33.9	66.1

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

Table 101: T-tests comparing means of caregivers who had been able to save any money - Kenya

	Mean amongst those who saved	Mean amongst those who did not save
Caregiver age	43.88*	47.81*
Caregiver education^	1.05	0.93
No. of adults in household	2.81	2.80
No. of children in household	3.67	3.57

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

Child well-being and child variables

Table 102: Pearson's r correlations coefficients for child well-being measures and child characteristics – children 2–10, Kenya

	Overall well-being	Overall health
Child age (all children)	.072	.102
Years in care (reunified children)	.262	.109
Age at reunification (reunified children)	.101	.217
Age at entrance to care (reunified children)	-.154	.183

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

Table 103: T-tests comparing child well-being measures by child groups – children 2–10, Kenya

	Overall well-being	Overall health
Child sex		
Female	1.63*	2.41*
Male	1.80*	2.92*
Child disability status		
No difficulties	1.71*	2.56**
With difficulties	1.42*	1.40**
Child placement type		
At-risk child	1.60***	2.17***
Reunified child	1.81***	3.09***
Child parental care status		
In non-parental care	1.71	2.80
In parental care	1.67	2.43
Child orphanhood status		
Non-orphan	1.64	2.40
Orphan	1.71	2.65

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

Table 104: Pearson's r correlations coefficients for child well-being measures and child characteristics – ALL children 11–18, Kenya

	Overall well-being	Overall life satisfaction	Community acceptance	Family acceptance	School belonging	Overall health
Child age	-.062	-.207**	-.114	.004	-.120	-0.01

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

Table 105: T-tests comparing child well-being measures by child groups – ALL children 11–18, Kenya

	Overall well-being	Overall life satisfaction	Community acceptance	Family acceptance	School belonging	Overall health
Child sex						
Female	1.46	6.09	1.47	1.87	3.14	2.38
Male	1.51	6.91	1.52	1.83	3.06	2.61
Child disability status						
No difficulties	1.50**	6.58	1.55*	1.86	3.15	2.57
With difficulties	1.35**	5.33	1.31*	1.78	2.90	2.13
Child placement type						
At-risk child	1.44	6.29	1.27***	1.84	3.09	2.11**
Reunified child	1.51	6.55	1.62***	1.86	3.12	2.68**
Child parental care status						
In non-parental care	1.49	6.47	1.62*	1.82	3.21	2.62
In parental care	1.48	6.46	1.43*	1.86	3.05	2.41
Orphanhood status						
Non-orphan	1.47	6.20	1.38*	1.88	3.08	2.12***
Orphan	1.49	6.54	1.59*	1.84	3.14	2.77***

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

Table 106: Pearson's r correlations coefficients for child well-being measures and child characteristics – reunified children 11–18, Kenya

	Overall well-being	Overall life satisfaction at survey	Change in life satisfaction	Community acceptance	Family acceptance	School belonging	Overall health
Child age	-.017	-.209*	-.033	.016	.020	-.119	-0.01
Years in care	.097	-.014	-.013	.087	-.059	-.100	0.20
Age at reunification	-.162	-.229*	-.119	-.077	-.021	-.201	-0.06
Age at entrance to care	-.237*	-.148	-.031	-.194	.044	-.093	-0.22*

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

Table 107: T-tests comparing child well-being measures by child groups – reunified children 11–18, Kenya

	Overall well-being	Overall life satisfaction at survey	Change in life satisfaction	Community acceptance	Family acceptance	School belonging	Overall health
Child sex							
Female	1.48	5.78*	-1.00	1.66	1.89	3.24	2.73
Male	1.52	7.03*	-0.85	1.60	1.84	3.04	2.652.
Child disability status							
No difficulties	1.53	6.60	-1.08	1.64	1.86	3.14	2.77*
With difficulties	1.38	5.92	0.33	1.53	1.81	3.01	2.08*
Child parental care status							
In non-parental care	1.50	6.42	-1.15	1.70	1.84	3.24	2.78
In parental care	1.51	6.65	-0.72	1.56	1.87	3.02	2.61
Child orphanhood status							
Non-orphan	1.55	6.33	-1.24	1.67	1.94	3.01	2.38
Orphan	1.49	6.48	-1.01	1.62	1.82	3.17	2.85

