Boston College
School of Social Work

THE WELL-BEING OF KENYAN CHILDREN REUNIFIED WITH FAMILY AFTER LIVING IN RESIDENTIAL CARE INSTITUTIONS

A dissertation
by

SARAH ELIZABETH NEVILLE

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SARAH ELIZABETH NEVILLE

Dissertation Chair:

Thomas M. Crea, PhD, Boston College School of Social Work

Committee Members:

Indrani Saran, ScD, Boston College School of Social Work

Margaret Lombe, PhD, Boston University School of Social Work

Abstract

About 5.4 million children worldwide live in residential care institutions (also known as "orphanages"), including an estimated 60,000 in Kenya alone (Desmond et al., 2020). Estimates suggest 80% of children in orphanages globally have at least one living parent (Berens & Nelson, 2015; Csáky, 2009; Petrowski et al., 2017), and human rights principles (United Nations General Assembly, 2010) have motivated the Kenyan government to carry out "care reform," reducing reliance on residential care and prioritizing family-based care for vulnerable children. In this context, many children have reunified with their families after living in residential care. The aim of this dissertation is to examine the experiences and well-being of such children. The first study uses qualitative methods to explore how Kenyan children and young adults who previously lived in residential care describe their lives in residential care and after leaving it. The second study describes the development of a quantitative measure of subject well-being tailored to the priorities of young people who have lived in residential care, and includes an exploratory factor analysis to determine the factor structure of the measure. The third paper uses multivariate analyses to examine how Kenyan reunified children's subjective well-being may statistically relate to child characteristics, including disability status, when controlling for child gender, age, and time since family reunification. Specifically, I hypothesize that having a disability will be associated with worse subjective well-being and more negative experiences of reunification than children without disabilities. Together, these three studies are designed to address gaps in existing knowledge related to successful transitions of children from residential care into families in Kenya, suggesting promising practices for social workers overseeing children's reunifications and future directions for research on this population.

Chapter I. Introduction

Background

Current estimates suggest that worldwide, about 5.4 million children live in residential care institutions, also known as orphanages, although reliable numbers are scarce (Desmond et al., 2020). The term “orphanage,” though a common colloquial term, is misleading however, as children are not necessarily placed in these institutions because of their parents’ deaths. In Sub-Saharan Africa, for example, studies estimated that in Liberia, 88% of children in residential care had at least one living parent; in Zimbabwe, the proportion was 59%; and in Ghana, up to 90% of children had one or both parents alive (Csáky, 2009). The reasons that children do enter institutions are complex and diverse, and often more related to their parents’ or extended families’ poverty than a lack of living relatives. Indeed, many children whose parents have died do not necessarily reside in residential care, but instead tend to live with other relatives (Martin & Zulaika, 2016).

These same patterns generally hold in Kenya: most children without living parents do not live in residential care institutions, and children in residential care often live there for reasons besides parental death. Only 1.2% of Kenyan children ages birth to 17 are “double orphans” with two deceased parents; 8.5% have lost one parent (Zulaika & Martin, 2017). Official statistics state that about 51,000 children, or 0.231% of the total child population, live in institutions in Kenya, though Desmond et al. (2020) estimate that the actual number is closer to 62,000 (0.278%). Chege & Ucembe (2020) posit a number of factors underlying why children enter institutions in Kenya, although they report that research and documentation on the phenomena are lacking. These factors mainly include poverty and the poverty-related issues of violence, abuse, neglect, and abandonment; these issues can lead to children's admission to institutions directly, or they may cause children to live on the street, and institutions may "rescue" them from street life. In addition, cultural factors interact with poverty to cause children to enter institutions, including stigma and discrimination against HIV/AIDS and disabilities, and practices such as genital cutting and early marriage. Families may seek residential care for their children given their inability to care for these medical needs, illnesses, or disabilities. Girls may also escape genital cutting and marriage by seeking shelter in residential care institutions (Chege & Ucembe, 2020).

Why, though, are residential care institutions used as a solution for these issues, which could perhaps be addressed in other ways? Traditionally, across Africa and in Kenya, children who could not live in the care of their parents were cared for in extended families and local community networks rather than in residential care (Chege & Ucembe, 2020; Lombe et al., 2019). These networks weakened over time as a result of deepening poverty and inequality (1960s to present), high rates of illness and death brought on by the HIV/AIDS pandemic (1980s to present), and the death and family separation caused by armed conflict (early 1990s, 2007-2008) (Chege & Ucembe, 2020). According to Chege & Ucembe, in the 1980s and 1990s, the World Bank and International Monetary Fund promoted policies designed to increase economic efficiency and stimulate economic growth, in part by decreasing the amount that the Government of Kenya spent on public social programs; this, they purport, led to increased poverty and inequality among Kenyan citizens (2020). Private charities, many of which came from the West, sprung up to fill this gap, including many which founded orphanages, based on a model of care imported from Western Europe (Chege & Ucembe, 2020). Easily able to elicit philanthropic support, especially from Western missionaries, prospective international adoptive parents, and "voluntourists" (foreign tourists who volunteer in residential care institutions), residential care became more and more entrenched in the fabric of Kenyan social services (Chege & Ucembe, 2020; Cheney & Rotabi, 2014). In 2015, it was estimated that there were over 830 residential care institutions in Kenya, which are officially called Charitable Children's Institutions (CCIs) by the Government of Kenya.

However, international frameworks do not support over-reliance on residential care institutions as a solution for at-risk children. The UN Convention on the Rights of the Child (CRC) states, "Where the child's own family is unable, even with appropriate support, to provide adequate care for the child, or abandons or relinquishes the child, the State is responsible for protecting the rights of the child and ensuring appropriate alternative care," which could include "foster placement, *kafalah* of Islamic law, adoption or if necessary placement in suitable institutions for the care of children" (United Nations General Assembly, 1989, art. 21). Thus, the Convention creates a clear hierarchy of care for children: first, children should be cared for in their own families; second, if that is not possible, governments must provide them with "alternative care," which can include foster care and adoption; third, and only "if necessary," children can be placed in "suitable" institutions as another form of alternative care.

Human rights frameworks also affirm the right to family care for children with disabilities in particular. The UN Convention on the Rights of Persons with Disabilities states that persons with disabilities have "equal rights with respect to family life" and that "[i]n no case shall a child be separated from parents on the basis of a disability" (United

Nations General Assembly, 2006, art. 23). Furthermore, national governments must, "where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting" (United Nations General Assembly, 2006, art. 23).

In 2010, the UN published a resolution to welcome the Guidelines for the Alternative Care of Children, a non-binding set of principles expanding on the CRC in regards to these topics (United Nations General Assembly, 2010). This document states that poverty should never be the sole reason for removing a child from the care of his or her parents and that governments must work to take children needlessly living in residential care institutions and reintegrate them with families. Instructions for implementing these guidelines, titled *Moving Forward,* were solicited and published two years later (Cantwell et al., 2012). These documents outline the multitude of strategies necessary to responsibly reintegrate large numbers of children from residential care institutions into families, including by building supportive social service systems, disability support services, child protection infrastructure, and a social work workforce. Having such systems in place enable proper case management, whereby trained professionals assess children in residential care and their families to determine their readiness for reunification, identify services (including services for children with disabilities) they will need in order to be successfully reunified, and monitor the children's and family's progress over time, intervening with additional support as necessary.

Following these frameworks and guidelines, Kenya has signaled its intent to undertake "care reform" to transition children from residential to family care. The

Kenyan Ministry of Gender, Children and Social Development's Department of Children's Services recommended a moratorium on the registration of new residential care institutions in 2008, and in 2017, the Government of Kenya barred any new ones from obtaining government-registered status (Chege & Ucembe, 2020). In 2021, Kenya's National Care Reform Strategy was finalized, which aims to guide government systems for the next ten years in the continued transition from residential care for children to family-based care. These reforms are also theorized to foster improved child health and development, as explained in the following section.

Research Evidence Motivating Care Reform

While the CRC's prioritization of family care is based on the abstract principle that the family is "the fundamental group of society and the natural environment for the growth, well-being and protection of children" (United Nations General Assembly, 2010, p. 2), empirical research on institutional care has further motivated governments, international actors, and civil society to promote care reform.

