CARE SYSTEM STRENGTHENING LEARNING SYNTHESIS

A realist evaluation of the Changing the Way We Care initiative in Guatemala, India, Kenya and Moldova

GHR FOUNDATION | Changing THE WAY WE care | CRS CATHOLIC RELIEF SERVICES | Maestral.

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Changing The Way We Care℠ (CTWWC) was 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 currently funded in part by Catholic Relief Services and the GHR Foundation.

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Contents

List of Acronyms

CCI	Charitable Children's Institution
CCF	Child Community Family (Moldova)
CIMO	Context, Intervention, Mechanism, Outcome
CoP	Community of Practice
CTWWC	Changing the Way We Care
EU	European Union
M&E	Monitoring and Evaluation
MEAL	Monitoring, Evaluation, Accountability and Learning
MIS	Management Information System
MLSP	Ministry of Labor and Social Protection (Moldova)
MoU	Memorandum of Understanding
NCCS	National Council for Children Services (Kenya)
NGO	Nongovernmental Organization
NPCP	National Program for Child Protection (Moldova)
OMNA	Municipal Office for Children and Adolescents (*Oficina Municipal de Niñez y Adolescencia*, Guatemala)
P4EC	Partnerships for Every Child (Moldova)
PPM	Municipal Public Policy (*Política Pública Municipal*, Guatemala)
PGN	Attorney General's Office (*Procuraduría General de la Nación*, Guatemala)
RESTART	Public Administration Reform (*Reforma sistemului de asistență socială*, national governance reform initiative, Moldova)
SBS	Secretariat for Social Welfare (*Secretaría de Bienestar Social,* Guatemala)
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Evaluation Summary

Introduction

Changing the Way We Care[SM] (CTWWC) is a global initiative aimed at promoting safe, nurturing family care for children through collaboration between families, communities, governments and other stakeholders. Since 2018, CTWWC has focused on reforming national care systems, strengthening family care, reunifying separated children and transitioning care services in Guatemala, India, Kenya and Moldova, with a smaller project in Haiti. The initiative has contributed to increased momentum and learning around care reform and a growing interest in long-term system strengthening.

CTWWC promotes sharing of good practices at local, national, regional and global levels. This includes subnational demonstrations of support to children and families, national system reforms, regional networking and sharing, and global collaboration. Demonstration countries were chosen based on criteria such as geographic diversity, socioeconomic status, governmental commitment and civil society engagement. Evaluations in year three and year five assessed the initiative's success in informing and influencing care reform. This evaluation aims to synthesize learning from the four demonstration countries to inform future care system strengthening efforts and support governments and their partners.

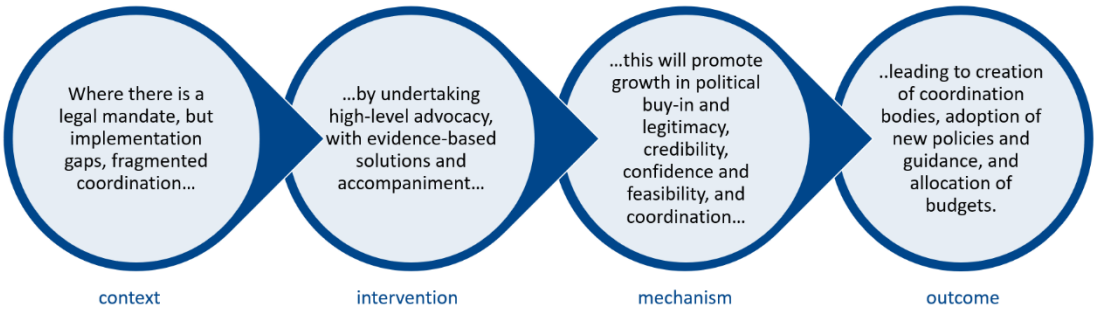
Methodology

The evaluation aims to gather data from each demonstration country, reflect on these experiences, and identify commonalities and differences to develop a theory of care system strengthening. Using a realist framing, the evaluation seeks to understand what works for care system strengthening (i.e., how, for whom, and why). Realist evaluations seek to understand how context influences hidden change processes, known as mechanisms, to reach outcomes. This evaluation uses context-intervention-mechanism-outcome (CIMO) configurations to present the findings. The evaluation also uses care system components—legislation, workforce, financing, monitoring and evaluation (M&E), social norms and service delivery—as a frame for analysis, as well as the Six Conditions of Systems Change model to look for hidden factors like relationships, power dynamics and mental models. The methodology follows a realist evaluation process of highlighting original theories of change from document reviews, reviewing Outcome Harvesting data, conducting interviews, and refining theories through group analysis and discussion.

Findings

Legislation, policy and coordination

Legislation supporting family-based care existed in the demonstration countries, but had gaps in policy, guidance and implementation. High-level advocacy, evidence and strategic partnerships were crucial for achieving change in policies and strategies. Government coordination at national and subnational levels was crucial for reforms to gain traction. In Moldova, legal and policy reform tied to European Union (EU) accession led to significant progress in deinstitutionalization planning. In Kenya, the National Council of Children's Services formed a Care Reform Core Team, and Guatemala's Foster Care Working Group exemplified shared accountability across multiple agencies. Subnational leadership in Guatemala, such as in Río Hondo, demonstrated the power of local data and models to motivate policy



adoption. Changes in legislation and policy were closely linked to service delivery changes, with many outcomes dependent on shifts in legal and regulatory frameworks.

Social service workforce

Systemic changes in the social service workforce for children's care emerged through capacity-building, partnerships and demonstrating success, which reduced resistance, shifted beliefs and established new norms. In Guatemala, Kenya and Moldova, initial resistance from key workforce members was addressed through targeted capacity-strengthening interventions, including multi-stakeholder working groups, training, advocacy and peer learning exchanges. For example, in Kenya, CTWWC collaborated with the Directorate of Children's Services to deliver case management training and supportive supervision. These efforts built confidence, shifted beliefs, and established trust and legitimacy through government engagement. In Moldova and Guatemala, the workforce experienced changes and expansions in roles, with new specialized roles created to match changes in services. Successful outcomes included initiating specialized services, adopting or improving care guidelines, and transitioning residential care providers to community-based services. Joint interventions with government, academia and practitioners embedded knowledge and practice within formal systems, enabling long-term adoption focused on family-based care and family strengthening aligned with national strategies and plans. Changes in the workforce were closely linked to changes in service delivery, financing and M&E outcomes.

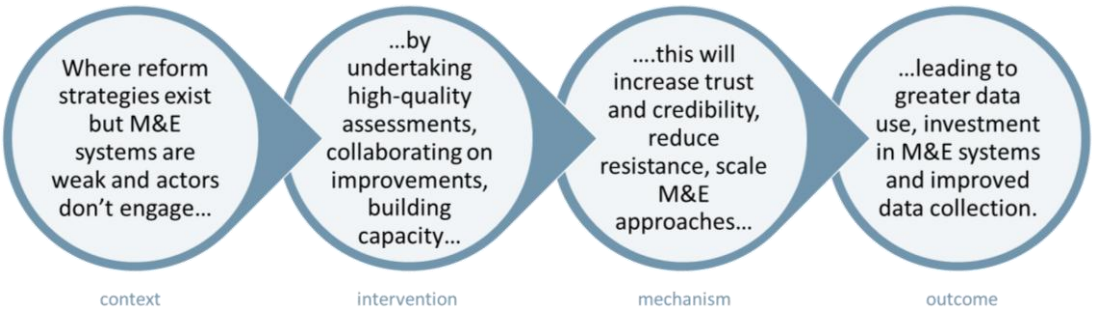
Financing

Change began with evidence-based advocacy, technical assistance, demonstration pilots, and engagement with financial authorities and private, faith-based donors. In Moldova, cost–benefit analyses and EU-aligned advocacy convinced decision-makers that family-based care was economically efficient and politically advantageous. The Ministry of Labor and Social Protection increased allocations for family support services, foster care and disability-focused programs. In Odisha, India, simplified tools and communication materials helped district officials allocate funds toward prevention and family-based alternative care. In Kenya, technical assistance to subnational governments created a model for localizing national mandates, enabling dedicated funds for care reform. In Guatemala, data-driven advocacy reduced perceived risks for municipal leaders, leading to budget allocations for child protection offices. In Tamil Nadu, India, engagement with faith leaders legitimized new approaches, leading parish committees to provide support for vulnerable families. Shifts in financing took longer, illustrating the importance of policy, workforce and M&E changing first.

Evidence and M&E

Finding opportunities within wider reform efforts that required new or improved data was key to achieving change in evidence and M&E. In Kenya and Moldova, early assessments engaged stakeholders, especially government, in driving

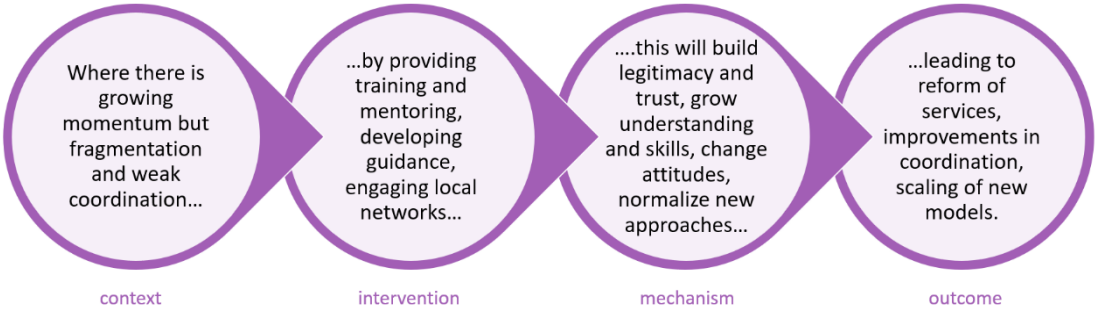
reforms. In Kenya, a situational analysis of residential care providers, conducted openly with government leadership, built trust and led to wide engagement and replication in other counties. In Moldova, deep-dive analyses and improved children's assessments led to further assessments and ongoing data collection. When senior officials requested new data, it allowed for prioritizing system improvements. In Kenya, rapid data collection during COVID-19 highlighted gaps, leading to improvements in the Child Protection Information Management System. In Moldova, high-level meetings led to significant decisions on deinstitutionalization and monitoring improvements. Embedding new data collection within official systems, with government input, legitimized reforms. Building awareness and providing training, supportive



supervision, and peer learning opportunities all built confidence in using new methods. Pilots and joint problem-solving reinforced confidence and commitment to data collection and use, linking it to case management improvements. Changes in evidence and M&E were closely linked to shifts in policy, workforce and financing.

Service delivery

Change to service delivery was achieved in various ways across the four countries, most commonly by building the knowledge and skills of service providers through practical training and mentoring. Capacity strengthening in case management, reintegration, prevention and family support was universal and often an early intervention. Changing beliefs about alternative care was key to shifting practices. Standardized processes, clear tools and supportive supervision helped strengthen confidence, consistency and quality in service delivery. All of the demonstration countries pursued a subnational pathway first, using demonstration areas to showcase practices for future scale-up. This localized approach empowered actors, fostered ownership and created local champions—such as departmental leaders in Guatemala, children's officers in Kenya and nongovernmental organizations (NGO) in Moldova and India. Relationship building and networking were also critical to increasing trust, coordination and shared agendas. In Kenya, revitalized local networks supported multi-sector collaboration and uptake of improved services. In Guatemala, local commissions brought together the Secretariat for Social Welfare (*Secretaría de Bienestar Social* [SBS]) and civil society, improving referrals and legitimacy. In Moldova, conferences and task forces built shared commitment among ministries, authorities, NGOs and donors. Government buy-in was essential for institutionalizing new practices through embedded tools, policies and processes. Alignment between political and administrative levels enabled consistent service delivery, coordination and reallocation of resources, as seen in municipal prevention funding in Guatemala and deinstitutionalization planning in Moldova. Finally, evidence, international good practice and demonstration through local pilots persuaded stakeholders to adopt and sustain new approaches. Changes in service delivery were closely tied to shifts in financing and workforce capacity, emphasizing the interdependence of funding, skills and sustainable service improvement.



Conclusions

When considering the findings all together, clear themes emerged on how systems strengthening unfolds across contexts, including:

- **Evidence and demonstration as catalysts**: In all components, evidence-based advocacy and pilot models or demonstrations were critical.
- **Government ownership as critical to reinforce, scale and sustain change**: Reforms gained traction when government actors assumed visible leadership roles and endorsed guidance and tools.
- **Partnerships and multi-stakeholder collaboration as foundations for legitimacy and accountability**: Across all areas, diverse coalitions created legitimacy, accountability and momentum.
- **Capacity building as an entry point**: Training, mentoring, technical accompaniment and peer learning were effective strategies that built skills, shifted attitudes and increased trust and confidence.
- **Alignment with broader agendas and values as frameworks for change**: Change was unlocked by framing reforms within existing priorities or norms. Aligning with what already mattered politically, economically and/or morally created powerful incentives for change and scaling of models.
- **Adaptive problem-solving in complex systems as critical for navigating challenges**: Progress often required navigating blockages, requiring flexibility, collectively seeking alternative pathways and engaging with champions or leaders.
- **Inter-linkage of system components as necessary for long-term change**: Changes in one component of the system affects others, highlighting the importance of a multi-component, long-term approach to system strengthening.

From the perspective of CTWWC, as an initiative seeking to support and inform care reform, it is clear that supporters of care reform need to embrace adaptive management and recognize that not all plans are feasible in practice. A suitable monitoring approach must be found to track and learn about systems change, and then to share that learning.

Recommendations

The following key recommendations are shared for governments leading care reform efforts and for agencies and organizations supporting system strengthening for children's care.

For **governments:**

- Embed family care in policy, budgets and broader agendas.
- Strengthen coordination structures.
- Institutionalize participation of people with lived experience.
- Invest in the social service workforce.
- Institutionalize evidence building and learning.
- Adopt a whole-of-system approach.