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

Moldova

Protective factors and caregiver variables

Table 108: Pearson's r correlations coefficients for caregiver protective factors and caregiver/household characteristics – Moldova

	Parental resilience	Social connections	Concrete assistance	Social/ emotional	Overall PFI
Caregiver age	-.340	-.283	-.352*	-.223	-.340*
Caregiver education	-.367	-.061	-.207	-.407**	-.266
No. of adults in household	.171	.252	.013	.074	.154
No. of children in household	.213	.327*	.212	.182	.270

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

Table 109: T-tests comparing caregiver protective factor mean scores by caregiver groups – Moldova

	Parental resilience	Social connections	Concrete assistance	Social/ emotional	Overall PFI
Caregiver disability status					
Disability	3.49	3.11	2.64	3.36	3.15
No disability	3.28	2.78	2.85	3.32	3.06
Caregiver widow stats					
Non-widows	3.37	2.88	2.82	3.33	3.10
Widows	2.87	2.50	2.81	3.31	2.86
Household locale					
Rural	3.20	2.63	2.70	3.25	2.95
Urban	3.62	3.46	3.21	3.58	3.47

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001. Note: Caregiver sex not used as a variable for Moldova data as only one caregiver was male.

Table 110: Pearson's r correlations coefficients for parenting practices and caregiver/household characteristics – Moldova

	Parental involvement	Positive parenting	Freq. of spanking	Freq. of slapping	Freq. of hitting
Caregiver age	-.176	-.104	-.125	-.070	-.077
Caregiver education	-.060	-.125	.059	-.017	-.105
No. of adults in household	-.082	-.070	.048	-.044	-.018
No. of children in household	.036	-.077	.087	.028	-.116

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

Table 111: T-tests comparing parenting practices by caregiver groups – Moldova

	Parental involvement	Positive parenting	Freq. of spanking	Freq. of slapping	Freq. of hitting
Caregiver disability status					
Disability	19.40	21.00	1.40*	0.20	0.20
No disability	18..93	20.62	0.49*	0.03	0.14
Caregiver widow status					
Non-widows	18.72	20.64	0.64	0.06	0.17
Widows	20.80	20.83	0.33	0.00	0.00
Household locale					
Rural	18.50	20.47	0.53	0.00**	0.16
Urban	20.56	21.30	0.80	0.20**	0.10

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001. Note: Caregiver sex not used as a variable for Moldova data as only one caregiver was male.

Table 112: Pearson's r correlations coefficients for couples communication (CFAT) and caregiver/household characteristics – Moldova

	CFAT Total
Caregiver age	-.394
Caregiver education	.069
No. of adults in household	.160
No. of children in household	.172

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

Table 113: T-tests comparing couples communication (CFAT) by caregiver groups – Moldova

	CFAT Total
Caregiver disability status	
Disability	21.75
No disability	23.19
Household locale	
Rural	21.44
Urban	25.67

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001. Note: Caregiver sex not used as a variable for Moldova data as only one caregiver was male.

Table 114: Pearson's r correlations coefficients for economic stability outcomes and caregiver/household characteristics – Moldova

	Household Hunger Score	Degree of worry about money	Ability to obtain funds in emergency	Ability to obtain funds in emergency (higher amount)
Caregiver age	.064	-.062	-.005	.046
Caregiver education	-.191	-.348*	.404***	.368*
No. of adults in household	-.161	.394**	-.052	-.181
No. of children in household	-.285	.043	-.046	-.054

Correlations statistically significant at *p<.05, **p<.01, ***p<.001. b. Cannot be computed because at least one of the variables is constant.

Table 115: T-tests comparing economic stability outcomes by caregiver groups – Moldova

	Household Hunger Score	Degree of worry about money	Ability to obtain funds in emergency
Caregiver disability status			
Disability	0.60	2.8	0.80
No disability	0.35	2.05	0.97
Caregiver widow stats			
Non-widows	0.33	2.39***	0.94
Widows	0.67	0.67***	1.00
Household locale			
Rural	0.50	2.00	1.00
Urban	0.00	2.60	0.80

Differences between means statistically significant at *p<.05, **p<.01, ***p<.001. Note: Caregiver sex not used as a variable for Moldova data as only one caregiver was male.