Some advocacy organizations believe the research base unquestionably recommends the reintegration of children from residential care institutions into families. For example, Disability Rights International claims "vast and overwhelming" research evidence that institutions are bad for children (Ahern, 2013), and the Lumos Foundation purports that "80 years of research proves that orphanages severely harm children" (Lumos, n.d.).

Indeed, a systematic review by the 2020 Lancet Group Commission on Institutionalisation and Deinstitutionalisation of Children found strong links between residential care and poor developmental outcomes in cognition, attention, and physical growth, and moderate links with socioemotional, mental health, and attachment difficulties (van IJzendoorn et al., 2020). Furthermore, when children living in residential care institutions are placed in families, they can show rapid developmental catch-up in growth and cognition and improvements in adaptive functioning (Humphreys et al., 2018; van IJzendoorn et al., 2020). However, children in Eastern European institutions were over-represented in these analyses.

Only a few quantitative studies in Sub-Saharan Africa have found similar results to the consensus reported in the Lancet (van IJzendoorn et al., 2020), and overall findings related to the effects of residential care in Sub-Saharan Africa are generally less conclusive. In Tanzania, children ages eight to 15 who had entered residential care prior to age four had worse internalizing and externalizing problems, aggression, and depression scores than children who entered residential care later than age four (Hermenau et al., 2014). One study of Rwandan children in residential care found that they had significantly more externalizing behavior problems than children in families (Nsabimana et al., 2019). Children reunified with families after living in residential care institutions in Ghana had higher levels of hope compared with their peers who remained in residential care (James et al., 2017; James & Roby, 2019).

In contrast, other quantitative studies have questioned this existing consensus. The Positive Outcomes for Orphans study tracks the development of children ages six to 12 in residential care institutions compared with orphans (children with one or both deceased parents or who have been separated from their parents) in family care in five countries: Ethiopia, Kenya, Tanzania, India, and Cambodia. So far, the study has found that children in residential care institutions had better overall health, fewer illness, fewer emotional/behavioral difficulties, better intellectual functioning, and better memory than orphaned children in families (Whetten et al., 2009). At three-year follow-up, results seemed to indicate that there were few differences between children in residential care institutions and children in families (Whetten et al., 2014). These findings have been disseminated in the mainstream media with titles such as, *Maybe Orphanages Aren't So Bad After All, Study Says* (Luscombe, 2014). This study also found the children in residential care institutions had experienced less physical and sexual abuse than those in families (Gray et al., 2015). Similarly, in a separate study focused on Uasin Gishu, western Kenya, children in residential care institutions were less likely to report having been raped or having engaged in transactional sex than orphaned or fostered children in families (Embleton et al., 2017). Smaller studies in Kenya and Ghana have also found that children in residential care institutions have better access to resources, including education, health care, nutrition, and shelter, than similarly vulnerable children in family care (Embleton et al., 2014; James et al., 2017). Finally, in Rwanda, children in residential care had greater emotional well-being and lower mental distress than children in foster homes (Caserta et al., 2017).

Some of these researchers have argued that care reform advocates are too hasty to paint all residential care institutions with the same brush, especially in Sub-Saharan Africa (Braitstein, 2015; Luscombe, 2014; Shawar & Shiffman, 2020). The so-called "evidence base," they say, is not contextually relevant to Sub-Saharan Africa because it is so dominated by studies of Eastern Europe (Luscombe, 2014). In addition, most of the studies have shown the harms of residential care during children's earliest years of life, but many children in Kenyan and African residential care institutions are of school age.

These researchers argue that residential care institutions should be considered as a valid option for at-risk children in Sub-Saharan Africa.

However, and perhaps most importantly, few if any of these studies, whether arguing for or against the use of residential care institutions, examine what happens to children when they leave residential care with the sort of robust family support services deemed necessary by the UN frameworks. With regards to Sub-Saharan Africa, it remains a contentious topic of debate whether residential care institutions should be used to care for vulnerable children or whether children should be removed from residential care and reunified with family, as researchers and policymakers disagree about which setting fosters better outcomes and whether children's rights to material resources should be prioritized over their rights to remain with their families. Additionally, while the Government of Kenya has already committed to implementing care reform, little contextually relevant empirical evidence suggests what sort of support services would best facilitate successful reintegration of children into families. Emerging qualitative work from the sub-continent suggests new directions for research attempting to answer these questions.

Quantitative Gaps in Sub-Saharan Africa

Roche (2019) conducted a scoping review of qualitative literature on the lived experiences of children in residential care institutions. He found that children's salient experiences within institutions, generally, were that they (1) enjoyed access to education and material things that their biological families could not provide, (2) enjoyed strong peer networks within their institutions, while some struggled with fighting, (3) generally were positive towards staff, and may have seen them as family, but sometimes struggled with favoritism, (4) sought greater autonomy and decision-making authority in their lives, (5) may have participated in their wider communities, or may have wished for more connection to them, (6) struggled to maintain relationships with biological family, (7) struggled with identity, sense of belonging, and being stigmatized as an orphan (Roche, 2019). This brief review identified several areas of inquiry that the quantitative research base has overlooked, particularly items four through seven. Individual studies across Sub-Saharan Africa substantiate this review's findings. In Ghana, former residents of a Western-funded "children's village" (whereby children live in family-like groupings in a designated area) reported that they felt alienated from their biological families and lacked the cultural skills to live in Ghanaian society (Frimpong Manso, 2012; Frimpong-Manso, 2017). Similarly, in Nigeria, young people leaving residential care struggled to integrate into communities and faced stigma for having lived in an institution (Sekibo, 2020). Former residents of residential care institutions in South Africa spoke of "a yearning for the human experience of connectedness" (Moodley et al., 2020, p. 7). In Zambia, many leaving residential care expressed fear, doubt, and worry about living independently and felt stigmatized in the community, but those with previous experiences interacting with their communities had more positive adulthood experiences (Januario et al., 2016). These phenomena have been documented in Uasin Gishu, Kenya, as well, although children also reported ways in which their peers and caregivers served as family to them in their institutions (Gayapersad et al., 2019).

Based on the existing body of evidence, quantitative inquiry has not yet evaluated the impact of residential care institutions on many different aspects of children's development and well-being that are relevant in Sub-Saharan Africa in particular, and especially ones that children themselves prioritize. The studies in this dissertation are designed to address this gap in the literature, through a close partnership with the Changing the Way We Care initiative in Kenya.

Study Context: Changing the Way We Care in Kenya

Changing the Way We Care (CTWWC), an initiative launched under Catholic Relief Services and Maestral International in 2018, is designed to carry out care reform and family reunification of children from residential care with the types of support recommended by the UN. The initiative aims to prevent children from entering residential care and to reunify children in residential care with safe, nurturing families. CTWWC works at the national level on instituting regulatory frameworks on children's care and influencing policy, at a global level influencing donors (e.g., US foundations and churches) to transition their support from residential care institutions to family care, and locally to directly reunify children with families and provide families with the support they need to reintegrate children into their care. They are carrying out this direct work in several countries, currently including Kenya, Guatemala, and Moldova.

In Kenya, the focus of this dissertation, CTWWC works with various governmental and non-governmental partners to support children in three counties: Kisumu, Nyamira, and Kilifi (Changing the Way We Care, 2021). CTWWC chose these three counties because of their different contexts, locations (with Kisumu and Nyamira in the west and Kilifi on the eastern coast), sizes, and levels of investment in alternative care, in order to demonstrate how care reform and family reintegration may operate in diverse counties with an aim of eventually scaling up to different regions of the country. CTWWC provides a range of family strengthening services to children who have reunified with family after living in residential care, as well as to children who live in families but have been assessed to be at risk of entering residential care. While a child still lives in residential care, an assigned case worker works with the child and family to assess their needs, prepare the family for reunification, and monitor and follow-up after reunification until case closure. This case management includes identifying necessary services which CTWWC delivers themselves or provides referrals for to other organizations. For children identified as at risk of entering residential care, CTWWC may provide this level of case management, or if not necessary, only one-time support services or referrals. To date, the types of direct family support services provided by CTWWC to reintegrating and at-risk families have included cash transfers, small business start-up funds, positive parenting training, food assistance, life skills training, and membership in savings and loans groups, among others.