For **organizations** supporting governments:

- Align with government leadership and national strategies.
- Strengthen capacity and accompany.
- Facilitate and utilize the engagement of people with lived experience.
- Leverage demonstration and evidence generation.
- Mobilize and redirect private resources.
- Champion social norms and mindset change.
- Support integrated systems strengthening.

Lastly, for the wider **care reform sector:** It is more critical than ever to continue to increase global understanding of what works, in what contexts, and why. Let's continue to contribute and share experience across contexts. Change can happen for all children!

Introduction

Changing the Way We Care℠ (CTWWC) is a global initiative designed to promote safe, nurturing family care for children that also acknowledges the need for collaboration between families, communities and governments and regional and global stakeholders. Since 2018, the initiative has focused on the reform of national systems of care for children, strengthening family care, reunifying separated children and families, and transitioning care services. Grounded in demonstration country work in Guatemala, India, Kenya and Moldova, and with a smaller project in Haiti, CTWWC has contributed to increased momentum and learning around care reform, and advanced a growing interest in long-term system strengthening.

CTWWC was designed to promote sharing of good practices between local, national, regional and global levels of operation and influence, including:

- Subnational demonstration of support to children and families, community engagement and transition of care models, all of which have been assessed and documented in order to scale good practices and inform national reforms.
- National system reform covering all components of legislation and policy, workforce, financing, monitoring and evaluation (M&E), social norms and service delivery to enable subnational change and monitored to inform learning that can be shared regionally and globally.
- Regional networking, sharing of learning and transfer of good practices to influence and promote collaboration and system reform in neighboring countries.
- Global collaboration and sharing to build momentum for care reform around the world.

At the inception of CTWWC, demonstration countries were chosen based on criteria including geographic diversity, socioeconomic status, governmental commitment, regional influence, civil society engagement and factors affecting children and family welfare. The vision was to demonstrate change in diverse settings and to synthesize the learning so that actors seeking to understand how care reform unfolds would be able to adapt and apply the learning to any context. Although CTWWC was implemented in fewer countries than originally planned, the commitment to strong M&E in the four main demonstration countries means that there is enough learning to begin to inform a synthesis process.

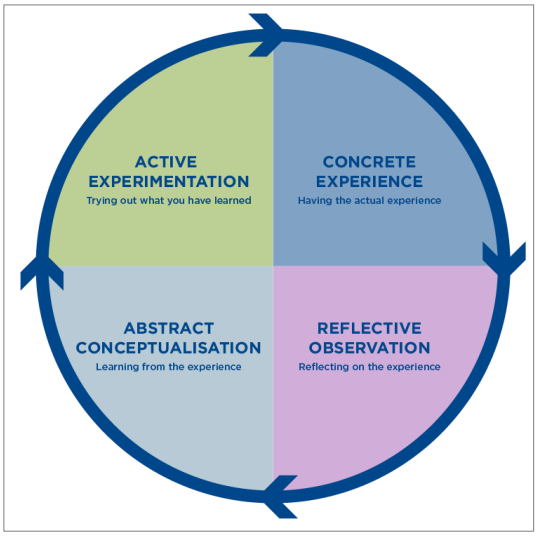
Evaluations undertaken in year three and year five[1] of the initiative assessed the success of the initiative in informing and influencing care reform, and annual and life of award reports[2] captured many details of implemented activities. This evaluation seeks to synthesize the processes of change in each of the four demonstration countries and present commonalities and differences that will be of use to others working on reforming and strengthening children's care systems so that all children can grow up in safe, nurturing family care.

[1] CTWWC (2023) Final Report: Changing the Way We Care Year 5 Evaluation https://bettercarenetwork.org/library/social-welfare-systems/child-care-and-protection-system-reforms/final-report-changing-the-way-we-care-year-5-evaluation.
[2] CTWWC (2024) Life of Award Report October 2018–March 2024 https://bettercarenetwork.org/life-of-award-report-october-2018-march-2024.

Approach and Methodology

Realist evaluation approach to system strengthening

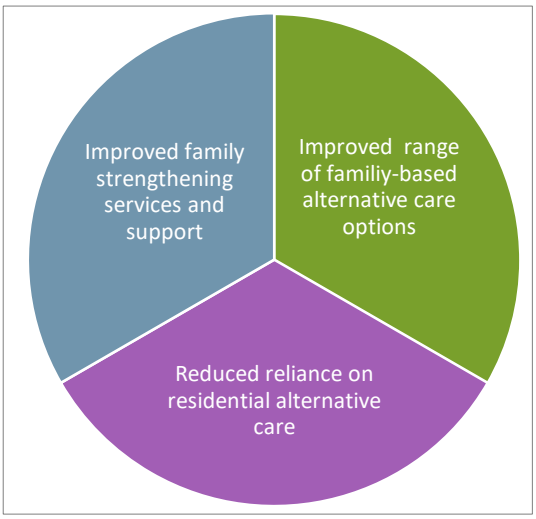
Figure 1: Kolb's learning model



The CTWWC year 5 evaluation highlighted the importance of following an experiential learning model such as Kolb's[3] (Figure 1) where experiences are reflected on and abstract conceptualizations are created in order for them to be tried in new contexts and new ways. This model was used within CTWWC's demonstration country implementation to inform scaling of local interventions, but it is equally applicable across countries when thinking about a whole system. Therefore, this evaluation set out to gather data on the experiences of each demonstration country, create space to reflect on and discuss these experiences, and identify commonalities and differences in order to develop a theory (or abstract concept) of care system strengthening that can inform wider efforts around the world. The aim of the evaluation fits well with a realist evaluation approach,[4] which is designed to help understand how the results of complex interventions have been influenced by the context in which they are implemented in order to produce policy recommendations that can be transferred across contexts.[5] Therefore, using a realist framing, the evaluation set out to answer the question: **Using the experience of CTWWC's demonstration countries, Guatemala, India, Kenya and Moldova, what works for care system strengthening? How, for whom and why?**

Within the CTWWC initiative, **care system strengthening** (or care reform, Figure 2) is understood to be a gradual process of moving a care system toward greater provision of family strengthening services and support, including a range of family-based alternative care options and the gradual reduction of the use of residential alternative care. The ultimate goal is more children living in safe and nurturing family care.

Figure 2: Care reform goals



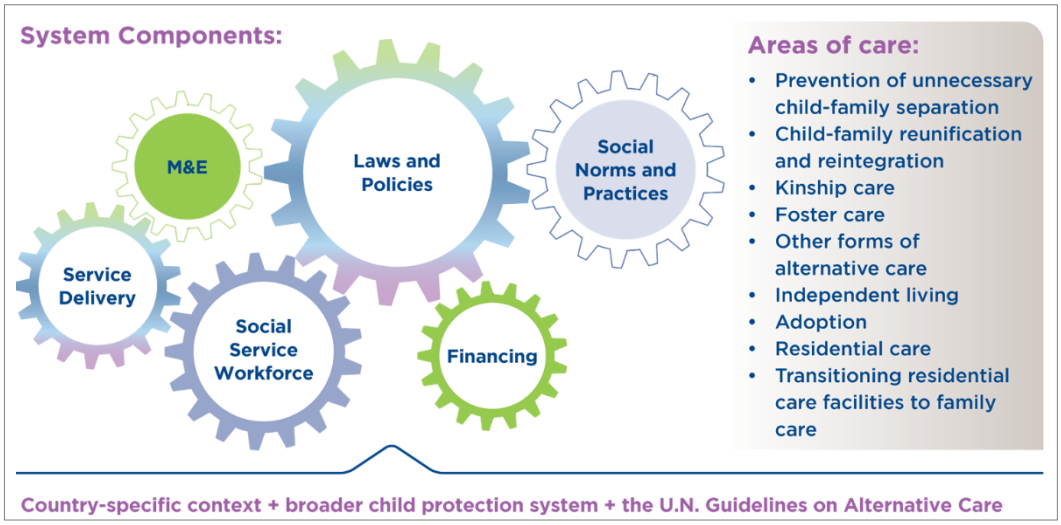
A system strengthening approach "requires various elements or components of a system … to work in tandem to deliver results for children. For the system to work, individual parts of the system need to be strengthened while also strengthening the relationships between these various parts."[6] System strengthening, as opposed to short-term projects addressing specific issues, is considered a more sustainable and equitable approach as it is holistic and seeks to improve provision of prevention and response services for all through the mandate of responsible government agencies. A system strengthening approach has been adapted to many sectors.

[3] See Simply Psychology: Kolb's Learning Styles and Experiential Learning Cycle for an overview of the model: https://www.simplypsychology.org/learning-kolb.html.
[4] See Better Evaluation: Realist Evaluation for a simple introduction: https://www.betterevaluation.org/methods-approaches/approaches/realist-evaluation.
[5] Gilmore B. Realist evaluations in low- and middle-income countries: reflections and recommendations from the experiences of a foreign researcher. *BMJ Global Health* 2019; doi:10.1136/bmjgh-2019-001638.
[6] UNICEF (2021). Child Protection System Strengthening: approach, benchmarks, interventions.

It is perhaps most well developed in health care,[7] but has also become a focus for child protection[8] (within which children's care sits) as well as sectors like Water, Sanitation and Hygiene (WASH).[9]

Whilst it is possible to conceive of **system components** that need strengthening in different ways, the Care System Assessment, which was adapted and used by CTWWC early in the initiative, presented the components as six-fold: laws and policies, social service workforce, financing, M&E, social norms and practices, and service delivery (see Figure 3). These system components are understood to apply across all forms of alternative care and adoption, as well as the prevention of unnecessary separation and the transitioning of residential care facilities to family and community care and support services. They can also be viewed in the broader child protection system in which alternative care sits. This set of components was also used with CTWWC's Monitoring, Evaluation, Accountability and Learning (MEAL) plan in various ways, including to categorize outcomes recorded through the Outcome Harvesting method[10] and to structure the revision of the initiative's Results Framework in 2023. As a familiar construct, these same system components have been used to structure the approach to this evaluation.

Figure 3: Care system components[11]



In addition, as CTWWC progressed, the Six Conditions of Systems Change model was found to be a useful way of understanding how change within a system happens. Several explanations of systems change use an iceberg image[12] to show that efforts to shift the visible components of a system, such as policies, services and financing, must consider the processes of change hidden beneath the surface of a system. The Six Conditions of Systems Change model builds on this idea and identifies the hidden pieces to include: relationships and connections, and power dynamics and mental modes (Figure 4), noting that if these are not addressed then "shifts in system conditions are unlikely to be sustained."[13] The

[7] World Health Organization (2007). Everybody's business: Strengthening health systems to improve health outcomes: WHO's framework for action. https://www.who.int/publications/i/item/everybody-s-business----strengthening-health-systems-to-improve-health-outcomes.
[8] UNICEF, op cit.
[9] UN Department of Economic and Social Affairs, Accelerating progress towards SDG 6: a system strengthening approach for water, sanitation and hygiene that leaves no one behind, https://sdgs.un.org/partnerships/accelerating-progress-towards-sdg-6-system-strengthening-approach-water-sanitation-and.
[10] See Better Evaluation: Outcome Harvesting for a simple introduction: https://www.betterevaluation.org/methods-approaches/approaches/outcome-harvesting.
[11] CTWWC (2023). National Care System Assessments: Guidance to conduct a participatory self-assessment to inform national strategic planning. https://bettercarenetwork.org/toolkit/individual-assessments-care-planning-and-family-reunification/assessment-forms-and-guidance/care-system-assessment-framework.
[12] The Iceberg Model, developed by systems thinker Donella Meadows, see: https://donellameadows.org/systems-thinking-resources/.
[13] Kania, J., Kramer, M. and Senge, P. (2018) The Water of Systems Change. https://www.fsg.org/resource/water_of_systems_change/.

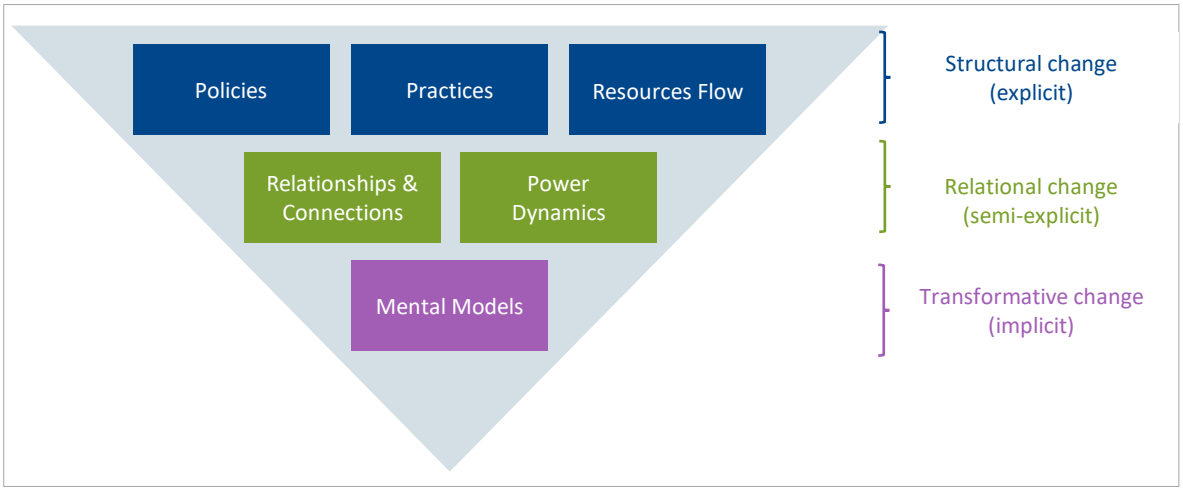
different conditions of change have also been used to categorize Outcome Harvesting results and to help the team understand the processes of change.

The semi-explicit or implicit conditions are:

- Relationships and connections: including quality of connections or communications among actors in the system, especially among those with different perspectives.
- Power dynamics: such as the distribution of decision-making power, authority and formal/informal influence among individuals or organizations.
- Mental models: including habit of thought, deeply-held beliefs and assumptions, taken-for-granted ways of operating that influence how we think, what do and how we talk.

