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Changing THE WAY WE care SM

Understanding Caregiver Protective Factors and Child Well-Being Amongst Families with Experience of Alternative Care

Household Survey Summary - Kenya

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Changing the Way We Care: promoting care reform


Photo by Karen Kasmauski for CRS

Changing The Way We Care℠ (CTWWC), launched in 2018, aims to promote safe, nurturing family care for children by supporting the reform of national care systems. CTWWC focuses on preventing child-family separation, transforming residential care and developing family-based alternative care. Implemented by Catholic Relief Services (CRS) and Maestral International, the initiative collaborates with donors like the MacArthur Foundation, USAID, and the GHR Foundation, and partners with entities such as national governments and civil society organizations, and international agencies such as the Better Care Network.

Residential care's detrimental impact on children's development has driven many governments to adopt family care reforms. This movement is supported by global investments and advocacy from civil society and individuals with lived experience, promoting family-based alternatives and strengthening care systems. CTWWC operates within this context to enhance capacity and resources, demonstrating care reform components and family care models across diverse settings.

CTWWC's demonstration efforts focus on Guatemala, Kenya, and Moldova – each with its own unique mix of drivers of separation, types of care systems, histories of reform and levels of political commitment. This diversity has allowed CTWWC to compare across contexts and generate learning and evidence to inform for national, regional and international stakeholders.[i]

Care reform in Kenya and CTWWC's role

In recent years, Kenya's government, with support from UNICEF and many civil society organizations, including CTWWC Kenya, has made significant strides in promoting family care for children. The cornerstone of these efforts are the Child Act (2022) and National Care Reform Strategy (2022), developed under the leadership of the Cabinet Secretary responsible for children's care. The strategy outlines a decade-long plan for care reform across Kenya and was informed by detailed analyses from CTWWC Kenya and partners.

Since 2018, CTWWC Kenya has pioneered care reform demonstrations in Kilifi, Kisumu, Nyamira, and Siaya counties, chosen to reflect Kenya's diverse contexts. These demonstrations have provided valuable insights into the processes and impacts of care reform. Lessons learned in these locations are now informing a push towards a national scale. In the demonstration counties, CTWWC Kenya collaborated with government and civil society to support the reintegration of children from residential care back into family settings, with particular focus on those who returned home due to COVID-19 protocols. To prevent family-child separation, CTWWC Kenya has invested in family strengthening interventions, including case management, positive parenting, and economic support – all with a lens of disability inclusion.

The initiative's success has sparked interest in neighboring countries, leading to regional engagement and learning exchanges facilitated by CTWWC Kenya, CRS and UNICEF.

Methods

A key feature of CTWWC's theory of change is building evidence on children's care and reform, particularly regarding reintegration from residential care, transitions to family-based care, and preventing separation. Therefore, CTWWC has undertaken surveys with families supported by CTWWC's demonstration efforts, with the aim of providing insights for policymakers and practitioners on the impacts of interventions to support reintegrating families and those at risk of separation. To this end, the survey addressed 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 box 1) in their life?
- What proportion of children at risk of separation from their families or who have been reunified or placed in family-based care are experiencing positive well-being (see box 2)?
    - How might caregiver protective factors correlate with child well-being?
    - How has the perceived well-being of children changed after their engagement with CTWWC?

Box 1: What do we mean by protective factors?

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:

- **Caregiver resilience***:* Managing stress and functioning well when faced with challenges, adversity and trauma.
- **Social and emotional competence***:* Caregiver-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.

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

The survey tool was developed in 2021, combing validated measures (including on disability, parenting skills, protective factors, hunger etc.), with a new measure on child well-being with input from children and young people in Guatemala and Kenya (see box 2). For Kenya the tool was adapted to fit the local context by adjusting terminology and phrasing of some questions and responses. The survey tools remained in English with key terms provided into Kisii, Luo and Kiswahili to allow for flexible translating as appropriate for each respondent.

There were three main components to the survey:

1. a section for primary caregivers to respond to about themselves and their household covering demographics, protective factors, parenting and economic stability,
2. a section for caregivers to respond to about the child in their care who had been reunified or placed in their care from residential care, or a randomly selected child if the family was receiving support to prevent separation covering child's demographics, disability, care history, health and education, and
3. a section for children aged 11 years and older to respond to about their health, education, well-being, and family and community acceptance.