It should also be noted that the onset of the COVID-19 pandemic in early 2020 disrupted planned care reform efforts, as 60% of children in residential care in Kisumu, Nyamira, and Kilifi, were abruptly sent home to avoid disease transmission. In response, CTWWC worked in coordination with government actors to prioritize the cases of the most vulnerable children and families, develop case management plans for children who had rapidly reunified as well as those still in residential care, and provide services to support their reintegration into family life. CTWWC provided cash transfers and COVID-related supplies and referrals to other service providers in the immediate aftermath of these events. Thus, many of the reunified children included in this dissertation may have joined families with less than ideal levels of planning and preparation.

Dissertation Purpose and Aims

The CTWWC initiative presents an invaluable opportunity to examine children's well-being in the context of supportive, planned family reunification from residential care in the understudied context of Sub-Saharan Africa. The overall purpose of this dissertation is to examine, within a sample of children in Kenya who have been reunified with family after living in residential care, correlates of the domains of well-being that are prioritized by young people who have lived in residential care. In order to meet this goal, this study will have three specific aims, outlined within each of the three papers below.

Paper one uses qualitative methods to explore young people's first-hand experiences of living in and leaving residential care institutions. The data consist of twelve focus groups with young people in Kenya, half of which were reunified children ages 11 to 17 who were reunified with the support of CTWWC, and half of which were young adults who left residential care before CTWWC began its operations.

Paper two develops a quantitative measure of the subjective well-being of children, tailored to the priorities of those who have lived in residential care, which was developed based on these same focus groups. Exploratory factor analysis was used on survey responses from young people ages 11 to 18 in Kenya as well as Guatemala[1] to create sub-scales that can be used in further analyses of the well-being of vulnerable children.

Paper three uses multivariate analyses to explore correlates of well-being amongst a sample of young people in Kenya reunified with family after living in residential care.

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[1] Although the rest of this dissertation focuses on Kenya, we included available data from Guatemala in this analysis to strengthen its statistical power and create a measure that could potentially be used in more than one cultural context.

We examined how children's well-being, specifically their change in overall life satisfaction from when they were in residential care to family care, as well as their scores on the subscales developed in paper two, statistically relate to children's characteristics, particularly disability status.

Conclusion

This three-paper dissertation contributes to a gap in the evidence base which currently informs the policy debate about how to best care for vulnerable children in Sub-Saharan Africa. It takes an innovative approach to conducting research for a specific subpopulation, children who have lived in residential care, in a localized, culturally appropriate way. The results of this study can inform policy and practice in Kenya and the wider region, by suggesting what sorts of supports governments should make available and that practitioners should provide for children reunifying with family, and can also serve as a model method for researching children's care in other regions and cultural contexts.

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Chapter II. Young People Who Have Lived in Residential Care Institutions in Kenya: Perceptions of Social Support and Freedom

Background

Residential care institutions in Kenya, which are colloquially called orphanages or children's homes and formally called Charitable Children's Institutions (CCIs), have seen steady growth in the past decades. According to Chege & Ucembe (2020), the number of children in Kenyan residential care institutions has grown progressively since the mid-twentieth century to today, where an estimated 50,000 to 60,000 children live in residential care (Desmond et al., 2020). A major driver of the increasing entrants to residential care has been increased poverty, which resulted from many factors, including unsustainable urbanization as well as reduced spending on social services recommended by the World Bank and IMF in the 1980s and 1990s (Chege & Ucembe, 2020). These changes caused the provision of social services to shift from public to non-governmental entities, many of which were faith-based organizations from Western nations. In recent decades, the HIV/AIDS pandemic and political violence also caused large numbers of children to lose their parents; such children would typically have been cared for in extended families and local communities, but economic forces weakened these networks, and non-governmental organizations imported the orphanage model of child care to absorb these children (Chege & Ucembe, 2020). Other reasons children enter residential care today is because they are living on the street, abused, neglected, discriminated against due to HIV status or disability, or to escape female genital mutilation and early marriage (Chege & Ucembe, 2020). Chege & Ucembe (2020) argue that the Kenyan government today relies unnecessarily on institutions to care for these children, rather than investing in services, such as household economic support and child maltreatment prevention initiatives, that would enable them to live in their families of origin or with other families in their communities. Issues of corruption and child trafficking have also been documented in Kenyan residential care institutions (Chege & Ucembe, 2020).

To address these issues, and in accordance with the UN Convention of the Rights of the Child and the UN Guidelines for the Alternative Care of Children, the Kenyan government announced its intentions to implement care reform efforts to transition systems of care to prioritize family care over residential care, and in 2017 barred any new residential care institutions from obtaining government-registered status (Chege & Ucembe, 2020; United Nations General Assembly, 1989, 2010). Care reform includes system-level reforms, such as the development of supportive laws and policies, as well as the reunification of individual children from residential care institutions with their original or extended families, or their placement with foster or adoptive families. This reunification ideally entails the provision of supportive social services (e.g., economic assistance, parenting education) which address the root causes of children's entering residential care in the first place, as well as careful oversight and case management by trained child protection and social work professionals.

Experiences of Those who have Lived in Residential Care

It is crucial that such policy and practice be informed by the voices of the affected population. A small but growing body of literature has explored the first-hand experiences of individuals who have lived in residential care and left residential care in Kenya.

Living in Residential Care

First, some studies have sought to highlight the voices of children currently living in residential care. A qualitative study with children in residential care in Uasin Gishu county, Kenya, found that children often formed family-like bonds within their institutions, drawing a sense of belonging and family from relationships with their caregivers and peers in the institution (Gayapersad et al., 2019). At the same time, those in larger institutions sometimes reported lacking the one-on-one care needed to form such bonds (Gayapersad et al., 2019). They also sometimes failed to develop their ethnic identity, having to speak English or Kiswahili in residential care instead of their mother tongue, and reported that life was relatively rigid, with limited freedom of expression and agency over their own lives (Gayapersad et al., 2019). A second qualitative study, which interviewed children in a residential care institution in Njabini, central Kenya, found that children appreciated having access to food and fewer tiring chores in residential care (Johnson & Vindrola-Padros, 2014). Many of the children in this study entered residential care because they had HIV, and the institution was able to meet their unique health needs by adhering strictly to medical recommendations that were challenging for their families; the children, however, continued to visit with their families while living in residential care (Johnson & Vindrola-Padros, 2014).

Reunifying with Family During Childhood

Fewer studies have looked at the first-hand perspectives of young people who have been reunified with their families during childhood. We could not identify any studies of children's experiences of family reunification after living in residential care in Kenya. Some studies have examined the phenomenon in other parts of Sub-Saharan

Africa, including Uganda, Ghana, and Zimbabwe. Interviews with reunified children ages 8 to 14 in Uganda found that children who previously lived in residential care enjoyed gaining useful life skills at home through doing chores; they had varied experiences in terms of harmony in their home, with some enjoying the caring bond with their parents and others experiencing discord amongst family members; and some did not have enough to eat in their families or lacked school fees (Walakira et al., 2022). In Ghana, 73% of a sample of reunified children reported preferring living with their families than in residential care (Frimpong-Manso et al., 2022), and when asked specifically about their challenges after reunification, children reported that chores or work interfered with their studies, they missed their friends from residential care, they had felt unprepared for reunification, their families and communities sometimes discriminated against them, and they lacked adequate food, shelter, and school fees after reunification (Frimpong-Manso, 2018). Finally, in Zimbabwe, 83% of a sample of reunified children preferred family life to residential care; many had enjoyed greater material resources in residential care, and often lacked school fees at home, but found fulfillment in being close to their biological relatives after reunification (Mahuntse, 2015).