These conditions of change align well with the realist idea of mechanisms, which are considered to be the often invisible, underlying social or psychological drivers of change amongst actors. The identification of mechanisms helps to describe how change happens and to understand why it has happened that way.

Figure 4: Six Conditions of Systems Change model[14]



Realist evaluations also seek to understand how context has played a role. The same intervention may trigger different mechanisms amongst actors in a system depending on the context in which it is implemented, thereby leading to a different outcome. These connecting factors in a change process are usually described in a context-mechanism-outcome configuration. In this evaluation, the addition of "intervention" was added to the configuration to help distinguish between what CTWWC did and the response or mechanism this triggered. As such, CTWWC refers to this as the context-intervention-mechanism-outcome (CIMO) configuration. (Figure 5).

Realist evaluations are theory-based. At the start of an intervention, the theoretical or intended process of change should be described and then tested and refined during implementation. Eventually creating a final program theory that can be used to inform future implementation.

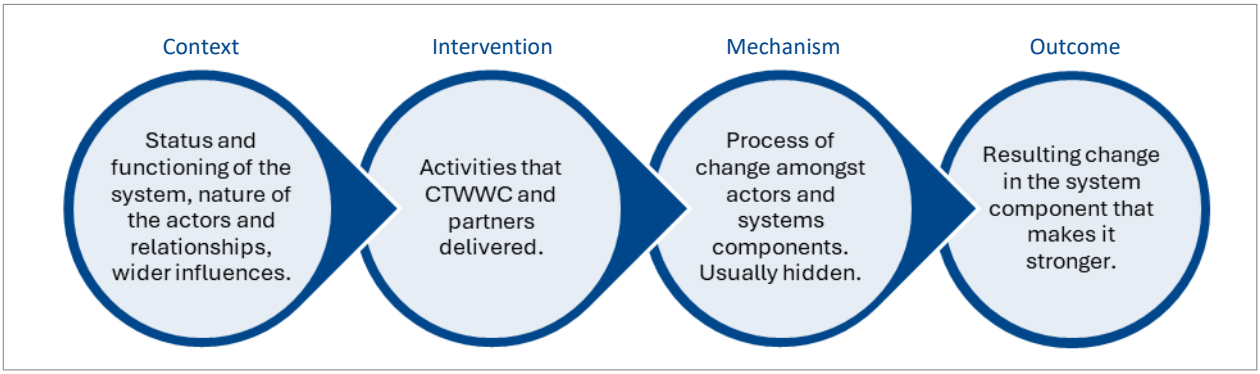
Realist evaluations using this approach have become an increasingly popular approach to understanding system strengthening interventions, especially with health care.[15] However, this is believed to be the first such evaluation of children's care system strengthening interventions.

[14] Kania et al, op cit.

[15] See for example:

- Manzi F, Marchant T, Hanson C, Schellenberg J, Mkumbo E, Mlaguzi M, Tancred T. (2020) Harnessing the health systems strengthening potential of quality improvement using realist evaluation: an example from southern Tanzania. *Health Policy Plan*, *35*. doi: 10.1093/heapol/czaa128.
- Oladimeji OJ, Fatusi AO. (2022) Realist Evaluation of the "Abiye" Safe Motherhood Initiative in Nigeria: Unveiling the Black-Box of Program Implementation and Health System Strengthening. *Front Health Serv. 10*. doi: 10.3389/frhs.2022.779130.

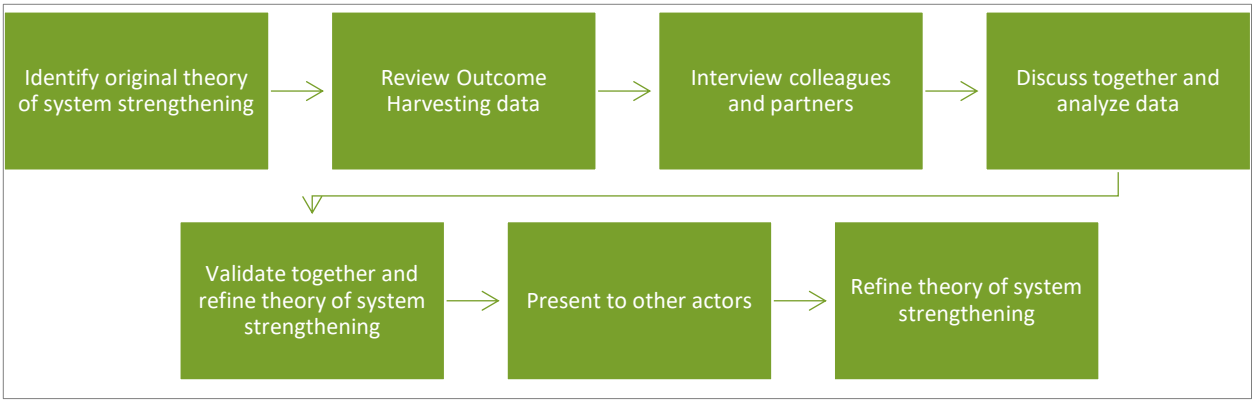
Figure 5: Context-Intervention-Mechanism-Outcome configuration



Methodology

The process of data collection, analysis and synthesis was originally planned to be cyclical and highly participatory, gradually bringing in more and more experiences of care system strengthening. However, due to the termination of CTWWC's award with the United States Agency for International Development (USAID) during the agency's closure in first part of 2025, the methodology was simplified and shortened. Nonetheless, CTWWC followed a realist evaluation process of identifying the original theory and plans for systems change found within documentation (proposals and workplans), reviewing Outcome Harvesting data collected as part of the initiative's ongoing monitoring, undertaking interviews with key actors in each country's care system, presenting and discussing the theory, reviews and interviews with team members from all four demonstration countries, analyzing the data and refining the original theories (Figure 6).

Figure 6: Methodology steps



These activities were undertaken by a diverse group of CTWWC team members, representing the four main demonstration countries and including practitioners, managers and MEAL team members. Throughout the process there were regular team discussions to share findings and discuss ideas. The diversity of voices in these discussions was important to ensure that the experiences of each country were well represented and that the synthesis between the countries could draw on the varied perspectives and experiences.

Identifying original theory of system strengthening: In order to surface the original theory of system strengthening for CTWWC, the team revisited some of the early documentation of the initiative looking for descriptions of theories and planned processes of change related to national care systems within the four demonstration countries. Key documents included the original application to the MacArthur 100&Change competition under which CTWWC was designed, the theory of change for the initiative and the linked results framework, the "Rebuild Strategy," which was written as a think piece to guide the senior management team in planning ahead and raising additional funds, and the workplan narratives

– Sharma KM, Jones PB, Cumming J, Middleton L. (2024) Key elements and contextual factors that influence successful implementation of large-system transformation initiatives in the New Zealand health system: a realist evaluation. *BMC Health Serv Res, 24(1).* doi: 10.1186/s12913-023-10497-5.

from the first few years of operation. The team compiled elements of the theories/plans that were found under different system component headings, including both the initiative-wide general theory and specific elements for each country.

Reviewing Outcome Harvesting data: A central monitoring methodology used by CTWWC to track change in care systems was Outcome Harvesting. This involved the creation of outcome statements regarding observed changes in actors within each national care system, as well as statements on relevance to CTWWC's objectives and the contribution made by CTWWC to the outcome. Over the life of the initiative, more than 400 outcomes were harvested.[16] Within this, 195 related to changes in the six system components within the four demonstration countries (see Table 1). A quantitative analysis of these outcomes was prepared for team members to review, as well as visuals representing chains of outcomes over time. In country groups, team members read through outcomes, looked at quantitative and visual results and noted what they observed in terms of patterns in data and reasons for the outcomes occurring. Initial ideas around mechanisms and contextual factors were highlighted. The findings were shared and discussed with the whole team.

Table 1: Number of outcomes harvested by country and system component

System component	Guatemala	India	Kenya	Moldova	Total
Laws and Policy	11	1	8	14	34
Social Service Workforce	4	0	7	8	19
Financing	7	10	17	3	37
M&E	0	0	8	6	14
Social Norms and Practices	3	3	3	4	13
Service Delivery	16	4	43	15	78
Grand Total	41	18	86	50	195

Interviews: Building from the review of the Outcome Harvesting data, each country team picked one outcome or chain of outcomes for three or four system components and conducted a realist interview with someone from outside CTWWC familiar with each outcome. The interviews focused on what happened in the "real world" through reflecting on the original theory and selected outcome. The interviews were designed to be a mutual conversation, where the interviewer shared the theory and outcome and asked the interviewee to share their experiences and perspectives. It was intended to be a chance for all involved to interrogate the proposed theory, discuss how change actually happened, and identify key contextual factors and mechanisms.

In total, 13 interviews were held across the four countries, covering all system components. Interviewees included academic counterparts, national and local government representatives, local implementing partner staff, peer nongovernmental organizations (NGO) staff and network representatives. Each interviewee provided their consent to participate. The interviews were recorded, with permission, and transcribed and cleaned with the help of AI. The entire evaluation team discussed what they learned from the interviews and highlighted their key insights. This helped inform the analysis, which involved a smaller group due to time and resource constraints.

Analysis: For the analysis, a smaller group of evaluation team members (two members per system component) reread the original theory and reviewed the Outcome Harvesting data, country reviews and interview transcripts. Each team member worked individually at first, and then discussed their findings in their pair group (one pair per component). Notes were taken on examples of:

- Contextual factors that enabled or hindered change, whether due to pre-existing situations, later changes in system components, or changes in a level within the system or wider content (regional, national, subnational, etc).

[16] Wakia, J. & Safronova, A. (2025) Outcome Harvesting within Changing the Way We Care: Report 2: results and system strengthening learning. https://bettercarenetwork.org/library/social-welfare-systems/child-care-and-protection-system-reforms/outcome-harvesting-within-changing-the-way-we-care-report-2-results-and-system-strengthening

- Mechanisms that help explain how and why change happened the way it did, especially regarding changes in relationships, coordination, power dynamics, commitments and mental modes, and across a range of levels (i.e., individual to the whole system).
- Outcomes, many of which were already recorded, and if further details emerged or new examples surfaced as a result of the discussions and interviews.

Some AI assistance was used during this process, always guided by prompts rooted in realist evaluation concepts and terminology, and only after team members had read and noted their own ideas.

Emerging themes were used to populate tables illustrating CIMO configurations: firstly, specific to each country, and sometimes at different levels within a country, and secondly, as generalized configurations summarizing commonalities across countries.

Presentation: A selection of the resulting CIMO configurations were shared during a virtual validation meeting with the entire evaluation team to promote familiarly with the configuration format, sense-checking and some initial meaning-making. The evaluation team then reviewed the proposed configurations for their own country as well as the generalized versions and provided their input and adjustments. The resulting generalized CIMO configurations were then shared with a larger group from CTWWC and its implementing agencies for further validation and sense-checking.

Limitations

This evaluation was undertaken during the closing phases of the CTWWC initiative after the termination of CTWWC's award with USAID during the agency's closure in first part of 2025. As noted, this resulted in a simplified and shortened methodology. It was not possible to have as much collaboration in person as was originally planned. Only 13 interviews were undertaken. Ideally there would have been at least two interviews per component, per country. Team discussions were conducted remotely, which was limiting and resulted in a lack of richness in the synthesis of ideas between team members from different locations. Similarly, the analysis was undertaken with limited team members, all of whom were working remotely and on a short timeframe. This was manged in part with help from AI. Ethical principles of using AI were upheld and approaches to AI were discussed before use, including types of prompts. However, these constraints did limit the analysis process.

The original design would have included opportunities to interview colleagues and discuss findings from other countries and care reform initiatives. The idea was to validate (or not) and deepen the understanding gained from CTWWC. This was not possible due to time constraints, but those involved hope it might still happen in the future through a collaborative process.

It is noted that CTWWC's Outcome Harvesting data set does not represent all of the change that happened in the care systems of each demonstration country. It also does not fully document who and what contributed to the change. Outcome Harvesting focuses on what is observable, and since the data was collected by CTWWC, it inevitably reflects what the CTWWC team knew about and felt was important to record. The data set was substantiated as part of earlier evaluations.[17]

Finally, the team involved in this evaluation was new to the realist evaluation approach. The lead author received training and a desk review of relevant literature was undertaken, with a special focus on the use of this approach to system

[17] For more information on the methodology followed by CTWWC, please see: Wakia, J. & Safronova, A. (2025) Outcome Harvesting within Changing the Way We Care: Report 1: methodological insights. https://bettercarenetwork.org/library/social-welfare-systems/child-care-and-protection-system-reforms/outcome-harvesting-within-changing-the-way-we-care-report-1-methodological-insights

strengthening. Effort was made to uphold the standards of realist evaluation,[18] but it is recognized that the team was learning as the process unfolded, which likely impacted the quality of the approach.

Findings

This section presents findings from this evaluation through the lens of the care system components. For each component, the **original theory** is presented based on early documentation and workplans for the initiative and an **overview of outcomes** recorded for that system component through the Outcome Harvesting monitoring methodology. These are followed by a narrative **description of the change processes** that were uncovered during the analysis of outcome data and interviews with key stakeholders for that system component, as well as notes on **linkages to other system components**. The processes for each country (where outcomes were recorded) are then summarized in **CIMOs specific to each country** and finally, a set of **generalized CIMOs** are presented.