Selection, invitation and informed consent procedures were undertaken in line with approved protocols (Boston College and Maseno University Institutional Review Boards). In Kenya, all households where a child had been supported by CTWWC after reunification from residential care in Kilifi, Kisumu and Nyamira counties were eligible for the survey, plus a random sample of households supported by CTWWC to prevent separation in Siaya county. In total, 321 caregivers were invited into the survey, of which 278 (87%) participated. Data was provided on 358 children by their caregiver, 232 were reintegrating from residential care and 126 were index children in households supported to prevent separation. In addition, 216 children aged 11 and over were identified to participate as respondents, of whom 166 (77%) completed the

survey. There were 156 caregivers and 180 children, supported as they reintegrated from residential care, who responded to surveys at both 2021 and 2023. Their responses were included in the analysis looking at change over time.

Amongst the caregivers who participated: 84% were female, the average age was 46 (although 22% were over 60), 18% had a disability, 46% were widowed and 41% were married, and 80% only had primary-level education. Amongst the children, 58% were female, the average age was 13 and two-thirds were teenagers, and 11% had a disability.[ii] About half of the primary caregivers were the child's mother and another 18% were grandparents. About 53% of the children had lost one or both parents.

Box 2: What do we mean by child-wellbeing?

The field of well-being research has seen two important developments in thinking in recent years:

- human well-being is multifaceted, made up of various aspects and domains, and
- the salient domains of well-being may differ by context and life circumstances.

For this reason, CTWWC sought to combine several measures of well-being and to be guided by children and young people who themselves had experience alternative care and reintegration. Workshops with them highlighted the need to consider both common domains of well-being such as health, happiness, basic needs and education, as well as other which are sometimes overlooked by adults or those without experience of alternative care such as freedom, choice of food, family belonging, community support, and feeling safe and peaceful at home.

For more information on how the child-wellbeing tool was developed please see: 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 and further analysis in the linked journal publication: "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" in Child and Adolescent Social Work Journal doi.org/10.1007/s10560-024-00968-x

Findings

The support received was helpful in the care of children, but some initial case closures were not well prepared. Caregivers in Kenya were very positive about the services they received (figure 1). This included home visits and cash transfers which had been underway for several years, as well as more recently introduced groups interventions such as parenting training, savings and loans groups and financial education using 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 (figure 2).

Figure 1: Helpfulness of CTWWC support, mean score
(scale 0–2, 0=didn't help, 2= helped a lot)

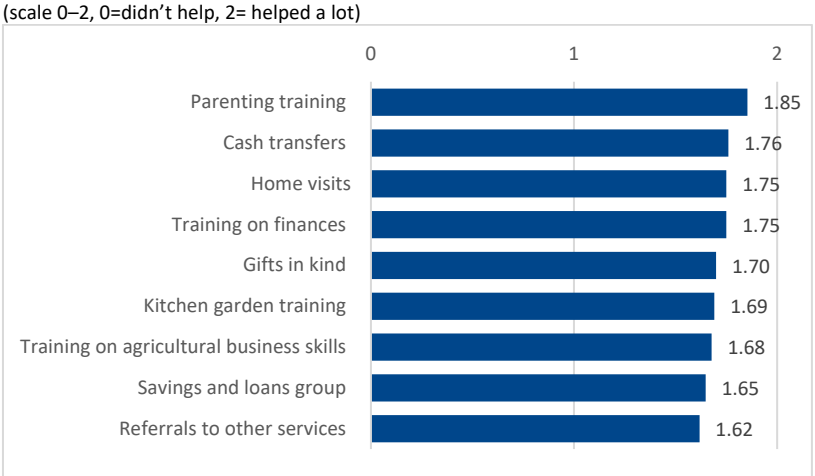
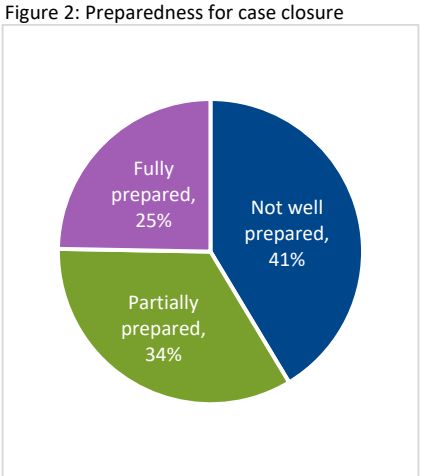