Leaving Residential Care as Emerging Adults

Many youth leave residential care not due to care reform and reunification efforts, but because their residential care institutions only provide care for children until they reach adulthood; Kenya's Children's Act of 2001 stipulates that children should leave residential care at the age of 18 (Children's Act of 2001, 2001). A few studies have explored the experiences of such young adults in Kenya. Some adults from Uasin Gishu, Kenya, reported that they considered their caregivers and peers in their former residential care institutions to be their families, they kept in touch after they exited the institution, and they considered those caregivers to be the grandparents of their children; on the other hand, some recalled conflicts with their caregivers and had struggled to transition to independent life (Gayapersad et al., 2019). Another study with young adults who grew up in residential care institutions in Nairobi County, Kenya, found that some participants felt ashamed being labeled an "orphan" or encountered stigma in their communities; some struggled to adjust to life outside residential care, lacking appropriate preparation and life skills, while others appreciated their newfound freedom; and many struggled to meet their material needs and experienced poverty (Ucembe, 2013). These phenomena are echoed by other studies throughout Sub-Saharan Africa, though there is also a growing effort to explore and highlight how these young adults also embody resilience (Frimpong-Manso, 2018; van Breda & Frimpong-Manso, 2020).

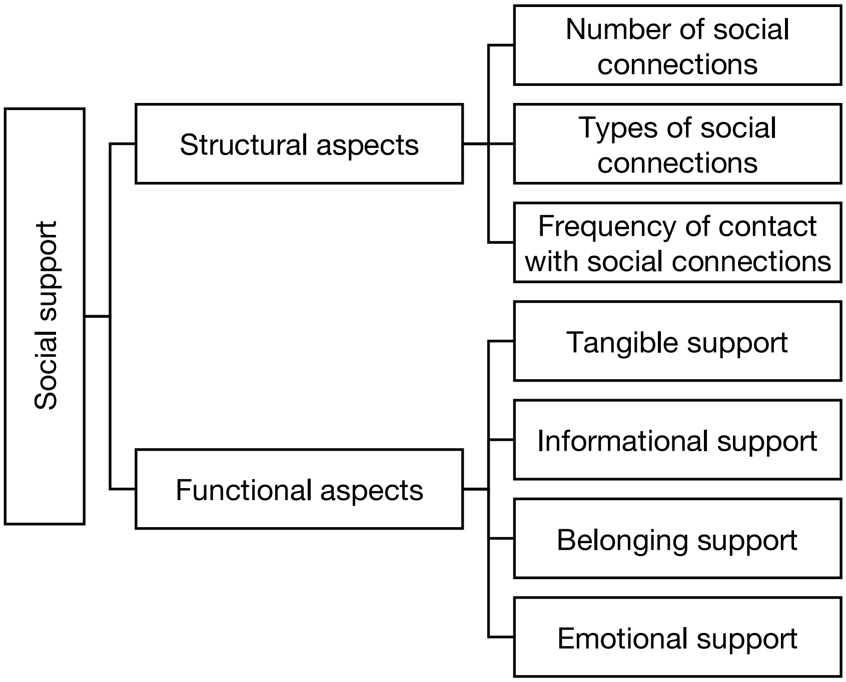
Study Aim and Rationale

Thus, although an emerging body of literature has begun to explore the first-hand experiences of young people who have lived in residential care in Kenya and across Sub-Saharan Africa, much less research has examined children who leave residential care and reunify with family during childhood. Generally, they tend to speak of being satisfied with their tangible support but dissatisfied with their opportunities for exercising personal freedom, life skills, and identity development in residential care, but it is unknown whether the experiences of those who left residential care in emerging adulthood are mirrored by those who reunify as children, and whether the results from the few studies of reunified children in Sub-Saharan Africa apply to such children in Kenya. To contribute to these gaps, this study uses data from focus groups to explore how young people in Kenya who have lived in residential care institutions describe and conceptualize their experiences of life in residential care and life after leaving residential care. We included two distinct groups of young people: children ages 11 to 17 who had been reunified with family within the context of CTWWC's care reform initiative ("reunified children"; *n*=39 participants in six groups), and young people ages 18 to 29 who exited residential care outside of this initiative, usually around age 18 ("young adults"; *n*=29 participants in six groups), in order to capture the perspectives of those who left care under varying circumstances and because their different levels of maturity and duration of life experience could lead to different insights on leaving care.

Social Support Theory

Social support theory can provide guidance as to how to understand the experiences of those who have lived in residential care (Frimpong-Manso, 2017); specifically, the concept of social support arose during data analysis as a framework that captured the majority of themes arising from participants' stories and experiences. Social support is defined as the help or assistance that individuals provide one another, including the care, services, and items parents or caregivers provide their children (VandenBos & American Psychological Association, 2015). Social support is often conceptually divided into structural social support, the quantity and types of social connections an individual has, such as marital status and living arrangements, and functional social support, which is the type of help and assistance that social connections provide (Cohen et al., 1985; Gallo et al., 2015). Functional social support has been categorized in different ways throughout the literature (Cutrona & Russel, 1990). One typology of the components of social support separates it into four categories (Uchino, 2004). *Tangible support* is defined as material items, money, and services, and can include specific things like basic needs (food, shelter) and education (i.e., tuition payments or school supplies) (Uchino, 2004). Next, *informational support* consists of advice and guidance; *emotional support* is expressions of care, concern, empathy, and other supportive emotions; while finally, *belonging support*, is defined as the presence of others with whom to spend time and engage in social activities, which fosters a sense of acceptance and belonging (Uchino, 2004).

Figure 1. Conceptual framework of social support



For this study, we chose to use social support as a theoretical framework under which to organize our results and conceptualize the data, particularly the functional aspects of social support.

Method

Sample and Participants

Focus group participants were recruited using maximum variation sampling, an approach that aims to recruit varied individuals who have experienced a common phenomenon (Miles et al., 2014). We used three strata for sampling (see Figure 4). The first stratum was the county in which the participants live (Kisumu, Nyamira, and Kilifi); these three counties were the only counties in which CTWWC had established operations at the time this study was conducted. The second stratum was whether the participant was (a) a child who had been reunified with family after living in residential care and was receiving services from CTWWC, or (b) a young adult who lived in residential care during childhood and was not receiving formal CTWWC services. Reunified children were eligible to participate if they had been enrolled in CTWWC services for more than one month, and young adults were eligible if they had exited residential care more than two years prior. To sample reunified children, eligible children were randomly selected from CTWWC's beneficiary lists using a random number generator. For young adults, participants were chosen via convenience sampling among the young adults with whom CTWWC had existing connections. For the third stratum, the reunified children were further divided by age range, so that focus groups were held with younger adolescents aged about 11 to 13 years, and with older adolescents about 14 to 17 years. The young adults were divided by gender, so that groups were all female or all male. This approach aimed to avoid group dynamics that could potentially discourage younger children's and women's contributions. Focus groups were meant to have four to eight participants per group.

For some focus groups in Nyamira, the smallest of the three counties, only three participants per group could be recruited despite best efforts. There were also three young adults who had exited residential care less than two years prior who were inadvertently included in the focus groups. Ultimately, the 12 focus groups contained a total of 70 participants (Figure 4).

Figure 2. Sampling strata for focus groups

Kisumu County				Nyamira County				Kilifi County			
Reunified children		Young adults		Reunified children		Young adults		Reunified children		Young adults	
Younger group (*n*=8)	Older group (*n*=8)	Men's group (*n*=8)	Women's group (*n*=6)	Younger group (*n*=5)	Older group (*n*=8)	Men's group (*n*=3)	Women's group (*n*=3)	Younger group (*n*=6)	Older group (*n*=6)	Men's group (*n*=7)	Women's group (*n*=7)

Of the 70 participants, 32 (46%) were female and 38 (54%) were male. Further breakdown of the focus group participants' demographic data can be found in Table 2.