Legislation, policy and coordination[19]

Original theory

CTWWC's aim was to strengthen local and national legislation and policies in line with United Nation (UN) Guidelines for the Alternative Care of Children and address gaps in their implementation through the creation or strengthening of strategies, guidelines and procedures, and through advocacy and capacity building. CTWWC acknowledged the crucial role of government and sought to build positive relationships in order to influence appropriate actors, often for memoranda of understanding (MoU). CTWWC also recognized the need to collaborate with subnational, national and international actors, including faith-based actors, to ensure a collective voice and shared language for advocacy and joint action on informing national and local strategies, plans and practice guidance. It was recognized that care policy landscapes are diverse and thus, strengths and gaps should be identified through assessments of care systems conducted during initial stages. These assessments were planned periodically to monitor progress. It was also anticipated that a "learning by doing" approach to supporting the reintegration of children from residential care would not only benefit children and families, but would also trigger policy changes by showcasing to government officials how safe and effective change could be achieved.

Overview of outcomes

CTWWC has driven significant legislative and policy advancements across Kenya, Guatemala and Moldova from 2019 to 2025 with 34 outcomes harvested in total. At national (29) and subnational (5) levels, outcomes reflect a sustained, strategic effort to strengthen guidance and oversight, with government actors (33) serving as the primary agents of change. The level of change varied by country, with Moldova's reforms occurring exclusively at the national level (16), Kenya's occurring primarily at the national level (9) with one subnational outcome, and Guatemala with both national (7) and municipal level (4) results. Key achievements include the development of national care reform strategies, updated regulations for residential care providers, standardized case management procedures, and the formalization of alternative care options such as foster care and Kafaalah. Collaboration extended beyond national governments to include multisectoral actors, such as civil society actors, especially faith leaders and networks of people with lived experience in all countries, national councils in Kenya and Moldova, academia in Guatemala and Moldova, and local authorities in Guatemala and Kenya, highlighting the initiative's inclusive approach.

[18] The RAMSES II Project (2017) Quality Standards for Realist Evaluation for evaluators and peer-reviewers https://www.ramesesproject.org/media/RE_Quality_Standards_for_evaluators_and_peer_reviewers.pdf.
[19] Although this system component appears as simply laws and policy in the diagram in Figure 1, CTWWC has found that coordination is part system strengthening and is a component that is often highlighted in other system models, such as the UNICEF Child Protection System Strengthening approach.

Description of change processes

Across all countries, legislation supporting family-based care was already in place, some more comprehensive than others; however, policy, guidance and implementation gaps persisted, requiring persistent advocacy, evidence and adaptive strategies. For example, amongst other issues, the implementation of alternative family-based care policies was held back in Moldova by a shortage of trained workforce engaged in care and protection of children, and in Guatemala by a minimal number of foster carers. Recognition of these issues, illustrated by relevant and up to date data, by key government bodies was a critical precondition for change.

External triggers also played an important role. In Moldova, European Union (EU) accession requirements heightened the urgency of reform, while in Kenya, regional care reform trends and national legislative reform created windows of opportunity. Multisectoral collaboration was another consistent factor, with engagement across health, education, justice, and faith-based actors seen as critical to systematize change. This was true at both national and subnational levels.

High-level advocacy paired with evidence and strategic partnerships were key to adoption of new policies. Moldova's comprehensive situational analysis provided a shared evidence base that directly shaped the National Program for Child Protection, while in Kenya, county-level assessments informed national strategy drafting. In Guatemala, evidence from documented reunification cases convinced the Secretariat for Social Welfare (SBS) leadership to elevate foster care nationally. These interventions were reinforced by formal partnerships (e.g., via MoUs between key actors) and coordination structures (e.g., the creation of Kenya's Care Reform Core Team), which helped foster multi-stakeholder engagement and ownership of the process.

At the subnational level, engagement designed to build policy literacy and create political buy-in ensured local ownership and feasibility. This was seen in Kenya where Nyamira county was supported to translate national mandates into localized policies for child protection and disability inclusion, and in Guatemala, where municipalities in Zacapa adopted family strengthening policies and guidance. Both Kenya and Guatemala included elements of technical accompaniment around policy development requiring a high level of credibility and trust between local government decision-makers and technical advisors.

In Moldova, legal and policy reform was strongly tied to the EU accession agenda, which elevated care reform as part of broader governance benchmarks. Building a strong evidence base through a comprehensive situational analysis legitimized the need for structured action, leading the government to integrate case management, invest in the workforce and strategically coordinate processes for reforms through the National Program for Child Protection (NPCP). While some delays due to political decisions regarding where the NPCP would be housed impacted progress, pivoting or adapting to a new option often overcame these barriers. This was illustrated by the launch of the NPCP in Moldova and by progress on deinstitutionalization planning, demonstrating that adaptive problem-solving could sustain momentum in different types of government environments.

Where governments assumed coordination roles, both at the national and the subnational levels, reforms gained traction. In Kenya, the National Council of Children's Services (NCCS) was supported to form a Care Reform Core Team, overcoming a tradition of siloed approaches and thereby increasing the number of informed and engaged actors believing in and contributing to reforms. Guatemala's Foster Care Working Group exemplified how shared accountability across multiple government agencies (e.g., SBS and *Procuraduría General de la Nación* [PGN]) and UNICEF legitimized reform and built momentum for scaling.

At the subnational level in Guatemala, municipal-level leadership proved especially powerful: data on risks of family separation combined with demonstration of the model in the capital of Zacapa motivated Río Hondo leaders to pass the Public Policy for Family Strengthening. As Mayor Oscar Ernesto Mata stated during its approval, it ensured that *"actions for family and community strengthening are carried out in an orderly and focused manner. Prior to the approval of the [municipal public policy], there was no municipal legal framework, and the actions were carried out in isolation."*

Component linkages

Changes in legislation and policy were closely linked to in-service delivery changes. Many service delivery outcomes are only achievable if the legal and regulatory frameworks have also shifted.

Country-specific CIMOs: Legislation, policy and coordination

Context	Intervention	Mechanism	Outcome
Guatemala - Subnational ▪ Municipalities lack legal framework for child protection, resulting in fragmented and isolated actions. ▪ Strong political will exists from municipal leaders, influenced by a successful model (e.g., the Municipal Office for Children and Adolescents [OMNA]) in the nearby capital, Zacapa. ▪ There is a clear need to institutionalize services and dedicate a municipal budget to ensure sustainability.	▪ Piloting coordination models like Family Care Commissions and a standardized Case Referral Route. ▪ Providing technical assistance to draft Municipal Public Policy (PPM) and develop operational manuals. ▪ Conducting advocacy and training workshops for municipal authorities on child protection systems, informed by subnational-level data. ▪ Advocating for and supporting the creation of budgeted municipal positions and a psychosocial clinic.	▪ Creating political buy-in by demonstrating feasibility and concrete benefits (e.g., faster reunifications) through successful pilot models. ▪ Reducing uncertainty and justifying resource allocation by building operational clarity through blueprints for roles, protocols and coordination. ▪ Embedding accountability within local governance by supporting the establishment of multi-level structures (e.g., commissions).	▪ Estanzuela and Río Hondo Municipal Councils (department of Zacapa) each approved a PPM for family strengthening and child protection, creating its first legal framework for coordinated action. ▪ Zacapa institutionalized childcare services by creating dedicated staff positions and a psychosocial clinic.
Guatemala - National ▪ There is a strategic government goal to reduce reliance on residential care and scale up family-based alternatives nationwide. ▪ Leadership within the SBS is committed to strengthening these programs.	▪ Designing and piloting standardized case management and referral protocols. ▪ Providing tools and training for national staff on family reunification and foster care processes. ▪ Facilitating multi-stakeholder collaboration to refine and validate a national strategy. ▪ Using subnational-level data to build cases for advocacy and awareness raising.	▪ Concretizing the change needed by proving a replicable model with evidence that the models worked and could be expanded. ▪ Making scaling feel feasible and reducing coordination gaps between agencies through standardizing tools and workflows. ▪ Legitimizing change and mobilizing internal resources for nationwide rollout via support from high-level champions within SBS.	▪ SBS leadership approved and launched a national foster care strategy and initiated a working group with key agencies to strengthen the national foster care program.

Context	Intervention	Mechanism	Outcome
Kenya - Subnational ▪ Kenya's devolved governance system mandates that county governments implement child welfare programs, creating a need for localized policies. ▪ National laws (e.g., the Children Act [2022]) require counties to develop frameworks for family-based care and disability inclusion, but these are missing, leading to fragmented services.	▪ Sensitizing county assembly members to secure political buy-in and conducting awareness sessions and training for staff on disability rights and care reform using local data to build the case. ▪ Providing technical support to draft localized policies and regulations. ▪ Facilitating workshops to develop implementation plans for enacted laws.	▪ Growth in capacity to recognize the need for reform and to develop and promote new regulations. ▪ Legitimizing change and growing political buy-in through a grounding in national and local mandates and responsibilities.	▪ Nyamira County Government approved a county Persons with Disabilities Act and Child Policy to implement childcare and disability inclusion initiatives.
Kenya - National ▪ The national government recognizes the need to shift from institutional to family-based care, but efforts are fragmented. ▪ The NCCS has a mandate to coordinate child protection, but is inactive. ▪ Care reform is a cross-cutting issue that requires collaboration across multiple ministries and county governments.	▪ Conducting advocacy and consultations with NCCS for a coordinated strategy. ▪ Supporting the formation of a government-led, multi-sectoral core team to drive the reform process. ▪ Providing technical and financial support for strategy development, including workshops and participatory evidence generation.	▪ Fostering government ownership and coordination by building understanding and supporting strategic leadership. ▪ Legitimizing the need for action from local evidence building and technical guidance.	▪ A multi-sectoral National Care Reform Core Team was formed to coordinate the reform process. ▪ The national government validated Kenya's first National Care Reform Strategy to shift from institutional to family-based care.
Moldova - National ▪ An existing Prime Minister-led National Council coordination is suspended. ▪ While legislation is largely adequate, significant systemic implementation gaps persist. ▪ Care reform is a key feature of EU accession agenda.	▪ Conducting a comprehensive care system situational analysis. ▪ Under an MoU with the government, serving as a technical partner to co-develop the national action plan, and taking responsibility for a significant portion of its activities. ▪ Supporting the formalization of functional multi-actor working groups.	▪ Legitimizing the need for structured coordination and partner involvement. ▪ Building institutionalized trust and credibility to influence the government's reform process.	▪ The Ministry of Labor and Social Protection (MLSP) formally launched the NPCP and publicly acknowledged key technical and donor partners that contributed to its development. ▪ MLSP established three coordination working groups to oversee the implementation of three general goals of the NPCP for 2022–2026.

Generalized CIMOs: Legislation, policy and coordination

Context	Intervention	Mechanism	Outcome
▪ Strong legal mandates exist, but with implementation gaps (workforce shortages, no foster care systems). ▪ Fragmented coordination and inertia across ministries and agencies. ▪ Systemic failures acknowledged, but top-down structures are stalled or ineffective.	▪ High-level advocacy and proposal development to frame urgency and identify solutions. ▪ Securing strategic partnerships and MoUs between multiple partners. ▪ Support to formalize practical coordination structures at the level of national government (e.g., core teams, working groups). ▪ Adaptive problem-solving to accommodate diverse perspectives on formation of structure.	▪ Engagement from senior officials signaled institutional commitment, overcoming bureaucratic inertia. ▪ Multi-actor credibility from technical and financial support across multiple partners. ▪ Operational feasibility of new structures from clear, co-designed mandates for partners focused not just on policy development but also on practical implementation gaps.	▪ Formal coordination bodies established with government ownership and diverse partner engagement. ▪ Commitments secured from key ministries and agencies. ▪ Systemic shift from policy development to implementation.
▪ Strong legal mandates for family-based care exist and a general need for change is present, but missing specific next steps for implementation. ▪ Implementation gaps become clearer during a crisis. ▪ High-level champions within national government agencies who want to prioritize reform. ▪ Fragmented and siloed stakeholders.	▪ Evidence-based advocacy using situational analyses, pilot results, and benchmarking, framed broader agendas (e.g., EU accession, UN guidelines) ▪ Ongoing dialogue and engagement of high-level champions. ▪ Forming strategic partnerships via MoUs and formal agreements. ▪ Multi-actor, coordinated problem-solving, especially during crises (e.g., COVID).	▪ Key actors in government and wider partners became convinced of the need for formal strategies through tangible evidence from pilots, analyses and alignment with broader agendas. ▪ Bureaucratic inertia overcome through authority of high-level champions. ▪ Increase accountability and collaboration from formal agreements and working groups.	▪ Formal strategies launched and coordination bodies established with cross-sector membership. ▪ Reforms shifted from policy to operation.
▪ Government is decentralized or multiple government agencies hold responsibilities for child protection and care. ▪ National laws exist, but local services are fragmented and coordination is absent.	▪ Sensitizing leaders on national laws to secure cross-sectoral buy-in. ▪ Training officials on policy drafting. ▪ Facilitating multi-stakeholder drafting and validation of local policies. ▪ Demonstrating feasibility of new approaches through pilots and models.	▪ Embedding policies into governance structures, ensuring sustained action. ▪ Reducing resistance and legitimizing action by framing local policies as fulfilling national mandates. ▪ Increasing confidence and political ownership from feasible pilots.	▪ Subnational policies and regulations approved, with dedicated legal entities and roles, creating a base for budgeting. ▪ Subnational government ownership evidenced by implementation frameworks and budget allocations.

Social Service Workforce

Original theory

CTWWC sought to strengthen the social service workforce by building capacity of workers and managers and by influencing resourcing, training and professionalism across cadres. CTWWC planned to work with both government and civil society to provide training and support to workers to demonstrate good practice, including standardized processes and tools, in case management for reintegration, alternative care and prevention of separation, including supportive supervision practices. CTWWC also aimed to develop guidance and toolkits, building from international good practice and demonstration learning, and working in close collaboration with government agencies in the hope that these practices would be nationally endorsed and adopted. Social service workforce assessments were to be undertaken where needed. Alliances with universities and government training institutions were planned to embed good practices and new training models for new workforce members and for professional development. Overall, universities were felt to have capacity around sustainable social service workforce development (training, qualifications, etc.) across country contexts. CTWWC aimed to build capacity of the national level to cascade training and workforce development to subnational and local levels.