Table 116: Chi-squared tests of significance for distributions of caregivers who had been able to save any money – Moldova

	% who saved	% who did not save
Caregiver disability status		
Disability	0.00	100.00
No disability	18.92	81.08
Caregiver widow status		
Non-widows	19.44	80.56
Widows	0.00	100.00
Household locale		
Rural	18.75	81.25
Urban	10.00	90.00

Chi-squared test statistically significant at *p<.05, **p<.01, ***p<.001. Note: Caregiver sex not used as a variable for Moldova data as only one caregiver was male.

Table 117: T-tests comparing means of caregivers who had been able to save any money – Moldova

	Mean amongst those who saved	Mean amongst those who did not save
Caregiver age	31.86	45.06
Caregiver education^	1.57	1.54
No. of adults in household	2.00	2.29
No. of children in household	4.00	3.66

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

Child well-being and child variables

Table 118: Pearson's r correlations coefficients for child well-being measures and child characteristics – children 2–10, Moldova

	Overall well-being	Overall health
Child age	-.058	0.229

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

Table 119: T-tests comparing child well-being measures by child groups – children 2–.10, Moldova

	Overall well-being	Overall health
Child sex		
Female	1.53	1.81
Male	1.61	2.19
Child disability status		
No difficulties	1.70**	2.71***
With difficulties	1.43**	1.20***
Care Type		
Family care	1.58	2.29
Foster care	1.54	1.59
Child parental care status		
In non-parental care	1.54	1.77
In parental care	1.61	2.43
Child orphanhood status		
Non-orphan	1.59	2.23
Orphan	1.64	2.25

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

Table 120: Pearson's r correlations coefficients for child well-being measures and child characteristics – children 11–18, Moldova

	Overall well-being	Overall life satisfaction	Community acceptance	Family acceptance	School belonging	Overall health
Child age	-.411	-.344	-.474	.090	-.168	-0.20

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

Table 121: T-tests comparing child well-being measures by child groups – children 11–18, Moldova

	Overall well-being	Overall life satisfaction	Community acceptance	Family acceptance	School belonging	Overall health
Child sex						
Female	1.54	8.20	1.10	1.76	1.93	1.89
Male	1.61	8.44	1.21	1.91	2.24	1.00
Child disability status						
No difficulties	1.70	10.00	2.00*	2.00	2.58	2.00
With difficulties	1.56	8.08	1.03*	1.83	2.06	1.50
Care Type						
Family care	1.57	8.17	1.12	1.83	2.04	1.58
Foster care	1.66	9.5	1.50	2.00	2.67	1.50
Child parental care status						
In non-parental care	1.62	8.50	1.13	2.00	2.29	1.75
In parental care	1.57	8.11	1.27	1.78	2.02	1.44
Child orphanhood status						
Non-orphan	1.63	8.57	1.50	1.89	2.45	1.71
Orphan	1.52	7.60	0.88	1.76	1.73	1.60

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

Annex 2: Survey tool

Below is the generic survey tool. Please note that there were some differences in terminology depending on context. Full translations to Spanish, Romanian and Russian were provided. Translation of key terms to local languages in Kenya were provided.

Caregiver survey

Caregiver and household demographics questions

What is your marital status?

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

What is the highest level of education you have completed?

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

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

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

Washington Group Short Set on Functioning (WG-SS)

To view WG-SS questions go to https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/.

Services from CTWWC

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

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

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

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

How well prepared did you feel for the home visits to come to an end?

- (0) Not well prepared
- (1) Partially prepared
- (2) Fully prepared

Household economic stability questions

[The following three questions come from the *Parenting for Lifelong Health* evaluation.[55]]

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

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

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

If you were facing an emergency, how difficult would it be for your family to get 7,500 Kenyan shillings/550 quetzales/1,200 lei? (You could get it by using savings, borrowing money, selling belongings, reducing spending, or any other way you can think of.)