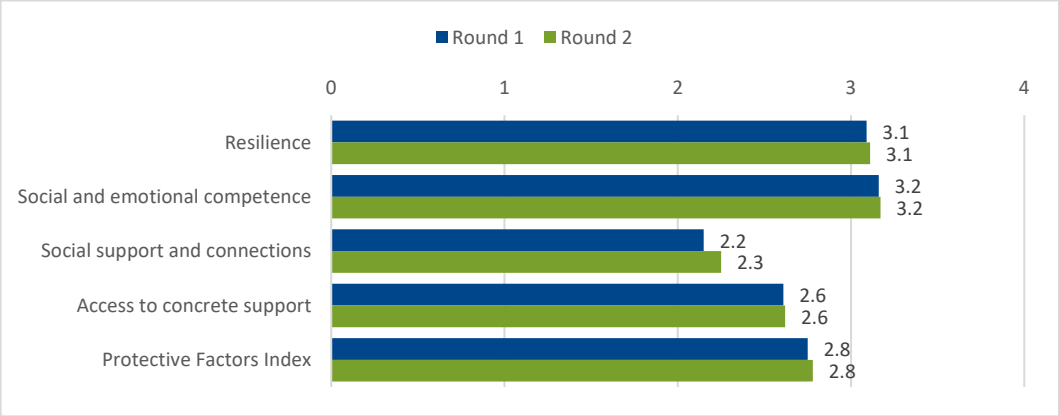
Figure 2: Preparedness for case closure



Protective factors were generally high amongst caregivers, with indications of areas for additional support to build economic stability.

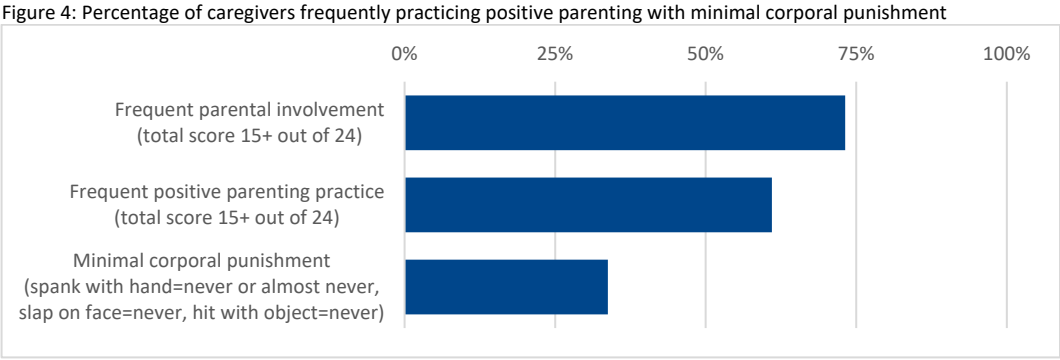
- Caregivers reported a high sense of internal resiliency and social and emotional competency, with lower levels of the external-facing social connections and ability to get concrete assistance (figure 3). These levels remained consistent between the two rounds of the survey. While this bodes well for the internal resilience of Kenyan families, 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, paying particular attention to male caregivers, widows and caregivers with a disability – for whom some protective factors were weaker.[iii]

Figure 3: Caregiver protective factors, mean score (scale 0-4, with 4 = greater protective factors)



- Most caregivers reported frequent use of positive parenting techniques (figure 4). These were more common amongst women, whilst caregivers with a disability and those with less education were less frequently involved with their children.[iv] 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. One third of caregivers reported hardly ever using corporal punishment (figure 4). But it is still used regularly by another third of caregivers. The importance of alternative discipline methods 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.[v]