Overview of outcomes

CTWWC has documented changes in the social service workforce across Kenya, Guatemala and Moldova from 2019 to 2025 through 19 outcomes, mostly at the subnational level (13), and reflecting change in government actors (12). Across contexts, outcomes emphasized investment in training, mentoring and professional development (e.g., case management training, positive parenting training, virtual induction modules, university partnerships). Moldova (8) and Kenya (7) recorded the most workforce outcomes. The majority (11) of outcomes were recorded in fiscal year (FY)24 in Kenya (5) and Moldova (6). Key achievements across contexts include strengthened case worker, social worker and community actor capacity; progress in care reform and, particularly, moving children out of residential care; improved collaboration and partnership; enhanced service provision and innovation in practice, especially around case management; and shifts in attitudes and understanding.

Description of change processes

Reform emerged through a gradual but reinforcing cycle of capacity-building, institutional partnerships and demonstration of success. This combination reduced resistance, shifted beliefs and established new norms, leading to systemic changes in the capacity of the social service workforce for children's care, particularly the reintegration of children and families and the transformation of service delivery. Across Guatemala, Kenya and Moldova, change processes had shared features. In each context, there was initial resistance from key members of the workforce. For example, court officials in Guatemala doubted the suitability of families, residential care managers in Kenya resisted reforms, and local authority and residential care social workers in Moldova were hesitant to engage in the deinstitutionalization process. These barriers were addressed through targeted capacity-building interventions, including multi-stakeholder working groups to improve case management tools and guidelines; case management and supportive supervision training; accompaniment in the completion of child and family assessments; advocacy and peer learning exchanges. For instance, in Kenya, CTWWC collaborated with the Directorate of Children's Services (DCS) and residential care networks to deliver case management training and supportive supervision. Later, CTWWC facilitated learning exchanges with the residential care partners of a private foundation (the Segal Family Foundation) to further scale the case management model. Such efforts activated key mechanisms of change including confidence building through learning and practicing new skills; shifts in beliefs as actors began to see that children, including those with disabilities, could thrive in families; and trust and legitimacy through the engagement of government systems. Across all three countries, CTWWC gained trust and credibility through consistent and collaborative engagement in demonstration areas or pilot interventions. This hands-on experience was an important basis from which reforms became more acceptable and sustainable. There were also examples of power dynamics changing as trust was built, with resistant leaders leaving

their posts and governments formally adopting new standards and guidelines. The workforce also experienced changes and expansions in their roles with new, specialized roles being created to match changes in services, such as increasing reintegration, family-based care, and family and community support. Together, these processes produced concrete outcomes, the most important being that the workforce was able to reunite children with families, specialized services were initiated, governments adopted or improved care reform policies, and residential care providers began transitioning from residential care to community-based services.

Successful outcomes that improved workforce performance could be linked to joint interventions with government, academia and practitioners that embedded knowledge and practice within formal systems (e.g., academic curricula, case management guides, government standard operating procedures [SOP], etc.) enabling long-term adoption focused on family-based care and family strengthening aligned with national strategies and plans. In Kenya, co-designed, practice-based approaches to care reform were integrated into the Kenya School of Government training modules, while an MoU between Moldova's MLSP, multiple universities and a multi-stakeholder working group provided a sustainable way to improve training of new social workers and promote ongoing professionalization. At the subnational level in Guatemala, training on family strengthening policies and interventions were integrated into teaching and internships with a regional university and directly linked to service delivery in the demonstration area. Trust in, and legitimacy of, training and care reform messages was critical and built by institutionalizing models with government endorsement as well as academic and practitioner engagement across all three countries.

Component linkages and key transferable insights

As might be expected, changes in the workforce were closely linked to changes in service delivery. These changes were mutually reinforcing. Finance and M&E outcomes were also closely linked, with greater allocation of financing leading to improvements in workforce capacity, and workforce training leading to improvements in data collection and use.

Country-specific CIMOs: Social Service Workforce

Context	Intervention	Mechanism	Outcome
Guatemala ▪ Government relies on a system of residential care, even for children living in poverty. ▪ Workforce does not have guidance from a consistent case management approach, particularly, family monitoring and follow up. ▪ Government sees the importance of family strengthening to prevent unnecessary family separation. ▪ Government is committed to working on developing family strengthening services. ▪ Limited engagement of academia in social service workforce development.	▪ Providing technical accompaniment to psychosocial teams in case management processes for children in residential care, including co-conducting psychosocial evaluations of children and families and presenting as evidence in court hearings to gain approval for reintegration. ▪ Delivering care reform and case management workshops for multi-sectoral workforce, including psychosocial teams, judiciary and local municipalities. ▪ Raising awareness of the importance of family strengthening and the prevention of unnecessary family separation as an important element of broader care reform. ▪ Establishing collaboration between local governments, academia and CTWWC for the provision of services and capacity building.	▪ Professional recognition and credibility of psychosocial professionals by judges from presenting reports in court. ▪ Shifting perceptions amongst workforce toward viewing families as able to care for children, even in poverty. ▪ Confidence and empowerment of the workforce once their work and evidence were validated. ▪ Institutionalization and normalization of good practices when universities integrated student practice placements into community clinics within professional training. ▪ Increased accountability and follow through amongst SBS staff to follow up on all cases as they now understood the importance of systematic monitoring for safe reintegration.	▪ Psychological care clinics installed and strengthened with teams to operate in 11 municipalities (Zacapa), bringing psychological care services close to families. ▪ Staff from municipalities and psychology students strengthened to implement family- and community-strengthening services. ▪ First academic actor engaged in care reform; pipeline of psychology graduates trained to support reintegration. ▪ Social workers more proactive in reunification and case management processes.

Context	Intervention	Mechanism	Outcome
Kenya • Local partners lack exposure to care reform practice. • National child protection training structures do not mainstream care reform. • Mostly private, residential care workforce lacks skills in case management, disability inclusion, family-based alternative care, family strengthening and reintegration. • Government workforce lacks skills in case management, technical oversight and supervision mechanisms.	▪ Learning exchanges between residential care providers. ▪ Providing joint supportive supervision with government. ▪ Training in case management, transition of care services and reintegration for government workforce, residential care providers and civil society. ▪ Positive parenting and other economic strengthening training for case workers and civil society. ▪ Supporting inclusion of care reform in Kenya School of Government child protection course.	▪ Increasing practical knowledge, confidence and buy-in amongst workforce on case management for reintegration and wider family strengthening support. ▪ Workforce diversification with specialized skills enabled delivery of new services. ▪ Institutionalization of care reform knowledge within formal government training system. ▪ Workforce empowerment through local ownership and use of standardized government tools.	▪ Social workers and case managers better able to support family reintegration; institutions beginning to shift toward family-based care. ▪ Strengthened capacity of Charitable Children's Institution (CCI) staff to implement family/community-based care; greater sustainability of workforce skills. ▪ Systemic, ongoing workforce capacity-building on care reform across all 47 counties. ▪ Consistent application of reintegration guidelines; improved quality of workforce practice.
Moldova ▪ Universities offer general training in social work with a significant gap in preparation on family-based care and case management. ▪ Continuous training of social workers is not structured or institutionalized. ▪ Skepticism of social workforce regarding family-based alternatives for children with disabilities. ▪ High workload and unmotivating salaries contribute to social workforce turnover. ▪ Workforce has limited influence in child protection decision-making. ▪ Weak accountability and follow-up mechanisms in social services. ▪ Children with disabilities over-represented in institutions; limited foster care options available.	▪ Supporting reforms of professional curricula through MoUs between government and universities. ▪ Development of qualification standards and job descriptions for child protection specialists. ▪ Capacity-building manual and workshops on case management, reintegration and wellbeing assessments. ▪ Accompaniment and technical support within subnational structures on monitoring and case follow-up. ▪ Piloting specialized foster care with training and mentoring for social workers. ▪ Support and encouragement of reform-minded leaders.	▪ Growing confidence and competence amongst social workers in applying structured tools and practices. ▪ Increasing legitimacy and recognition of the workforce as credible once reforms are anchored in academic and state structures. ▪ Empowerment of workforce to implement new practices without obstruction through shifting power dynamics. ▪ Shifting attitudes toward disability and family care from exposure to successful foster placements.	▪ Academic programs integrated care reform content, producing graduates trained in family-based social work. ▪ Social workers applied case management standards, conducted wellbeing assessments, engaged actively in reintegration planning and began consistent follow-up of reintegration cases, improving quality and safety. ▪ Social workers more proactive and aligned with care reforms at territorial and institutional levels. ▪ Social workers gained confidence supporting foster families.

Generalized CIMOs: Social Service Workforce

Context	Intervention	Mechanism	Outcome
▪ International guidance and national mandates prioritize care reform but the social service workforce is undervalued, limited in capacity (e.g., numbers, roles, turnover) and resistant to reform processes. ▪ Professional training and development pathways are fragmented and/or weak (e.g., universities are not engaged, national training systems are not embedded in reforms).	▪ Embedding reforms in social work education and government systems. ▪ Collaboration, coordination and partnership with universities. ▪ Strategic engagement, advocacy, peer learning and technical meetings to build multi-stakeholder capacity.	▪ Growing professional legitimacy and confidence as social workers' skills were recognized and validated. ▪ Increasing trust in, and legitimacy of, reforms once anchored in national/state and academic institutions.	▪ Workforce empowered to influence decisions. ▪ Institutionalization of training and reform in academic curricula and national government courses, which produces workforce cadres that are confident, committed and trained in family-based care.
▪ International guidance and national mandates prioritize care reform, but alternative care is still reliant on residential models and there is resistance to change from institutional leaders and the wider workforce. ▪ Ongoing supervision and accountability systems for the workforce are absent or underdeveloped, which is undermining long-term workforce quality.	▪ Targeted capacity building and accompaniment of workforce and government leadership, including in demonstration models and pilots. ▪ Development of standards, case management tools and models of supervision through workshops on integrated case management, accompaniment models and case tracking systems.	▪ Changing power dynamics and attitudes as resistant leaders lose influence and workforce begins to see and experience the viability of changes in family care and support, including for children with disabilities. ▪ Growing awareness of need for reforms amongst government and their increasingly active involvement in implementation promotes belief in the sustainability and scalability of social service workforce professionalism. ▪ Increasing belief in, normalization and ownership of tools and models from engagement of diverse actors, including government.	▪ Greater buy-in from workforce and local/state authorities, enabling transition from residential to family care and support. ▪ Workforce begins systematic use of case management and family strengthening approaches**.**

Financing

Original theory

CTWWC sought to redirect funding from residential care facilities to family and community care services. CTWWC hoped to "unlock millions of dollars in redirected resources to support education, health and social services that will benefit children and families for years to come."[20] The initiative intended for financial modeling and evidence, such as investment cases and cost-benefit studies, to convince governments and other actors, particularly major donors, regional policy bodies and private trusts and foundations, that care reform could be sustainable and scalable. CTWWC believed they needed, and would be able to conduct, a funding stream analysis (public and private) in every country and that this kind of analysis was a "low hanging fruit." CTWWC also understood the dynamics of funding for residential care facilities, that is, the interplay between country-level implementation of children's services and outside-of-the-country funding, particularly the importance of private and often faith-based small donors.

Overview of outcomes

CTWWC recorded 37 outcomes categorized as changes to financing. The vast majority of these were at the subnational level (25). Around half involved government actors (18), whilst others involved residential care actors in Kenya, such as donors, networks and managers (6), civil society actors (6) and faith-based actors (4). A common type of change seen in the outcomes was the redirection of public or donor funds toward family strengthening and community-based services. For example, in Guatemala, three municipal mayors approved new budgets for their local child protection offices to develop family strengthening actions. In India, local government units in four districts allocated 5% of their untied grants to child protection services and programs, a financing option outlined in the Mission Vatsalya guideline as of 2022. Another common change within these outcomes was the redirection of private resources by donors to, and operators of, residential care facilities. This included a donor in Kenya approving a request to fund family-based care, and a Kenyan residential care facility investing in vehicles and accommodation for a new community disability program. Subnational changes in financing, including financing for coordination, organizing workshops and direct support to caregivers, were some of the first financial shifts documented by Outcome Harvesting. National-level changes, like a ministry in Moldova approving a financing mechanism for a foster care pilot, took longer, but were essential for systemic impact.

Description of change processes, with examples from each country

Across the countries where CTWWC worked, financing alternative care was historically focused on residential care, leaving family- and community-based alternatives, as well as family strengthening and social support, underfunded. The contexts differed: in Guatemala, Kenya, and India, decentralized governance meant there was local authority, but often limited awareness, tools and resources to redirect funds. In Moldova, a centralized system under strong EU accession incentives created opportunities for national policy and budget shifts. In all locations, fiscal constraints, reliance on outside donor funds and entrenched norms around residential care, including amongst private and faith-based donors, created barriers to reform of financing.

The processes of change began to emerge when the combination of evidence-based advocacy, technical assistance, demonstration pilots, and, in some cases, direct engagement with financial authorities and private, faith-based donors aligned with existing incentives and power structures. In Moldova, fiscal persuasion was decisive, as cost–benefit analyses and EU-aligned advocacy convinced decision-makers that family-based care was both economically efficient and politically advantageous. The MLSP changed its national budgeting approach, increasing allocations for family support services, foster care and disability-focused programs. In Odisha, India, simplified tools and communication materials bridged the gap between complex national mandates, like Mission Vatsalya, and local government capacity, giving district officials the confidence to allocate funds toward prevention and alternative care. District collectors formally dedicated 5% of untied local government funds to child protection, thereby empowering committees and services to act. Similarly, in

[20] CTWWC application to the MacArthur 100&Change competition, 2018.