Table 2. Characteristics of focus group participants (N [%] or M [SD])

	Reunified adolescents (younger) (*n*=17)	Reunified adolescents (older) (*n*=22)	Young adults (*n*=29)
Sex			
Female	6 (32%)	13 (59%)	13 (45%)
Male	13 (68%)	9 (41%)	16 (55%)
Age (years)	12.8 (1.8)	15.0 (1.2)	23.4 (3.6)
Age of entering residential care (years)	7.5 (3.3)	10.0 (3.1)	9.5 (3.0)
Age of exiting residential care (years)	11.5 (2.1)	14.1 (1.6)	18.6 (1.7)
Years in RCI	4.0 (3.3)	4.1 (3.8)	9.1 (3.3)

Data Collection Procedure

The focus groups were facilitated by pairs of social work staff who had worked with CTWWC in some capacity. The dissertation author trained the facilitators via two-day trainings over Zoom. Training included in-depth discussion of research ethics, interview techniques, and protocols for referring risk of harm cases for immediate follow-up as well as referral to local services. The focus group protocol contained several activities and its design was informed by previous studies that elucidated domains of well-being in diverse contexts, such as with Native American college students and children involved with the English child welfare system (Ng et al., 2014; Selwyn et al., 2017; Sharma et al., 2013; Walker et al., 2012; Wood & Selwyn, 2017; World Health Organization, 1998; Zhang & Selwyn, 2020).

To foster rapport, facilitators began by explaining the purpose of the focus groups to participants, holding an ice breaker, setting group norms, and asking participants to choose pseudonyms. Having the young people choose their own pseudonym helped keep their identity confidential on the audio recordings and other data, while adding a sense of fun and personal agency in a small way to the activity. Participants were then given paper and drawing tools and asked to draw a picture, or if they preferred, write a list or story, of their life in residential care on one side and their life after leaving residential care on the other side. This allowed participants to reflect on their experiences silently and independently without the pressure of immediately sharing them with others. Then, participants were then asked to share their work verbally with the rest of the focus group, which was audio recorded and transcribed by the facilitators. The facilitators also translated the discussion into English from Kiswahili, Luo, or Kisii, where necessary.

Analysis of participants' verbal presentations were the focus of this study. The focus groups then proceeded with other activities which were not the focus of the current study (see Paper III).

Analysis

This exploratory qualitative study falls under the umbrella of phenomenology, a type of inquiry that seeks to describe individuals' shared lived experience and distill them into a description of the "essence" of the phenomenon they experienced (Creswell & Creswell, 2018; Creswell & Poth, 2018). The analysis followed many of the tenets of consensual qualitative research, which relies upon iterative approaches, multiple researchers' analyses of the data, as well as discussion and consensus-building amongst researchers rather than calculations of interrater agreement statistics (Hill et al., 1997, 2005).

The first step consisted of the dissertation author reading all twelve focus group transcripts to immerse herself in the data. Next, initial coding was conducted by the dissertation author and two other coders, who were also social work doctoral students, as a group (Saldaña, 2016). This group coding process involved open coding a subset of the transcripts, using an inductive approach that relied on concepts emerging directly from participants' voices (including in vivo codes and process codes) rather than researcher-driven concepts, while at the same time being governed by the overarching research questions (Saldaña, 2016). The group of coders iteratively revised, combined, and split codes as they proceed through the transcripts until they reach a point of saturation where new codes were not being added. At this point, they noted as a group that the emerging codes fit under an existing theoretical framework, social support, and decided to organize the codes under this framework as they finalized the codebook. Third, the researchers coded all twelve transcripts in NVivo using this codebook; each transcript was independently coded by the dissertation author and by one of the other two coders. For each transcript, the two sets of codes were then combined into one version, and the team met to discuss their coding choices and reach consensus on the analysis.

Results

The results of this study are presented using social support theory as an organizing framework for the data. Overall, participants most often talked about their experiences of life in residential care and after residential care in terms of the *functional support* they did or did not receive—including *tangible, informational, belonging, and emotional support*. In addition, one theme that did not fit into social support theory also arose, as they spoke about the *freedom* they did or did not have—including their freedom of movement and decision-making over their own lives.

Functional Support

Tangible Support

The most prominent theme across all participants was the presence and absence of tangible support. Participants tended to compare and contrast the material things they had in residential care and after leaving residential care. Nicollete, age 15, summarized her experience by saying, "When I was in orphanage, life was easier….You are provided with everything you ask for." This sentiment was shared by many participants, both reunified children and young adults.

Basic needs. Both reunified children and young adults spoke of having better access to "basic needs," like food, shelter, and clothes, in residential care than outside residential care. Shreya, a reunified 14-year-old, explained, "At the CCI we could eat breakfast, lunch, and supper. At home, sometimes you can eat in the morning but no lunch; you are forced to stay without food the whole day until evening." Judah, a 21-year-old who had lived in residential care from ages 9 to 19, also shared, "In the orphanage we were being given three meals in a day, that is breakfast, lunch and supper… So, I think that was okay, because at times at home you can go without, but at least in the orphanage every meal was being provided." Dorcus, age 18, speaking about her current living situation after reunification, noted, "Shelter and place to sleep is a challenge. If there are no rains, I can say it's better, but [if] it rains the house leaks."

A minority of children had a different experience: Sandra, age 11, said that, "life was hard in the orphanage…[I] did not have clothes; [I] did not eat well or attend school regularly… life at home is better because [I] dress better, and [I] eat better now."

School. Reunified children often talked about having their school fees paid for when they lived in residential care, and having time to focus on their studies, while at home, their enrollment was more precarious. Dorcus, a reunified 18-year-old, said, "After leaving [the] CCI, life has been difficult… I get sent home from school due to lack of school fees," an experience shared by many children in the study.

Paid school fees were not the only thing that enabled children's educational achievement. Many also needed time and space to study, and multiple participants valued that in residential care, studying was their only "job." Reunified seventeen-year-old Mbigo explained:

> While at the CCI,…I used to study at a nice place with enough light and when I had a question or I'm stuck during my studies, it was easier to get assistance from my fellow children and friends at the CCI. Things are different at home because I have no friends to study with and light for studying during the night is a problem

> since we use very small tin lamps or candles. This makes studying at night very difficult.… After school at the CCI, I was only expected to wash my school uniform and go for my evening classes after eating supper. At home, I'm required to do a lot of tiring chores. For instance, after school, I'm required to immediately drop my school bag and go fetch water before I can start washing utensils. Thus I don't get enough time to study at home.

On the other hand, there were a few children who mentioned that they did not attend school regularly when they lived in the CCI, or that their educational needs were being met at home, but this was less common. One child, Ronaldo, noted, "Life in the CCI wasn't good or bad. It was in between. In the CCI, [I] was attending school…now at home things haven't changed because [I am] attending school and [I am] happy because now [I] was able to choose the school that [I wanted] to study in."

Many young adults recounted that their education was paid for while in residential care. However, several mentioned that this stopped, and they could not find similar sources of funding for continuing onto higher education, after exiting residential care. Tanisha, 19, explained,

> After finishing my Form 4 in 2021, I've been staying at home with nothing to do. From my experience, most of the children who stayed at the orphanage, after completing their Form 4 examinations, most of them are not taken to any college or university, and most of them come out of Form 4 with good grades. Pursuing further education after Form 4 is not guaranteed for most children that have left institutional care.

Similarly, 21-year-old Serena noted,

> At home I have to fight for my life because no one will fight for me. No one was bothering to take me to the next level, now that I had finished Form 4, I was waiting to go to the next level like in college, but I just stayed at home.

Self-reliance. Young adults who left residential care after completing their childhoods spoke about needing to "hustle" and find ways to meet their needs for tangible support after leaving. This sometimes proved stressful but was also something participants drew meaning from. For example, 21-year-old Peter said,

> My life when I was in children's home, I can say it was somehow better, comfortable…everything was being provide there. But now when you see me, after [I] am out from [the] children's home, now life begins there, I now learn how to hustle, how to look for what I want, nobody is providing for me, so it's kind of encouraging somehow…as we grow we learn on how to defend on ourselves.

Similarly, Johnte, age 27, said,

> I am happy to be home because as I become my own responsibility, I can buy my own things by working hard, I do not depend on anybody to get my own things, just my hustle and my God. In the institution, I depend[ed] on the management hundred percent to get needs…at the institution we were given things like soap, we were being bought clothes. But at home you have to struggle to buy your own clothes, so my mum used to buy for me, you can imagine at the age of 20 after my Form 4, I did not have the money to buy those things and I was like lazy and my mum used to support me to buy those things…after that when I joined college, I started hustling and making friends, it made my life straight for me not to be dependent on anybody.