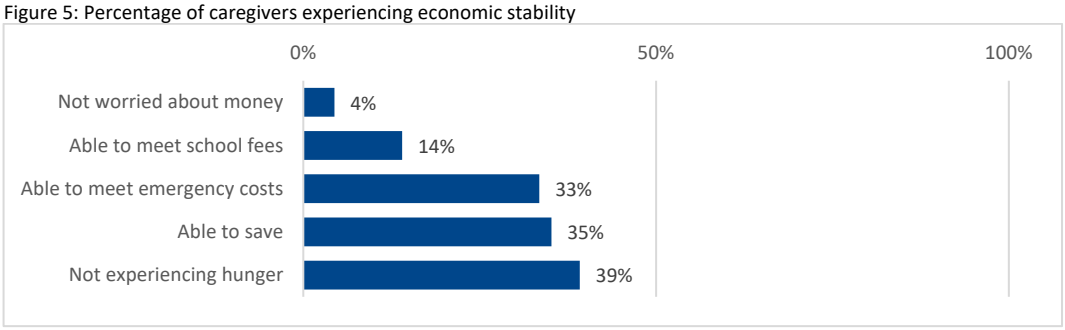
Figure 4: Percentage of caregivers frequently practicing positive parenting with minimal corporal punishment



- In terms of economic stability, nearly all caregivers are worried about their financial situation (figure 5), which had worsened between the two rounds of the survey. Two-thirds of households also experienced moderate hunger (figure 5). This reflects the overall economic situation in Kenya which until the COVID-19 pandemic was one of the fastest growing economies on the African continent and had reached lower-middle income status as a country.[vi] However, significant challenges to sustainable and inclusive economic growth were exacerbated by economic disruptions caused by the pandemic, ongoing corruption and economic. This situation clearly impacted children's education with over 80% of families in the survey not being able to meet school expenses, with three quarters also reporting that children had missed school as a result. Nonetheless, a remarkable one-third of caregivers were able to save money – a practice encouraged by the local savings and loans groups set up by

CTWWC Kenya – and a quarter could meet costs in an emergency (figure 5). There is evidence to suggest that women caregivers, widows and those with a disability were less economically stable.[vii] However, when taken together with the results on protective factors (above) and child well-being (below), these findings suggest that even in an economically strained context, when families have strong protective factors, they are buffered against stressors in their environment and can still keep their children safe and cared for.

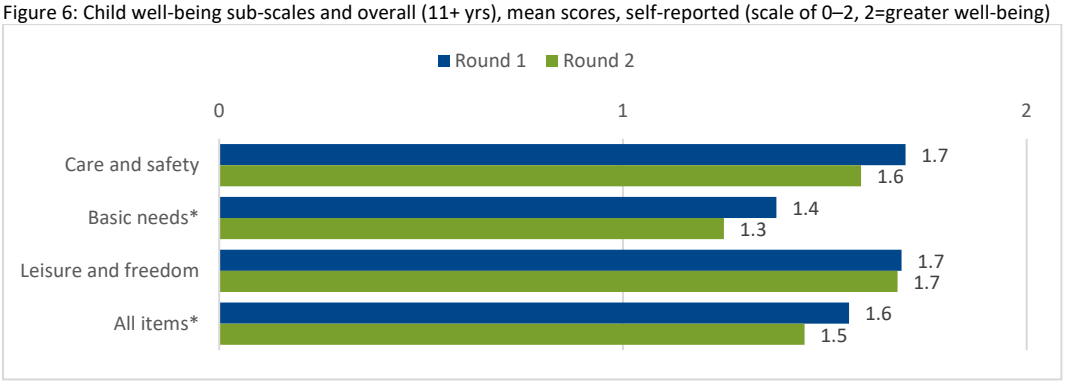
Figure 5: Percentage of caregivers experiencing economic stability



Children's health and well-being were reported to be generally positive, with some elements of concern around food and education. Children aged over 11 reported their well-being as positive, especially for care and safety, and leisure and freedom, but they felt they were missing out in terms of their basic needs. The basic needs subscale significantly dropped between the two rounds of the survey (figure 6) – this subscale includes aspects of food, school, health and hygiene. Children with disabilities reported lower well-being than those without disabilities.[viii] Amongst both children aged 2–10 and those aged over 11 years, concerns were raised about having enough food to eat and adequate materials for school, mirroring findings from caregivers about the struggle to pay school fees and in children's school enrolment dropping between round 1 and 2 of the survey, although it is still at a high level (88%).