Kenya, technical assistance to subnational governments to draft and enact policies created a feasible model for bringing national mandates into county governments' understanding and priorities allowing for dedicated funds for care reform, while aligning care reform with local values enabled residential care providers and faith-based organizations to redirect their own resources into structured community-based support and disability-inclusive services. In Guatemala, the systematic documentation of service gaps and data-driven advocacy reduced perceived risks for municipal leaders, creating political will to invest in child protection structures. Municipal mayors allocated budgets to establish and strengthen local child protection offices, including the creation of the Municipal Office for Children and Adolescents in Zacapa. In Tamil Nadu, India, repeated engagement with faith leaders and hierarchical endorsement from bishops legitimized new approaches, shifting deeply-held notions of charity. Parish committees committed to providing monthly financial and food support for vulnerable families, embedding the ideas within faith structures and ensuring sustainability through religious legitimacy.

Component linkages

Shifts in financing took the longest to change, showing the important linkages to policy and coordination, as well as workforce and M&E. Building momentum of change in these other system components was important to unlocking financing.

Country CIMOs: Financing

Context	Intervention	Mechanism	Outcome
Guatemala ▪ Pre-existing gaps in cross-sector coordination for care reform results in fragmented and under-resourced child protection services. ▪ A national decentralization policy empowers municipalities to take ownership of child protection services and financing, and municipal leadership demonstrates political will to prioritize changes.	▪ Systematically documenting service gaps in child protection and presenting data-driven arguments to municipal leadership about needs and solutions. ▪ Targeted training and technical assistance for operational planning, including framing proposals aligned with existing municipal priorities and systems. ▪ Developing ready-to-use administrative tools and implementation protocols. ▪ Establishing pilot programs to demonstrate service model feasibility, and documenting to promote service models to others.	▪ Changing understanding and attitudes of decision-makers due to improved data on community needs and strengths linked to concrete, actionable policy issues. ▪ Building confidence and reducing sense of risk amongst municipal actors through use of co-developed tools and proven models. ▪ Legitimizing investment of resources through data and a clear implementation path.	▪ The mayor of Zacapa approved the redirection of municipal resources to formally establish the OMNA, including the hiring of a dedicated coordinator and allocation of office space and equipment. ▪ The mayors of Palestina de los Altos, San Juan Olintepeque and Concepción Tutuapa approved redirection of financial resources with the aim of developing family strengthening services.
Kenya ▪ Devolved system mandates counties to implement child protection in line with national laws, requiring localized policies and resourcing that are largely absent. ▪ High poverty rates and systemic barriers increase risks of family separation.	▪ Conducting awareness sessions and trainings for subnational government staff and community groups. ▪ Providing technical support for collaborative drafting of local policies, guidelines and implementation plans in line with national strategies and legislation. ▪ Promoting and sharing example policies, guidelines and plans.	▪ Growing policy literacy and political will through training and sensitization. ▪ Increasing operational feasibility of locally-owned and built polices and linked budgets. ▪ Increasing acceptance and replications through alignment with local values whilst also matching national priorities.	▪ Subnational governments enacted localized policies and allocated budgets to implement national care reform laws. ▪ Residential care providers redirected resources to direct, sustainable support for families and caregivers, preventing child-family separation. ▪ Civil society and faith-based organizations allocated their own funding to support the scaling of new approaches, including family-based alternative care options like Kafaalah.

Context	Intervention	Mechanism	Outcome
Moldova ▪ A centralized governance system, steered by the MLSP. ▪ Political prioritization of deinstitutionalization (including EU accession priorities). ▪ Economic constraints and a pressing need for cost efficiency. ▪ Gaps related to disability-specific service provisions, including foster care.	▪ Conducting high-level evidence-based advocacy with government and parliamentary actors, aligning reform with EU accession goals. ▪ Developing and presenting an evidence-based investment case and cost-efficiency analysis for family-based care. ▪ Providing technical support to reform foster care systems and develop institutional transformation plans, including finance and human resources. ▪ Facilitating stakeholder (government and non-government) workshops to build consensus and refine national priorities. ▪ Documenting and sharing Moldova's care reform successes and various service models.	▪ Increasing understanding of decision-makers on long-term savings and better economic and social outcomes of family-based care. ▪ Elevating prioritization of high-level political leadership by alignment with centralized governance and EU goals. ▪ Increasing understanding of viability and decreasing resistance to change from documented success of models.	▪ The government of Moldova changed its approach to social service budgeting and increased funding for a minimum package of child and family protection services, including family support, family-based alternative care and services for children with disabilities.
India – Government (Odisha) ▪ A national guideline (Mission Vatsalya) mandates local governments plan for and use 5% of untied funds for child protection, but districts have limited awareness, guidance and implementation capacity. ▪ District authorities hold significant power to direct administrative priorities, including financing and use of budget.	▪ Providing technical support to develop district-level child protection plans and funding. ▪ Developing simplified communication and capacity building materials to explain policy mandates, operating processes and guidance. ▪ Facilitating discussions, sharing of learning and evidence at high-level government meetings. ▪ Documenting practice in initial districts and supporting government actors to share across districts.	▪ Increasing understanding and confidence to act amongst local officials by translating complex national guidelines into simple, actionable steps. ▪ Growing momentum for funding allocation within the subnational government system from increased technical capacity and confidence of key district officers. ▪ Growing buy-in and empowerment of local governance structures to institutionalize child protection priorities and resource allocation and to act as gatekeepers.	▪ The District Collector directed the strengthening of all local child protection committees and the utilization of local government funds for child protection priorities, including prevention and alternative care services for children in need of care and protection.

Context	Intervention	Mechanism	Outcome
India – Faith-Based (Tamil Nadu) ▪ Parish committees have resources and authority for community welfare, but traditionally focus on institutional care or ad-hoc charity. ▪ There is a high prevalence of vulnerable families at risk of separation due to poverty.	▪ Conducting training sessions for parish councils and faith leaders on gatekeeping and family strengthening. ▪ Engaging parishes as community gatekeepers to identify and respond to prevent separation and enable reintegration. ▪ Engaging hierarchical church leadership (bishops, priests) to endorse family-based care. ▪ Holding sustained follow-up dialogues to reinforce concepts and encourage financial redirection. ▪ Documenting parish practices as gatekeepers and champions, and sharing with church leaders.	▪ Increasing legitimization of new approaches from top-down endorsement from bishops and priests, and alignment with core religious values of community support. ▪ Reframing of understanding of charity from handouts to structured, preventative support that keeps families together through repeated engagement.	▪ A parish committee decided to provide monthly financial and food support to vulnerable children and their families to prevent separation and institutionalization.

Generalized CIMOs: Financing

Context	Intervention	Mechanism	Outcome
▪ Systems with legal mandates for care reform and strong leadership that recognises the need, but with implementation gaps.	▪ Evidence-based advocacy, multi-level engagement and technical assistance (TA), which bridges the gap between policies and implementation; demonstration work supporting advocacy and TA. ▪ Ongoing alignment to political cycles.	▪ Growing sense of urgency, legitimacy and reducing perceived risk by concretizing solutions. ▪ Empowerment of officials to reallocate resources through clear alignment with relevant mandates. ▪ Increasing sustainability of initial political will though embedding change in official plans and budgets.	▪ Government allocated funds and owned coordination of care reform.
▪ Systems with fiscal constraints or mandatory spending rules (e.g., Moldova's cost savings from reintegration, Odisha's 5% Gram Panchayat Development Plan requirement) where financial efficiency or compliance and pressing social needs create structural incentives for reform adoption.	▪ Evidence-based advocacy, high-level political engagement, and technical capacity-building. ▪ Multi-stakeholder coalitions (government-NGO-UNICEF) sustain reforms, while demonstration work validates approaches. ▪ Strategic alignment with political cycles and priorities ensures traction. ▪ Documentation and sharing of promising and best practices to encourage reform.	▪ Increasing recognition of the value of reform amongst decision-makers based on fiscal insights (cost-benefit evidence, policy compliance) and operational proof points (pilot successes). ▪ Empowering of subnational governments through technical support and coalition-building. ▪ Increasing political ownership and sustained commitment through alignment with national and international mandates.	▪ Government works to increase funding for social service provision.
▪ Systems with strong faith-based governance structures and unmet family needs where traditional charity norms coexist with policy mandates for family-based care, but face systemic gaps in gatekeeping and implementation. ▪ Faith institutions' operational leverage and proximity to vulnerable families enable faith actor mobilization.	▪ Evidence-based advocacy and faith structure engagement legitimize reforms. ▪ Technical capacity-building and institutional mimicry scale models, while champion mobilization demonstrates viability. ▪ Strategic alignment with faith governance systems ensure sustainable adoption. ▪ Document promising practices and support residential care providers to share through trainings, meetings and networks.	▪ Increasing understanding and commitment to family strengthening and prevention of separation through alignment of messaging with faith values and legitimacy from engagement with faith hierarchies. ▪ Increasing local ownership through champion-led adoption.	▪ Faith-based organizations traditionally supporting residential care pioneer directing funds to support families and prevent separation.

Evidence and M&E

Original theory

CTWWC sought to strengthen the availability of data related to children in care and to promote the demand and use of data. CTWWC recognized that all demonstration countries lacked a comprehensive M&E framework and well-functioning management information systems (MIS), which are often linked to routine data gathered through case management. The original intention was to invest in these MISs and train key actors at multiple levels to ensure data would be accessible to inform decisions.

Overview of outcomes

Evidence and M&E outcomes were one of the least common types of change recorded by CTWWC, all occurring in Kenya (8 outcomes) and Moldova (6). Of the 14 outcomes recorded, 11 were national-level changes and 10 were changes in government actors. Although there were some changes in the gathering and use of data in the early stages of the initiative, such as a situational analysis of residential care in five counties of Kenya that brought many actors together around the vision for care reform, most of the outcomes occurred in the later years of the initiative, from 2023 onward. The outcomes fall into two main groups: first, engagement in, requests for and support of new data collection to better understand the provision and financing of children's alternative care, especially residential care; and second, improvements to functioning and use of MISs linked to care reform.

Description of change processes

Key to achieving change in the area of evidence and M&E was finding opportunities within wider reform efforts that required new or improved data to unlock progress. In both Kenya and Moldova, evidence-building was an initial strategy to engage the wide group of stakeholders, especially government, who were involved in driving reforms. One of the first steps undertaken in Kenya was a situational analysis of residential care providers in the demonstration countries who had been identified by the government. By undertaking the data collection in an open and participatory manner, with visible government leadership, trust was built with residential care providers and information about future reforms was well received, leading to wide engagement in future activities within the demonstration counties and replication of the situational analysis in other counties. In Moldova, deep-dive analyses of different areas of the care system, including the publication of improved children's assessments for those remaining in residential care, with government and civil society involvement, led to requests for further assessments and ongoing data collection and use practices. The analyses and assessments were significant in informing the government's plans and bringing stakeholders together in their understanding of where reforms were needed.

Similarly, when senior government officials requested new data in recognition of existing gaps, it allowed for the prioritization of improvements to existing systems. In Kenya, this happened during the response to the COVID-19 pandemic when residential care facilities were closed and children were returned to families with minimal preparation and support. CTWWC's rapid data collection to identify families' needs, flagging a gap in systematic data collection, eventually led to DCS prioritizing improvements to the Child Protection Information Management System (CPIMS). In Moldova, high-level meetings around evidence-based roadmaps and policy briefs, including the responsible Minister, led to significant decisions around deinstitutionalization plans and improvements to linked monitoring of children remaining in institutions. Rolling out the collection of requested data through existing systems—through residential care providers required reporting into CPIMS in Kenya and regular monitoring reports in Moldova—embedded new data collection within official, routine systems of data collection, which were designed with input from the national government.

Finally, building awareness of the need for data and providing training, refresher courses, supportive supervision and peer learning opportunities to care providers built understanding and confidence in using new methods. Beginning with pilots in demonstration areas and amongst a few partners, as well as jointly addressing problems that arose and

encouraging use of data, reinforced confidence, made improvements feel possible, and built ownership and commitment toward data collection and use. Linking data collection to improving case management processes allowed training and support to improve daily practice in both areas at the same time.

Component linkages

Many of the M&E outcomes occurred late in the initiative and only occurred in Kenya and Moldova. As noted, enough progress in the care system needs to be observed for investment in M&E to be viable, especially in policy, workforce and financing.

Country-specific CIMOs: Evidence and M&E

Context	Intervention	Mechanism	Outcome
Moldova ▪ Existing child protection MIS and annual reporting, but with limited verification. ▪ Service provision was decentralized, but a reform was initiated to consolidate it under a new national plan. ▪ National plan for care reform aligned with EU accession.	▪ Undertaking initial analyses of monitoring system, including child assessments. ▪ Facilitating high-level conferences to discuss analyses and collaboratively build plans. ▪ Training and mentoring civil society partners in M&E activities. ▪ Training and mentoring residential care providers in case management and reporting with national monitoring framework. ▪ Supporting digitalization of case management tools with national access.	▪ Growing understanding and ownership of M&E through engagement and collaborative design and use. ▪ Legitimatizing reforms and creating political incentives through alignment with national plans and EU accession. ▪ Improving accountability and collaboration through regular and more accurate reporting.	▪ The MLSP published assessment reports on children in residential care, requested financial analysis on two forms of alternative care and family strengthening, strengthened its use of data by requesting updated information on children in residential care, and supported a national care leavers study ▪ Local implementation partners agreed to continue compiling data in reintegration beyond donor requirements, as it proved useful in demonstrating impact.
Kenya ▪ Gaps in national MIS (alternative care missing) and low data input and use. ▪ Large number of non-State residential care providers and distrust due to past policy decisions (moratorium on new registrations). ▪ Weak but improving coordination and oversight mechanisms. ▪ Unexpected crisis (COVID-19) highlighted need for data improvements. ▪ Decentralized child protection oversight at county-level.	▪ Leading government-endorsed and highly participatory situational analysis of residential care and rapid data collection on children who left residential care during COVID-19 pandemic. ▪ Facilitating multi-stakeholder engagement on improvements to national child protection MIS in line with national strategy for care reform and with public endorsement from government. ▪ Training, technical support, supportive supervision and peer learning for local care providers and managers on roles and use of MIS, linked to case management training.	▪ Increasing shared understanding, skills and confidence through participatory peer learning. ▪ Growing trust, buy-in and motivation amongst diverse stakeholders through positive framing and government endorsement, alignment and ongoing support. ▪ Improving local problem-solving capacity from technical accompaniment. ▪ Growing desire and motivation to replicate success in demonstration areas that act as “proof of concept.” ▪	▪ Government and residential care providers participated in national and county-level data collection exercises to track children who had left or remained in care. ▪ The national child protection MIS was revisited and enhanced with new modules for alternative care. Trainings and refresher sessions increased reporting, with several residential care providers starting to use the MIS in demonstration areas and beyond. ▪ Plans were initiated for a desk review and publication on transition of care data in Kenya to build evidence and inform future practice.