Reunified children did not usually need to work to provide for their own needs after leaving residential care, but continued to rely upon adults, some of whom could not provide for them. However, in one case, 15-year-old Nicollete spoke of relying on her own money:

> At times you are out of sanitary towels, and you go to the house mother [in the CCI] who will provide. But at times at home, my mother does not have money to buy…at home you have to look for your own money, even if you had your own savings, you have to use [it], because at times my mother does not have money.

Informational Support

Young people valued the advice and information they received in residential care and in their families. Two main types of informational support emerged: receiving psychosocial support and advice ("guidance and counseling," as some participants called it), and being taught useful skills that would serve them later in life ("life skills").

Guidance and Counseling. Young people, both reunified children and young adults, noted how important it was to have adults helping to guide them in life and provide psychosocial support. Ravey, a 22-year-old who had lived in residential care from ages 8 to 20, explained,

> Our [house-]mother and [house-]father in the orphanage used to talk to us about being responsible for everything… I thank God they helped me, that's why I am who I am today. I follow the advice given to me especially at the orphanage, the advice has made us live a good life, and because outside the orphanage, you never know what happens.

Similarly, 21-year-old Serena said, "The people at the orphanage used to look after us well, and we got advice from our elders like when you are stressed, you can talk to the caregiver at the institution and they give you advice."

One young woman, 24-year-old Apple, did not find such guidance available after leaving residential care. "There were people who were hired to come and motivate us [in residential care], they did guidance and counseling to us on how to move on with our life," she said. "At home…there were no longer…motivation people. The motivation we get only from parents, but there is no one that is qualified."

However, many of the reunified children, who returned home while still minors, received this informational support from their parents as well. Reunified 15-year-old Zuchu explained, "At home I feel happy because I'm with my parents…so they advise me on some of the things I was not told in the orphanage…we have time to sit down and have a talk on things that affect girls." Similarly, reunified 16-year-old Njoroge said,

> In the orphanage, we had loving and caring staff who acted as parents and guardians. At home life is more free and you are allowed to share talks with guardians. They encourage us on how to carry on with life and solve problems that comes across our life situations.

Finally, some participants also valued the advice and support they received from peers in residential care. As 16-year-old Njoroge put it, “Life in the orphanage was good because we were there as youths and agemates, and we could share things concerning our lives, and again everybody could support one another even through studies at night.” Being able to study with peers was very important to some children, and was a highlight of residential care. Reunified fourteen-year-old Messi, who spent almost his whole life in residential care, said, “Life is different at home because…sometimes I lack friends or someone who can help me when I’m stuck during my evening studies.” However, thirteen-year-old Margaret was happy that she did not lack this at home: “Whenever I want to study with my friend, I just ask for permission from my mother…There is nothing that I dislike about my life at home after leaving the CCI.”

Being Taught Life Skills. Some reunified children mentioned they had been taught skills like cooking and washing utensils in residential care. But more frequently, these participants talked about learning important life skills after reunifying with their families. Reunified fourteen-year-old Zenah explained, “While in the orphanage, we did not know how to cook because everything was being done for us, but because now we are at home, you can help your mother with house chores like cook, fetch water, and fetching firewood.” Reunified child Mbosso, age 14, also noted that “at home, one learns to do some chores, which will otherwise help him in future.” Reunified child Njoroge, 16, also said, “it’s good to be home since we have learnt to do some of the house chores and manual work that we did not know like, herding cattle… We help parents to cook and even with errands.”

Young adults, who left residential care on the cusp of adulthood, did not mention this topic as often. Some implied they lacked the life skills they needed to adapt to independent living; Karisa, age 25, noted, “I didn’t know how to support myself…Life was tough because here I came while not knowing anyone and I didn’t know where to start.” On the other hand, April, age 25, said, “In the orphanage…they taught us how to deal with the real life and how life was outside the home.”

Belonging Support

Another prominent theme was belonging support: participants spoke of how they valued simply being with someone, usually their family, without mentioning getting tangible, emotional, or other types of support from them. The children who reunified with their families as minors talked about this particularly often. Afro, a reunified child aged 14, explained,

> Life is good in the orphanages, but there are other things which are lacking there, like for example you will know little about your parents and you will know little about your people, but if you stay with your family, you will get to know about them more.

Zenah, a reunified child aged 14, who lived in residential care from ages 12 to 13, wrote on her activity paper: “At home we…enjoy stories with my brothers and sisters, my mother is very happy to see me closer to her, and it’s so precious to be with my parents and family.” Reunified fifteen-year-old Nicolette wrote, “At home I am happy because I’m with my mother beside me who give[s] guidance in working hard in school for my future, plenty of clothes to wear, and I see my family every day who can help me in my studies.” One relatively reticent participant, 13-year-old Maria, only shared one sentence about life at home: “See cousins and grandmother every day.” (“Does that make you happy or sad?” followed up the facilitator, to which she responded, “Happy.”)

The young adults tended to speak about lacking belonging support when they were in residential care. As Kaboom, age 27, said, “Living in the CCI, the institution, I missed my relatives for sure. I missed the bond, though I still had another bond in the institution, but I missed my family and relatives.” Some noted that being unable to visit with family was one of the drawbacks of life in residential care. Swalha, age 23, said, “Even if your family or your friends come, sometimes you will be allowed to only greet them and go back to your room.” Diox, 27, found it upsetting when “sometimes the guardians could come and visit people at the institution, and you find out that you had no one to come and visit you and even give you [a] gift.” For one participant, 27-year-old Kithi, the rarity of family visits caused problems transitioning to life outside of residential care. “We were given only two days in a year to visit home,” he said, so when he came home he “didn’t know where to go, my siblings ha[d] married and moved so I had to stay at a neighbor’s place.”

Multiple young adults struggled with this lack of connection and acceptance outside of residential care. Johnte, 27, recounted, “I was like a visitor in my own village. I did not know my family members…so I found it hard adapting to that kind of environment… And lost in my own home, because I did not know people.” Ravey, age 22, found that her extended family stopped accepting her once she stopped bringing orphanage-provided food to them. “When we were in the orphanage, they used to send us to visit our relatives once schools close, and life was easy then and the relatives used to welcome us…we used to come with our own food, maize flour, and clothings. There was nothing that we used to ask from the relatives,” while on the other hand, “after leaving the orphanage they saw us as burdens." Twenty-four-year-old Apple's difficulties were with the wider community rather than her family:

> When I was taken back to my family, love was only [from] my family, and the nearby children and the neighbors also used to discriminate [against] me. I was like a paper to them since I did not know them, I did not grow up with them, I was a stranger to them.

Many of these young adults had drawn belonging support from peers in residential care, creating family-like relationships there. Ravey, 22, said, "We were being taught to stay together as a family, so there is no messing with others because we are one," and Clara, 21, appreciated that, "when I was in the institution I was also taught how to stay with others, how to care for others and also how to love each other as brother and sisters." Chief, 34, liked bonding with children from all over Kenya: "Others were coming from other places like we have some coming from the Kalenjin, some from Western, so we interacted like family, so that is one thing I liked." Sometimes the transition from this lifestyle to independence was difficult for them. Arani, age 17, said, "when you are in an institution you feel like you are surrounded by [a] big family but after leaving you feel lonely." Similarly, at home, 21-year-old Serena "was too bored also because I was used to staying with so many people."

Emotional Support

Both reunified children and young adults also talked about the emotional support they received or lacked in residential care and in their lives afterwards. Emotional support was often highly intertwined with informational support, for example, when life advice and guidance were accompanied with concern and empathy; these are described in the section above. In this section, we describe how children experienced emotional support by being treated with love and care, or lacked emotional support by being mistreated or harshly punished.

Some reunified children pointed out that they received love in residential care. Maximilia, reunified child aged 14, said, "you are loved and treated with care"…"[we] respected everyone, we were not bullied by our elders or other children." Sixteen-year-old reunified Njoroge remembered, "[in] the orphanage we had loving and caring staff who acted as parents and guardians." Boss Lady, reunified child aged 15, also reflected, "At the orphanage my life was good. I was shown love." However, some experienced harsh punishment. Fifteen-year-old reunified child Masi said the children were treated unfairly, recounting,

> Mostly you would not find the security guards around. The kids would fight a lot and harm each other and then when the guards would come back, they would just put you down and start beating you even without being sure if you were the one fighting or the one who started the fight or not. But at home there is more order because if kids fight, the guardians will first try to get to the root of the issue and then give us a punishment accordingly.