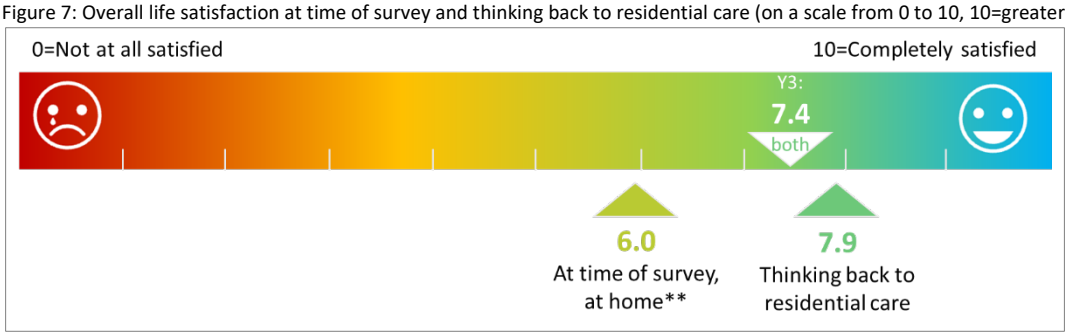
For children reintegrating from residential care, the concern about food and education is likely to be reflected in a reduction in their overall life satisfaction between the two survey rounds. In round 2 children were reporting life in residential care to be slightly more satisfying than at home, with a significant drop in their sense of satisfaction at home (figure 7). Children with disabilities also reported significant lower life satisfaction at home than children without disabilities.[ix] This is a concern which highlights the importance of continued support for families where a child is reintegrating, especially to meet their basic needs and ensure access to quality education. Further investigation is needed to understand these results, but it is likely that children had access to more regular meals, school supplies, clothing and other basic needs in residential care compared to at home. This is a call to residential care providers to consider transitioning their programming to services that help the children in families and communities. Since the survey also revealed that many families remain in contact with residential care providers, this suggests good connections and potential understanding of the communities' needs and dynamics.

Figure 6: Child well-being sub-scales and overall (11+ yrs), mean scores, self-reported (scale of 0–2, 2=greater well-being)



Significance levels of change between rounds: * p<.05

Figure 7: Overall life satisfaction at time of survey and thinking back to residential care (on a scale from 0 to 10, 10=greater satisfaction)



Significance levels of change between rounds: ** p<.01

Caregiver protective factors are significantly linked with children's well-being. Children in families where their caregivers reported stronger protective factors, especially internal resilience and social and emotional competency, have a higher sense of well-being and of family and community acceptance. Children's well-being and sense of acceptance is also positively correlated with more frequent practice of positive and involved parenting by their caregivers. This shows the importance of investing in family strengthening and support as a critical part of undertaking reintegration from residential care, alternative family-based care and prevention of family-child separation.

Recommendations

Initial recommendations that have emerged through engaging with the survey findings include:

- **Case management remains crucial** in providing alternative family-based care, reintegration, and family strengthening, especially for those at high risk of separation. This approach enables social workers to address the diverse strengths and needs of children and caregivers. During the process of reintegration, it is critical to ensure that adequate time is taken to prepare both the child and their family members for the next steps in the process. Therefore, it is important to invest adequately in the workforce to ensure caseloads are manageable, procedures can be followed and there is adequate time for every step in the process, including safe case closure.
- **Disability inclusion must be prioritized** in the design and implementation of family care and strengthening services to ensure children with disabilities and children cared for by caregivers with disabilities are not left behind during the transition away from residential care and so that they can fully benefit from family support programs to prevent (re)separation.
- **Family strengthening must include linkages to social protection schemes and access to quality education** to overcome the pull of residential care as a way for families to provide basic needs and educational opportunities for their children. As the Kenyan government continues to encourage the transition of residential care providers towards family and community support programs these should consider economic strengthening and school opportunities.
- **Community engagement can strengthen reintegration and family care** efforts by building understanding of the experiences of children in care amongst communities, schools, faith leaders, and service providers to reduce stigma and promote acceptance, particularly for children with disabilities. Group interventions like parenting schools and savings groups can help build key skills as well as social connections amongst families.
- **A protective factors framework and strengths-based approach** is critical to empowering families and has been shown to be strongly linked to child well-being. They should continue to frame care reform policies, practice and research.
- **Investment in evidence-generation alongside practice is needed** to inform care reform practices and policies. This should include dedicated research projects, centered on the experiences of children and their families, as well as through routine administrative data and national surveys. Research should focus on care practices and on linkages to other sectors such as health, early childhood development and education. CTWWC should aim to undertake another round of their household survey to understand the situation of children and families further into their reintegration journey in the Kenyan context.