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

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

[From here to end of section, questions come from CRS COFE/SILC evaluation.[56]]

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

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

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

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

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

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

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

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

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

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

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

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

Household Hunger Scale (HHS)

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

How often did this happen in the past 30 days?

- (0) Rarely (1–2 times)
- (1) Sometimes (3–10 times)
- (2) Often (more than 10 times)

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

How often did this happen in the past 30 days?

- (0) Rarely (1–2 times)
- (1) Sometimes (3–10 times)
- (2) Often (more than 10 times)

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

How often did this happen in the past 30 days?

- (0) Rarely (1–2 times)
- (1) Sometimes (3–10 times)
- (2) Often (more than 10 times)

Parents' Assessment of Protective Factors (PAPF)

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

Response options:

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

Resilience subscale

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

Social connections subscale

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

Concrete assistance in times of need subscale

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

Social and emotional competency of children subscale

- I maintain self-control when my child misbehaves or doesn't listen.
- I help my child learn to manage frustration.
- I stay patient when my child cries or gets upset.
- I play or have a conversation with my child when we are together.
- I can control myself when I get angry with my child.
- I make sure my child gets the attention he or she needs even when my life is stressful.
- I stay calm when my child misbehaves or doesn't listen.
- I help my child calm down when he or she is upset.
- I am happy when I am with my child.

Alabama Parenting Questionnaire (APQ)

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

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

Response options:

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

Positive parenting scale

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

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

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

Corporal punishment questions

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

Couples Functionality Assessment Tools (CFAT)

Now I would like to ask you some questions about your relationship or marriage. Please tell me what you do when a problem arises in your relationship.

- We try to discuss the problem.
- We express our feelings to each other.
- We suggest possible solutions and compromises.
- We blame, accuse and criticize each other.
- We threaten each other with negative consequences.
- I call my partner names, swear at him/her or attack his/her character.
- My partner calls me names, swears at me or attacks my character.

Response options:

- (0) Very unlikely
- (1) Unlikely
- (2) Somewhat likely
- (3) Likely
- (4) Very likely

Caregiver report on the child

Child demographics and household structure

How are you related to [child name]?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Children's care history (for reunified children)

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

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

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

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

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

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

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

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

How often did that usually happen?

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

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

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

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

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

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

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

Washington Group UNICEF Child Functioning Module (CFM)

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

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

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

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

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

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

(4) Excellent

(3) Very good
(2) Good
(1) Fair
(0) Poor[Question from *Measure Evaluation OVC Surveys.*]

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

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

[Question from *Measure Evaluation OVC Surveys.*]

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

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

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

*Displayed for children ages 5–10 enrolled in school

Response options:

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

Child self-report survey on well-being

Child health

Would you say that in general your health is……?

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

Contextualized well-being tool developed through focus group discussions

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

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

- I feel I am supported by my relatives.
- I'm happy with how much time I get to spend with my family.
- I feel like I'm part of my family.
- I get love and care from my parents/caregivers.
- I'm treated differently from the other children in my household.
- I'm treated differently from other children in my village/neighborhood/compound/community.
- I am as happy as other kids my age.
- I have a comfortable place to sleep at night .
- My home has a good environment for studying.*
- I feel safe where I live.
- My home is peaceful.
- I have someone to ask for help if I feel unsafe.
- When I make a mistake, my parents/caregivers help me improve.
- I am afraid of what will happen if I don't listen to my parents/caregivers.
- My parents/caregivers treat me with respect.

*Displayed for children enrolled in school.

Response options:

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

Overall Life Satisfaction (OLS)

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

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

Family and community acceptance

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

Response options:

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

Community acceptance

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

- Old and young people in this community like you.

Family acceptance

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

School belonging

I'm finally going to read you six more statements about school. Please tell me how much you agree. You can say strongly agree, agree, neutral (neither agree nor disagree), disagree, strongly disagree.

- I feel like I belong at school.
- I make friends easily at school.
- Other students seem to like me.
- Most of the students in my class(es) are kind and helpful.
- If I have a problem at school my teachers will help me.
- My teachers care about me.

Response options:

- (0) strongly disagree
- (1) disagree
- (2) neutral
- (3) agree
- (4) strongly agree