Some children also said there was bullying in residential care. Benzema, age 14, said,

> Life was not good in the orphanage. When we were eating, other kids would come and take our food away by force. If we follow them, they will beat us and threaten us that if we reported them, we would see. But at home it is better because if anybody bullies me, I will tell my dad and he would stop it.

Similarly, reunified child DJ Afro, 13, noted, "Life was hard in the orphanage because there was bullying. The other kids would take our food and beat us very much. At home nobody is taking my food away."

Young adults spoke of both emotional support and mistreatment in residential care. Apple, 24, shared, "While at the [children's] center, life was really enjoyable. There was a lot of love and support from those who took care of me, they did not mistreat me." Kasimba, age 26, whose parents passed away in a fire, was able to find a parental figure in residential care: "There was one matron who I am really thanking her, she used to care for me as my own mother."

However, the young adults also spoke of mistreatment, discrimination, and discord in residential care. Twenty-two-year-old Ravey recounted being beaten "using water pipes" for infractions such as "when you fail your exam" or "when you fight with others." Twenty-seven-year-old Johnte remembered, "There was a lady who took me as son, she took care of me. As time goes, management changed, a new person came and again life was not so good, let me say life was not much fair…like you found out that when your sponsors [i.e., donors to the orphanage] bought you some stuffs you could not get them all, you only get a few." He also recalled bullying taking place: "There were people who liked…bullying young children… They want you [to] wash their clothes, [or] fetch water for them for shower."

Some young adults spoke of mistreatment in their families after leaving residential care as well. Cheetah, 20, said, "Life in the orphanage is…better… At home…people are struggling to provide but when they do not get that it leads to frustration, so…you start becoming a baggage to him or her, so whenever anything goes wrong at home I am direct to it." While 25-year-old April remembered receiving "parental and guardian care" in the residential care institution, she said that at home,

> most of us are neglected by our relatives… I stay with my grandmother and my uncle, who is a brother to my dad, is a drunkard. At times he comes home drunk and beats you up, but when you tell the sisters, my aunties, about it, they do not care and even wish you should [go] back to the orphanage. This leads to depression. I started to solve my own problems at a younger age up to now. At times, these lead us to drug abuse or to things that are really bad things.

Freedom

One theme that arose from the data did not fit under the framework of functional social support: participants also spoke about how personal freedom, agency, and decision-making power over their own lives may have differed between residential care and in their lives after leaving.

Some reunified children found life in residential care very rigid, and felt they could not make decisions over how they spent their time or where they could go. For example, reunified 17-year-old Mbigo expressed his dissatisfaction by saying, “At the CCI, there was no freedom of movement as it was difficult to be allowed to visit family members. We were not allowed to move outside the CCI compound. We could only move out of the compound when going to school and when we [were] coming back to the CCI from school.” Many of the children’s comments about this rigidity were related to food. Ramaro, reunified child aged 16, noted that at home, “you can get meals at any time, and anything you need at home you can be given very fast.” Mercy, reunified child aged 16, also said that “in the orphanage…you may miss food, and nobody makes a follow up for that. At home there is parental care and if you miss food, like for example you were not there when they were eating, some food will be kept for you to eat later.” Fifteen-year-old reunified child Ings also valued this sort of freedom, saying, “in terms of food, at home it is better [than in residential care] because I can eat at any time when I get hungry, and it is better because I can go to the farm and cut down our own banana and cook for myself if am very hungry.” Maximilia, reunified child aged 14, remarked that in residential care, “you cannot make your own desire or change the food you want to eat,” and additionally, while at home, “your opinion is listened to and respected…[and] you can rebuke error in the house rule or change if you feel it's not right." However, Ings also saw a negative side to freedom: "At home there is a high chance of getting involved with bad groups and becoming bad mannered."

On the other hand, some children valued having increased opportunities for play and leisure in residential care when they were not expected to spend too much time working or doing chores. Boss Lady, reunified child aged 15, recounted, "while [we] were in the orphanage…we were playing and we were free, unlike home, where you come back from school and bathe, wash your clothes, and do other things." Fifteen-year-old Zuchu had the same reflection: "In the orphanage we were free, everything was done for us, we just had to shower and read." Dorcus, reunified child aged 18, also liked that in residential care "we would go to watch TV every evening" and 15-year-old reunified Harmonize enjoyed having "enough time to play and tell stories with other children."

Young adults had similar reflections regarding lacking freedom of movement in residential care, but also noted that freedom could come at the cost of safety and security. Twenty-three-year-old Swalha talked about this issue in detail:

> While in the orphanage, there is no freedom to decide on things because most of the times you find that things have already been decided so you don't get to participate in making any decision. While at home, however, most of the times you have to decide for yourself, it's either you decide to go and hustle so that you eat, or you will have to sleep without eating. Freedom given at the orphanage is you are not allowed to go outside the gate [laughter]… But after leaving the orphanage, you have freedom, you can do everything, but this freedom after leaving the orphanage [means] one does not also have security… When living in the orphanage there is enough security because they care, for example, if a child is kidnapped outside the gate, they are the ones that will be answerable about where the child went. But after leaving the orphanage, at home, there is no one who is here, the families are telling the child, "do not go outside at 1 p.m.," but the child will just go even if they are told, because they say that they are grown up… But according to me, the more the freedom, the less the security.

Other young adults echoed that there were benefits and drawbacks to increased freedom outside residential care. Serena, age 21, said, “At home there is also too much freedom, you can just go and there is no limited time when one has to stay outside. Like in the case of the orphanage, you can go out but you are given a specific time so that you come back before that time. For example, we used to be in the dorm by 8 p.m. every day.” Dagaza, 25, preferred his freedom, describing that in residential care, “life was good, everything provided, but no freedom, you need something and you are not given, or they stop you from getting it. So for me, life outside the CCI is better than at the CCI, [where] I get everything but you are not free.”

Discussion

To our knowledge, this is the first study that has examined the experiences of children in Kenya who reunified with family as minors after living in residential care. This study was able to gather the experiences of 70 children and young people who had left residential care institutions, both within the context of care reform efforts and due to “aging out” of residential care at the cusp of adulthood. When these participants were presented with an extremely broad, open-ended invitation to share their experiences in residential care and after leaving residential care, they tended to speak about the types of social support they received or lacked in both settings, as well as the levels of freedom and personal agency they enjoyed. As the analysis was inductive in nature, the results likely represent the experiences and aspects of life that participants found most salient and meaningful to them (rather than experiences commonly found in the literature). Across the twelve focus groups, there was a great diversity of experiences, with participants mentioning positives and drawbacks of both life in residential care as well as life after leaving residential care.

At the same time, the themes and findings from this study of three Kenyan counties corroborate results of other studies of Kenya as well as across Sub-Saharan Africa. For example, many participants noted that they had stronger tangible support in residential care than in families (Embleton et al., 2014; James et al., 2017; Walakira et al., 2022), that they experienced emotional support (e.g., loving care) or lack thereof (e.g., mistreatment) in both care settings (Embleton et al., 2017; Gayapersad et al., 2019; Gray et al., 2015), that they were dissatisfied with the rigidity of life in residential care (Gayapersad et al., 2019; Roche, 2019; Walakira et al., 2022), and even appreciated the ability to choose what and when to eat after exiting residential care (Walakira et al., 2022). It is also notable that while some reunified children receiving CTWWC services no longer enjoyed the levels of tangible support that they had had in residential care, none reported that they were unsafe or mistreated in their family placements.

The wide diversity of experiences reported by our participants underscores the idea that children can receive varied quality of care and support in both residential care institutions and in family-based settings (Braitstein, 2015). Some researchers have used this finding to argue against care reform and for continued investments in residential care institutions (Braitstein, 2015; Whetten et al., 2014). However, investments in social services should not be planned using data alone; the interpretation of data must be guided by values and human rights principles.