Generalized CIMOs: Evidence and M&E

Context	Intervention	Mechanism	Outcome
▪ Crisis that puts children at risk; government pressured to respond.	▪ Support from experts to conduct rapid data collection with government leadership to inform decision-making.	▪ Increasing credibility and relevance of data to critical decisions.	▪ Data is used to inform immediate plans and responses, and may increase demand for data in future.
▪ Government commitment and clear overarching strategy for care reform, and existing but weak/underutilized child protection MIS. ▪ International pressure for care reform.	▪ Demonstrate usefulness of data by supporting high-quality data collection and use. ▪ Support collaborative improvements to MIS and wider M&E systems under government leadership and in line with national strategy.	▪ Leaders gaining practical insights into how data is essential for planning, policy and international obligations. ▪ Growing trust and shared ownership of improvements; embed within existing systems and workflow.	▪ Government requests more data to aid decision-making linked to care reform strategy. ▪ Government sustains demand and use of data through existing systems.
▪ Local care and service providers are not fully engaging with national data collection processes (one-off studies or routine MISs).	▪ Engage local actors to raise awareness of purpose. ▪ Align with overarching government strategy/plans. ▪ Build local capacity and problem-solving ability through training and supportive supervision. ▪ Undertake pilots or demonstration area improvements, and share learning with public government endorsement.	▪ Increasing trust and lowered resistance from clarity of purpose and alignment with “official” change. ▪ Growing understanding and experience that data is useful for reporting and advocacy. ▪ Increasing legitimacy, acceptance and momentum for scaling of pilots and early improvements that have shown what is possible.	▪ Local actors more likely to institutionalize or voluntarily participate in data collection and use.

Service Delivery

Original theory

CTWWC aimed to demonstrate good practice through direct service delivery in demonstration areas at the family and community level to prevent the unnecessary separation of children and to support the reintegration of children from residential care facilities into safe, nurturing families or independent living, based on the best interests of the child. It was expected that this would require the development and training of key actors in a strong case management approach that would also strengthen families' abilities to engage in supportive childcare practices and access family and community services already available in the demonstration areas. Demonstration efforts would also support the development of a range of family care options such as foster care, kinship care or domestic adoption, as well as support for care leavers to move into independent living. CTWWC would also accompany residential care facilities as they become providers of community-based services (or close, if needed). The longer-term aim of the demonstration work was to show governments and communities that change is possible and provide a small model of good practice that could be scaled up and replicated. It was hoped that learning and evidence from demonstration areas would be documented and used as a tool for advocacy to influence stakeholders to carry out reform.

Overview of outcomes

CTWWC recorded 78 outcomes that were categorized as changes to service delivery. Most of these were at the subnational level (64) and were amongst residential care actors (32) and government actors (24). More than half of the outcomes (42) involved changes in practices within residential care providers, such as improvements in case management and reintegration practices or progress with transition planning and development of new service models. Another 31 outcomes were related to improvements in family strengthening, including changes in gatekeeping mechanisms, expansion of the reach of services and disability inclusion adaptations. Only five outcomes were related to changes in the provision of family-based alternative care, such as foster carer selection and training improvements. Local-level changes in service delivery were some of the first to be achieved, linked to early demonstration efforts through raising awareness and training of service providers and local authorities. National-level changes, such as the development or endorsement of plans and tools, took longer to achieve, but were often related to further outcomes at the local level.

Description of change processes

Change to service delivery was achieved in many ways across the four countries, but by far the most common approach was to build the knowledge and skills of service providers through practical training and mentoring to enable the application of new practices. Building capacity in case management, reintegration of children with families, and prevention services and support for families was universal. This was often one of the first interventions that CTWWC delivered and was noted in the initiative's first evaluation, conducted in year three, to be a powerful entry point as it "seems to have a neutralizing effect to existing institutions' objections, as it so clearly centers on caring for the child and is a direct action aimed at reducing any harm from trying different care approaches (reunification, prevention)."[21] This highlights the importance of changing beliefs about what "good care" means in order to shift service delivery. It was important that service providers understood the value of case management, reintegration and family strengthening and how they themselves were in line with this mission if they were to take it up and improve their practice. Standardizing the processes, through clear guidance and tools, and building supportive supervision capacity helped to build skills and confidence in the application of new practices. It also created consistency in decisions and follow-up.

All of the demonstration countries pursued a subnational pathway first, using demonstration area implementation to test and illustrate practices with the aim that they could eventually be scaled. Pursuing this local change first empowered local actors and promoted a sense of local responsibility as well as a desire to showcase good practice from which others could

[21] CTWWC Year 3 Evaluation, 2022

learn. Local leaders became champions for further change, such as the Director of SBS Zacapa and the departmental governor in Guatemala and CCI managers and sub-county children's officers in Kenya, as well as local social assistants and NGOs (Child, Community, Family [CCF], Keystone, Partnerships for Every Child [P4EC]).

Another common approach was investing in relationship building and networking, which was seen to increase trust, communication, and shared understanding and agendas among stakeholders. In Kenya, pre-existing local networks and national coordination mechanisms were revitalized to allow for multi-sector collaboration and stakeholder buy-in, which reinforced good practice and the uptake of service improvements. In Guatemala, local coordination was achieved through the Commissions for Children and Adolescents, involving SBS and local civil society. The creation or renewing of these commissions expanded the pool of resources and expertise and improved referral pathways. They all created legitimacy for service improvement due to diverse membership, which helped to overcome political barriers and high turnover within the judiciary. In Moldova, high-level conferences, technical task forces and workshops brought together ministries, local authorities, NGOs and international donors, which built common understanding and commitment to service improvements.

Also common to all demonstration countries was the essential factor of government buy-in, which allowed for the institutionalization of practices through embedding tools, processes and policies, all of which made outcomes more durable. This buy-in was achieved at different levels, such as through departmental governors in Guatemala, sub-county children's officers in Kenya and parliamentary leadership in Moldova. Service delivery improvements hinged on political and administrative alignment so that local service providers felt the need to align with government policy, plans and procedures. Government leadership also allowed for subnational and national coordination to reinforce good practices and the (re)direction of funding toward service improvements, as seen in municipal funding of prevention services in Guatemala and deinstitutionalization plans in Moldova. Additional pressure was felt when practices were backed by international pressure, such as from the EU accession process in Moldova.

Finally, the use of evidence, international good practice and case examples persuaded actors to adopt new approaches to service delivery and maintain them. In all four countries, demonstration efforts were crucial to changing minds and making changes feel not just possible, but normal. In Kenya, case management guidance, building on international good practice, to support the reintegration of children from residential care in demonstration counties helped to normalize these practices for CCIs in other counties. Further, the replication of OMNAs across 11 municipalities in Zacapa, Guatemala created visible results that were reinforced by results from household surveys and allowed for wider engagement of departmental leadership. Whilst in Moldova, following national situational analyses and reviews of international good practice, the implementation of specialized foster care, family strengthening programs and faith engagement pilots built understanding and evidence to inform wider scaling efforts.

Component linkages

It is important to note that changes in service delivery were closely linked to changes in financing and the workforce. Many outcomes are only achievable if financial resources have also shifted. The emphasis in many interventions to improve services is on building the capacity of the workforce at multiple levels.

Country-specific CIMOs: Service Delivery

Context	Intervention	Mechanism	Outcome
Moldova ▪ A national, collaborative child protection plan exists. ▪ Government agencies are the main social service providers, with some local support from civil society. ▪ Service provision is fragmented under local authorities, with constrained local budgets and therefore, uneven provision of services between locations and unclear accountability. Decentralized budgeting was replaced recently by centralized budgeting to help address gaps. ▪ Care reform is a key feature of EU accession agenda.	▪ Training and mentoring social assistants in improved case management and reintegration planning at the residential care facility level. ▪ Studies and pilot interventions on specialized foster care for children with disabilities and family support services. ▪ High-level, multi-stakeholder convenings on care system planning and financing. ▪ Coordination meetings with key parliamentary and government stakeholders to finalize deinstitutionalization planning. ▪ Supporting the development of deinstitutionalization plans.	▪ Changing minds and building skills and confidence amongst local practitioners. ▪ Changing minds and building buy-in with government (national and subnational) on economic and social benefits of deinstitutionalization and prioritization of family care. ▪ Legitimizing and reinforcing active implementation by relevant authorities in line with national government plans. ▪ Building wider stakeholder commitment and action from participation in, and deference to, national planning.	▪ Government and wider stakeholders acted to progress transformation of all residential institutions and provide prevention and family-based care services, including services for children with complex needs, countrywide. ▪
India - Church in Tamil Nadu ▪ Church-run CCIs operate with limited integration with state systems. ▪ CCI staff lack exposure to, and are uncertain of, case management approaches and new family strengthening models. ▪ Strong religious and moral values and commitment to care for children.	▪ Learning visits, sensitization and mentoring of Catholic religious leaders managing CCIs. ▪ Structured exposure to family-based care, and accompaniment in adapting practices. ▪ Engagement with church hierarchy and use of peer examples to influence reluctant actors.	▪ Changing attitudes driven by reflection on faith-based values aligned with children's best interests, triggering emotional engagement and moral conviction. ▪ Growing legitimacy through Church leadership endorsement and peer modeling.	▪ Several Church-run CCIs initiated structured transition plans, incorporated case management approaches, and committed to reduce institutional placements in favor of family strengthening models. ▪ Broader cultural shift within religious orders beginning to emerge.

Context	Intervention	Mechanism	Outcome
Guatemala ▪ Child protection agencies are working in silos with low visibility of lead national agency. ▪ Local municipal offices have extremely limited staff and focus more on events rather than service delivery. ▪ Weak and inconsistent political will and lack of coordination meant support for children and families was missing or fragmented. ▪ Local actors are not engaged in systemic change. ▪ Over time, some growing availability and willingness of the local government to support care reform.	▪ Local sensitization meetings with municipality leaders resulting in cooperation agreements, joint planning and sharing of learning. ▪ Developing guidance and providing training and accompaniment for government and non-government on case management, positive parenting and prevention of separation. ▪ Delivering case management and positive parenting training, and supporting others to replicate. ▪ Coaching *hogares* (residential care facilities) in making transition plans and exploring new service models. ▪ Convening local actors and facilitating discussions around the role of municipalities in the prevention of separation.	▪ Legitimization of new practices through formal agreements/plans. ▪ Building technical skills and confidence. ▪ Normalization of new services within municipal mandate by leveraging existing/provided for structures and networks. ▪ Growing shared vision and mutual accountability through multi-actor coordination. ▪ Reducing resistance by reframing care reform as focused on child well-being, supporting families and preventing separation. ▪ Shifting mindsets at the national level by demonstrating need, viability and interest at lower levels.	▪ In 11 municipalities in Zacapa, OMNAs established/reactivated, psychosocial services expanded, Family Care Commissions created, Schools for Parents implemented. ▪ In Zacapa, a Departmental Commission on Children and Adolescents of Zacapa created to coordinate actions that contribute to family care, protection of children and adolescents, and prevention of unnecessary separation. ▪ Several *hogares* advanced reforms through the adoption of structured case management and community-focused service models.
Kenya ▪ Growing government leadership of care reform, with emergence of new policies and guidance. ▪ Large number of non-State residential care and social service providers. ▪ Limited coordination mechanisms among State and non-State actors. ▪ Decentralized government child protection and social service structures. ▪ Strong community and religious structures with a mission to serve families and children. ▪ Missing or fragmented gatekeeping and referral mechanisms.	▪ Multi-stakeholder meetings and forums with clear messaging aligned with government policy. ▪ Training and consistent accompaniment, with visible engagement of county child protection government actors. ▪ Use of collaboratively-designed and government-endorsed guidelines and tools. ▪ Engagement through existing local networks and community structures, including the Catholic Church and Islamic forums.	▪ Building understanding and skills amongst CCI staff and community leaders to normalize provision of new approaches/services. ▪ Growing trust through consistent, collaborative engagement, with endorsement from government or religious leaders. ▪ Fostering legitimacy, shared vision and confidence through peer support (seeing and learning about change) and peer pressure (not wanting to be left behind). ▪ Aligning with shared commitment to children and family, already present in local structures.	▪ CCIs in demonstration counties progressed in transitioning, including admissions reduced or stopped, case management and reintegration support improved, and new family-strengthening services initiated. ▪ Local case conference committees established/strengthened to coordinate gatekeeping. ▪ Community and local government-initiated support to families to prevent separation. ▪ Care leaver network formation and strengthening (registration, strategic planning, etc.).