Cross-Country Conclusions

CTWWC undertook this survey in three countries: Guatemala, Kenya, and Moldova. Looking across the different contexts revealed some interesting conclusions.

- **Women hold the responsibility for child rearing**: In all three countries, women overwhelmingly serve as primary caregivers, underscoring the need for programs that support women in these roles and promote equitable male involvement in caregiving.
- **Caregiver education level is often low**: Many caregivers have only primary education, plus lower education correlated with lower financial stability. This suggests a need for parenting materials and economic strengthening approaches to be targeted for those with lower education levels.
- **Disability plays a significant role**: Outcomes vary significantly for children and caregivers with disabilities, including lower community acceptance and economic stability and greater isolation – highlighting the need for inclusive support and family-based care.
- **Local context can make a difference to protective factors:** In Kenya, social isolation was felt more by caregivers in urban areas than rural areas, while in Moldova and Guatemala, social connections were higher in urban areas. Family strengthening approaches must be tailored to urban and rural settings within each country.
- **Navigating case closure needs special attention**: Families' sense of preparation for case closure varied widely, indicating a need for a focus on this critical point of a case management process, with more enhanced and consistent processes needed.
- **Drivers of separation must be addressed across the continuum of care**: Children often enter residential care due to factors like education access and disability, emphasizing the need for targeted early intervention, cross sectoral efforts and accessible family-based alternatives.
- **Family strengthening support is valued**: Varied family strengthening strategies were highly appreciated, including parenting support and cash transfers in all three countries. Integrated case management and service referrals, where consistently implemented, also show positive outcomes for families.
- **Research on children's care is complex and needs investment**: Research on care outcomes is complex due to individualized case management processes and ethical constraints. Involving children in the process has provided valuable insights. This underscores the need for creative, well-resourced approaches to generate reliable evidence for care strategies.

Detailed reports on both rounds of the survey - in Year 3 (2021) and Year 5 (2023) of the CTWWC initiative, can be found in the Better Care Network library at:

- https://bettercarenetwork.org/library/social-welfare-systems/data-and-monitoring-tools/year-3-review-guatemala-and-kenya-household-survey
- https://bettercarenetwork.org/year-5-household-survey-understanding-caregiver-protective-factors-and-child-well-being-amongst

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Notes

[i] Please visit changingthewaywecare.org and bettercarenetwork.org/about-bcn/what-we-do/organizations-working-on-childrens-care/changing-the-way-we-care for more information

[ii] This is based on the Washington Group/UNICEF Child Functioning Module which is used for analysis of survey results.

[iii] Male caregivers had slightly lower social emotional scores compared to female caregivers (male 3.02, female 3.23, p<.05). Caregivers with a disability had slightly lower social connection scores compared to those without a disability (with a disability 2.00, without a disability 2.33, p=.05), as did caregivers who had been widowed compared to those were not widows (widows 2.13, non-widows 2.38, p<.05).

[iv] Female caregivers practiced positive parenting more frequently compared to male caregivers (female 16.81, male 15.54, p<.05). 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). The higher a caregiver's education level, the more likely they were to be involved with their children (r=.190, p<.01)

[v] The more children in the household, the more frequently the caregiver used spanking (r=.124, p<.05). 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). Female caregivers hit with an object more frequently than male caregivers (1.00, male 0.57, p=<.01).

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

[vii] Widows worried more about money than those who were not widowed (widow 2.71, non-widow 2.55, 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). 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). 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).

[viii] Children with a disability reported lower levels of well-being (with functional limitations 1.35, without functional limitations 1.50, p<.01).

[ix] Overall life satisfaction was lower for children with a disability compared to those without (with functional difficulties 1.35, without functional difficulties 1.50, p<.01).

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

Changing The Way We Care℠ (CTWWC) is implemented by Catholic Relief Services and Maestral International, along with other global, national and local partners working together to change the way we care for children around the world. Our principal global partners are the Better Care Network and Faith to Action. CTWWC is funded in part by a Global Development Alliance of USAID and the GHR Foundation.

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