Generalized CIMOs: Service Delivery

Context	Intervention	Mechanism	Outcome
▪ Pressure (from global/regional agendas, national policy shifts/ commitments) to reform care provision and social services, but leadership is not visible, is weak or changing, and local service provision is fragmented.	▪ High-level advocacy, multi-stakeholder convenings, technical assistance to policymakers. ▪ Training and mentoring of select service providers who show interest, with government engagement.	▪ Legitimization of reform and trust-building from observing government commitment. ▪ Building government visibility, confidence and ownership of reform. ▪ Illustrating change through early adopters to build confidence in viability.	▪ National/state authorities adopted and drove reform of services. ▪ Engagement of new stakeholders and formation of multi-stakeholder groups spread key messages, leading to replication and scaling. which influence higher-level reforms.
▪ Service providers are siloed and capacity (knowledge, skills, resources) is limited.	▪ Training, mentoring, accompaniment and exchange visits to demonstrate case management, reintegration and family-strengthening approaches. ▪ Technical assistance to pilot new models within an adaptive management and learning framework.	▪ Changing minds and building practitioner confidence through learning-by-doing. ▪ Normalizing new approaches through peer examples. ▪ Confirming moral, religious and professional conviction that family care is preferable.	▪ Gradual adoption of new practices and increased functional local service provision to support families. ▪ Improvement in case management and reduced admissions in residential care.
▪ Coordination mechanisms are weak or fragmented, with unclear accountability for child protection and referral pathways.	▪ Facilitate multi-stakeholder forums and evidence-based dialogues. ▪ Promote the use of government-endorsed guidelines and tools.	▪ Trust-building and shared visions and roles amongst key stakeholders. ▪ Legitimacy and mutual accountability through collaborative agreements/forums.	▪ Reduced duplication and improved alignment and coordination of services. ▪ Functional gatekeeping and referral mechanisms.
▪ Strong community and religious networks exist with moral authority and commitment to children and families, but limited integration with formal systems.	▪ Support convenings within existing networks and structures for sensitization aligned with faith/moral values and commitments, and co-design of family support services within current mandates/missions.	▪ Building understanding of reform messaging within existing world views. ▪ Legitimacy from endorsement by respected leaders reduces resistance. ▪ Collaboration and peer modeling motivates change.	▪ Community-based and faith-run service providers strengthened collaboration as well as initiative transition and development of new/improvements to service models.

Conclusions

Transferable insights for each system component

Using the realist evaluation approach, the CTWWC team sought to reflect on and learn from the experience of systems change in the initiative's demonstration countries. Beginning with reflection on the theory at the start of the initiative, looking across the outcomes gathered on system components, and discussing within the initiative's team and with collaborators, the evaluation process was an opportunity to identify commonalities and differences and consider what transferable insights might be drawn from looking across the four experiences. These are presented here by each system component.

- **Legislation, policy and coordination**

  Care systems with clear overarching child protection laws, but with major implementation gaps in the provision of family-based alternative care and family strengthening support (context), respond to evidence-based advocacy, technical partnership and structured multi-stakeholder coordination (interventions). These interventions trigger political ownership, institutionalize trust and facilitate operational clarity (mechanisms), leading to the approval of new policies and the establishment of governance structures that prioritize family-based care over institutionalization (outcomes).

- **Social service workforce**

  Care systems with an existing national mandate for reform, but with workforces historically oriented toward residential care and thus, with limited knowledge and skills around family-based alternative care and family strengthening, and with weak professional recognition (context), respond to targeted training, technical accompaniment, co-creation of new models and learning exchanges, and institutional embedding of reforms (interventions). These interventions trigger professional confidence, shifts in attitudes, institutional legitimacy, and greater ownership and normalization of new approaches (mechanisms), leading to a more competent, professionalized and sustainable workforce able to deliver and champion family care and support over residential care (outcomes).

- **Financing**

  Care systems with overarching child protection laws, but with fiscal constraints, implementation gaps and entrenched norms around residential care (context) respond to evidence-based advocacy from fiscal studies and pilot models with multi-level advocacy that resonates with specific values (e.g., policy compliance for government, theological alignment for faith-based actors, economic sense for governments and donors, etc.) and technical assistance (interventions). These interventions increase credibility and feasibility of reforms, raise legitimacy and reduce resistance (mechanisms), leading to governments and nongovernmental agencies allocating and/or redirecting funds toward family-based care and social services as well as residential care providers, including those that are faith-based, committing financial and in-kind support to strengthen families and preventing separation (outcomes).

- **Evidence and M&E**

  Care systems where governments have a clear strategy for reform, but where M&E systems are weak, under resourced and underutilized (context), respond to high-quality assessments to inform decision-making, collaborative improvements to management information systems and capacity strengthening at multiple levels (interventions). These interventions trigger increases in trust and credibility among leaders, reduce resistance and increase shared-ownership and motivation to scale among local workforce and service providers (mechanisms), leading to data being used to inform immediate plans, governments investing in M&E systems and local actors institutionalizing improved data collection.

- **Service delivery**

  Care systems with fragmented service provision and weak coordination (context) respond to targeted, government-endorsed capacity-strengthening, multi-stakeholder convenings to develop guidelines and tools, and to sensitize faith and community networks aligned with their moral values (interventions). These interventions trigger increasing legitimacy, trust, confidence, skills and value alignment (mechanisms), leading to progressive change toward stronger family care and support services as well as well-functioning coordination and referrals (outcomes).

System-wide themes

When considering the findings together, clear themes emerged on how systems change and strengthening unfolds. These themes, presented below, are aimed at synthesizing the learning in a manner useful to others.

- **Evidence and demonstration as catalysts.**

  In all components, evidence-based advocacy and pilot models or demonstrations were critical. Demonstration work (case management pilots, situational analyses, cost–benefit studies, family strengthening services, etc.) legitimized reforms, reduced resistance, changed mindsets and showed decision-makers that change was feasible.

- **Government ownership as critical to reinforce, scale and sustain change.**

  Reforms gained traction when government actors (ministries, councils, municipal leaders) assumed visible leadership and coordination roles, drafted overarching strategies, and endorsed guidance and tools. These actions validated the changes and shifted them from ad-hoc projects to institutionalized, sustainable reforms that could be scaled over time. Government ownership brought others along in the change process.

- **Partnerships and multi-stakeholder collaboration as foundations for legitimacy and accountability.**

  Across all areas, diverse coalitions (government, NGOs, faith leaders, people with lived experience, academia, donors, communities) created legitimacy, accountability and momentum. Formal structures (e.g., core teams, commissions, national working groups and MoUs) institutionalized these relationships, outlined clear responsibilities and increased accountability. Paired with government in coordination roles, non-government partners were more willing to collaborate with each other.

- **Capacity building as an entry point.**

  Training, mentoring, technical accompaniment and peer learning opportunities were effective strategies that not only built skills, but also shifted attitudes and increased trust and confidence. This was true for faith leaders, government stakeholders, residential care operators and civil society organizations. Capacity building activities were most often a gateway to launch a longer process of change, including legislative change, development of standards and willingness to transition services.

- **Alignment with broader agendas and values as frameworks for change.**

  Change was often unlocked by framing reforms in terms of existing priorities or norms: EU accession in Moldova, decentralization in Guatemala and Kenya, Mission Vatsalya in India, and religious values in faith-based contexts. Aligning with what already mattered politically, economically and morally created powerful incentives for adoption of change and scaling of demonstration models. Fostering and encouraging various champions, from government to faith leaders, meant that those broader agendas and the spread of family care values were supported from behind by CTWWC, but driven forward by those who could legitimize and further influence change.

- **Adaptive problem-solving in complex systems as critical for navigating challenges.**

  Across components, progress often required navigating blockages (e.g., stalled councils, resistant leaders, resource shortages, political changes, global pandemics, etc.). This required flexibility, collectively seeking alternative pathways, and an ability to pivot rapidly as well as opportunistic engagement with champions and leaders. Adaptation was a shared mechanism to sustain momentum. The existence of good networks and collaboration

ensured a sense of “speaking with one voice” and a shared responsibility to problem-solve and navigate challenges when necessary.

- **Inter-linkage of system components as necessary for long-term change.**

  Tracking change across system components shows how changes in one affect or are impacted by changes in another. This highlights the importance of a multi-component, long-term approach to system strengthening. This will be a challenge in the future given the substantial changes in the funding landscape for children’s care reform at the time of writing in 2025, and yet, it is ever more important to reach scale and sustain changes that are critical for child and family wellbeing.

Insights for those supporting reforms

From the perspective of CTWWC, as an initiative seeking to support and inform care reform, it also clear that for those in this role it is important to:

- **Embrace adaptive management and recognize that not all plans are feasible in practice.**

  CTWWC had a large goal, and a lot has been achieved alongside our partners. But reform is a long process in an ever-evolving environment, so being able to recognize when things are not working and adapting to that is a key strategy and a necessary skill. One colleague reflected recently that our initial desire to embrace our failures as well as our successes was uncomfortable and hard to start with, but now she can see how much learning and progress has come from this approach.

- **Find a suitable monitoring approach to track and learn about systems change; share learning.**

  Although Outcome Harvesting was initially selected as a viable method for monitoring and evaluating regional and global influence, it turned out to be most useful for understanding system strengthening. It allowed the ongoing, systematic capture of examples of change overtime, as well as influences on and linkages between those changes. Outcome Harvesting was also a good fit with Realist Evaluation for understanding system strengthening below the surface and reflecting on similarities and differences in how and why change unfolds across contexts. We believe this is the first evaluation to use the realist approach to look at children’s care system strengthening, although it has been used on health system strengthening interventions. It is important to continue to increase our understanding of what works in which contexts and why.

Recommendations

Given that the results of this evaluation build on the implementation of a complex, multi-country, multi-year initiative, the following key recommendations are shared for governments leading care reform efforts and for agencies and organizations supporting system strengthening for children's care.

For Governments

- **Embed family care in policy, budgets and broader agendas.**

  Leverage national priorities such as EU accession, decentralization, disability inclusion, child protection reform and poverty reduction strategies. Ensure reforms are backed by implementation frameworks and resources for preventing separation, family strengthening and family-based alternative care, and always with consideration for disability inclusion.

- **Strengthen coordination structures.**

  Establish or reinforce government-led reform bodies (e.g., core teams, national working groups, councils, commissions) with authority to guide, learn from and adapt reforms. Do not see reforms as stagnant, one-off exercises. Build flexibility to adjust national and subnational visions, plans, strategies and budgets in response to crises, political shifts, new opportunities and the evolving needs and strengths of families.

- **Institutionalize participation of people with lived experience**

  Create formal mechanisms for children, young people, care leavers, parents and others with direct experience of care systems to inform policy, strategy and service delivery. Their perspectives help identify practical gaps, shift mindsets and strengthen accountability.

- **Invest in the social service workforce.**

  Engage and work with nongovernmental organizations and academia to institutionalize training modules that include case management, family strengthening, reintegration, service transition and disability inclusion within government human resource systems, national or subnational curricula, and other training systems. Create career pathways, supportive supervision structures and practice, and institutionalize a system of continuous professional development to reduce turnover and increase professionalism, recognition and motivation.

- **Institutionalize evidence building and learning.**

  Strengthen monitoring and evaluation through the development or improvement of MISs to routinely collect and analyze data, and make data accessible and useful. Link case management, financing and policy reforms to evidence. Embed learning from successes and failures, enabling informed-adjustment to strategies and approaches over time.

- **Adopt a whole-of-system approach.**

  Recognize the interlinkages of system components. Policy reforms will only succeed if financing, workforce, service delivery and social norms are addressed together. Pursue reforms as part of a long-term, whole-of-system strengthening strategy. Additionally, consider all actors within that system and find ways to meaningfully engage them. Include people with lived experience, civil society organizations, other relevant ministries, the faith community and service providers in visioning, evaluating, designing and implementing inter-sectoral approaches to children's care.

For those supporting governments

- **Align with government leadership and national strategies.**

  Understand the national vision for children's care and support within existing national strategies and values frameworks (e.g., decentralization, national strategy, religious commitments) even if these are still evolving. Work

through formal mechanisms (MoUs, commissions, working groups) to reinforce government ownership and legitimacy.

- **Strengthen capacity and accompany.**

  Provide practical training, mentoring and peer exchanges for government, non-State service providers, residential care providers, smaller civil society organizations and community members. Pair formal training with technical accompaniment that is flexible and responsive to shifting contexts, needs and strengths. Support government and nongovernment actors to strengthen the capacity of each other. Train trainers, support learning events, share learning and capacity building materials openly. Adapt training and capacity strengthening as reform contexts changes.

- **Facilitate and utilize the engagement of people with lived experience.**

  Support networks of care leavers, parent groups and youth advocates to meaningfully participate in reform processes. Provide safe spaces, training and resources so their voices are not symbolic, but have real influence on decision-making. Encourage and support State actors to formalize mechanisms for participation.

- **Leverage demonstration and evidence generation.**

  Nongovernment partners are often the ones who pilot or demonstrate new services and new ways of working. Continue to pilot and rigorously document new models (e.g., foster care for children with disabilities, family strengthening, faith-based prevention initiatives). Share results widely to inform government decision-making and to reduce resistance by showing that change is feasible. Sharing can include facilitating visits to implementation sites when such visits can be done safely and with opportunities to reflect on the practices observed.

- **Mobilize and redirect private resources.**

  Advocate with donors, residential care operators and faith-based organizations to continue redirecting (as opposed to stopping) resources from residential care to family support and community-based services. Use investment cases and cost–benefit analyses to demonstrate the fiscal and social advantages of reform to governments and to those to whom such fiscal evidence is compelling.

- **Champion social norms and mindset change.**

  Engage influential champions within existing structures where they have influence (locally, nationally and beyond). This can include faith leaders, academics, local officials and people with lived experience. They have become the strongest voices for continued change in CTWWC demonstration countries, regionally and globally. Champions help to shift perceptions about family care. Normalize family-based alternatives by aligning reform messages with prevailing social, political, and moral values and norms by working with and learning from existing champions. Have champions build new champions.

- **Support integrated systems strengthening.**

  While resources may be limited, avoid siloed interventions. Combine workforce training with service delivery pilots, financing support and data system improvements so that reforms reinforce each other and achieve sustainable scale. When this is not possible, seek partnerships with integrated systems strengthening in mind. Find others who can complement your capacity and resourcing, and work in collaboration and partnership.

Lastly, a message for the wider care reform sector**:** It is more critical than ever to continue to increase global understanding of what works, in which contexts, and why. CTWWC hopes that there will be a way, in collaboration with many partners and through platforms like the Transforming Children's Care Collaborative, to continue to contribute and share experience, evidence and learning from care reforms across the many contexts of the world. Change can happen for all children!