The Convention on the Rights of the Child asserts that “the best interests of the child shall be a primary consideration” in all actions concerning children (United Nations

General Assembly, 1989, art. 3). Legal scholars worldwide have been wrestling with the "best interests" standard for decades, however (van Krieken, 2005). Van Krieken (2005) points out that in the context of divorce, courts' custody decisions deal with "the balancing of competing concerns—short versus long-term interests? emotional versus material needs? religious upbringing versus formal education? urban versus rural environments? –and there is no objective way to determine how that balance is to be struck" (p. 32). There is also no objective way to weigh the benefits of residential care (e.g., children's material needs being met) against its drawbacks (e.g., severed connections with kin and community of origin). Some have tried, however: Embleton et al. (2014) use a human rights framework to advocate for residential care in Kenya, because they found that children in residential care often enjoyed their rights to health, education, rest and leisure, and an adequate standard of living, among others.

But while it is possible to invest in supportive social services that ensure that children enjoy all of their rights within families, it will never be possible for residential care institutions to adequately ensure children's right to "be cared for by his or her parents" (United Nations General Assembly, 1989, art. 7) or to "grow up in a family environment" (United Nations General Assembly, 1989, pmbl.). This is why the UN Guidelines for Alternative Care assert that,

> Financial and material poverty, or conditions directly and uniquely imputable to such poverty, should never be the only justification for the removal of a child from parental care, for receiving a child into alternative care, or for preventing his/her reintegration, but should be seen as a signal for the need to provide appropriate support to the family. (United Nations General Assembly, 2010, para. 15)

The diverse, sometimes even completely opposite, experiences reported in this study, underscore the importance of investing in individualized case management and social work oversight. Indeed, the UN Guidelines for Alternative Care assert that "[a]ll decisions, initiatives and approaches…should be made on a case-by-case basis" (United Nations General Assembly, 2010, para. 6). The experiences of reunified children in this study indicate many areas in which greater support should be provided to families when reunifying children, including help with school fees, household economic assistance, and positive parenting training for caregivers. The stories of young adults show the need for continued follow-up by social workers after reunification, so that if a young person is not receiving adequate love and protection in their family, a more suitable family situation can be found for them. This individualized case management approach entails planning these services while a child is still living in residential care, and only carrying out reunification after adequate assessments, service planning, and preparation of both children and caregivers (Cantwell et al., 2012). Proper investment in these mechanisms and services, including through funding and legislation, can ensure that across Kenya, children can live in "the natural environment for the growth, well-being and protection of children": a family (United Nations General Assembly, 2010, para. 3).

Limitations

There were also limitations to this study. In some cases, we could not meet our goal of meeting four participants per focus group. In an ideal situation, our maximum variation sampling plan might contain more strata, for example, disability status, reason for entering residential care, and type of family care (e.g., two biological parents, single parent, grandparents, other kin, foster care). However, we hope that a diversity of experiences might have been captured within the sample incidentally. In addition, while including three counties is a strength of the study, as these three counties represent varied regions of the country, the findings may not be generalizable outside Kenya, and may have limited generalizability to the rest of Kenya, which contains 47 counties. Finally, the young adult participants were recruited through networks of adults who had left residential care that CTWWC had connections with, and these participants may have been systematically different than young people who have left residential care but did not choose to participate in such groups.

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Chapter III. Development of a Child-Informed Measure of Subjective Well-Being for Research on Residential Care Institutions and their Alternatives

Background

The United Nations and other human rights groups have underscored the importance of children living outside parental care having an active role in any policymaking about vulnerable children's care and protection (United Nations General Assembly, 2010). In tandem, researchers have been using quantitative methods for decades to examine the well-being of children who live in or formerly lived in residential care institutions (RCIs), also called children's homes or orphanages (van IJzendoorn et al., 2020). In general, such investigations have aimed to determine the causal impact of living in residential care institutions and of family reintegration on children's health, development, and well-being. The findings of these studies have also contributed to policy recommendations regarding whether children who cannot live in parental care should be placed in residential care or other methods of family-based alternative care, and whether "deinstitutionalization" should be carried out and child welfare systems reformed so that children in institutions can be returned to family care (Goldman et al., 2020).

Some child outcomes receive more attention in these studies than others. European children in infancy and early childhood are overrepresented in studies of children who have lived in residential care (van IJzendoorn et al., 2020; Whetten et al., 2009), more so than older children from other areas of the globe, and thus the most prevalent outcome measures used are relevant to this population. The 2020 Lancet Commission on the Institutionalisation and Deinstitutionalisation of Children conducted a systematic review to answer the question of whether growing up in residential care institutions negatively affects development or mental health, and whether leaving institutions and joining families leads to recovery from these adverse trajectories (van IJzendoorn et al., 2020). Their database search strategy was designed to include a wide range of outcomes, including medical (e.g., growth, stress regulation, respiratory-related, nutrition), as well as education, delinquency, and others. Ultimately, within the 308 studies they included in their meta-analysis, 55 studies measured child physical growth, 46 measured physical health, 20 head circumference (as a proxy for brain development), 116 cognition, 146 socioemotional development, and 28 attention. Although researcher-driven measurements of children's outcomes can lend to important insights, children's voices and perspectives on residential care and family reintegration are also crucial to respecting child rights within the context of policymaking and research on vulnerable children (United Nations General Assembly, 2010). However, of the outcomes included in the Lancet Commission, only "socioemotional development" could potentially measure children's own perspectives on their "outcomes," and it is unclear what measures were used in the studies included in this category.

The Quantitative Measurement of Well-Being

"Well-being" is a concept that typically aims to capture a comprehensive range of positive life outcomes. The field of well-being research has seen two important developments in thinking, that (1) human well-being is multifaceted, made up of various aspects and domains, and that (2) the salient domains of well-being may differ by context and life circumstances.

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

Both objective and subjective well-being can be measured unidimensionally. For example, an individual's annual income is a common unidimensional indicator of objective well-being. Unidimensional indicators of subjective well-being include, for example, answers to questions like, "Overall, how satisfied are you with your life nowadays?" or responses from the "Cantril Ladder" tool, wherein respondents imagine a ladder where the top represents the best possible life and the bottom the worst, and select a step of the latter to represent their own quality of life (OECD, 2013). Others recognize the importance of using multidimensional measures, that is, evaluating multiple dimensions or aspects of well-being. For example, the OECD suggests evaluating human well-being with a variety of objective measures related to income, wealth, housing, employment, education, health, and more (OECD, 2011). There are also multidimensional measures of subjective well-being, like Oxfam's Humankind Index for Scotland, which asks participants to rate their own well-being in 18 sub-domains as varied as health, relationships, safety, leisure, and transportation (Oxfam Scotland, 2013; Walker et al., 2012).

Conceptualizations of well-being can also differ by context. Organizations including the World Health Organization and Oxfam have recognized this, and as a result, have used qualitative methods, including focus groups and ranking exercises, to determine which dimensions of well-being are important to populations in certain contexts. They have used these findings to create quantitative, multidimensional well-being measures to inform policymaking and practice that affect these populations (McGregor et al., 2015; Walker et al., 2012; World Health Organization, 1998).

Measures of well-being specific to children have been developed as well. For example, the Personal Well-being Index: School Children (PWI-SC) measures children's subjective well-being in seven domains (standard of living, personal health, achievement in life, personal relationships, personal safety, feeling part of the community, and future security), using items like, "How happy are you about how safe you feel?" (Cummins & Lau, 2005). The scale is designed for global use with any children, and thus the questions are quite broad and non-specific. In England, researchers created a well-being measure specifically for children living outside of parental care in order to more finely assess their needs and adjust child welfare policies accordingly (Selwyn et al., 2017; Wood & Selwyn, 2017; Zhang & Selwyn, 2020). They first held focus groups with children in out-of-home (i.e., non-parental) care, then used the results to draft indicators, conducted member-checking with a subset of focus group participants, reduced the number of items to a manageable amount, piloted the survey, conducted cognitive interviewing, and finally revised the survey (Selwyn et al., 2017; Wood & Selwyn, 2017).

To our knowledge, no such process has been conducted with children who have experienced residential care in low- and middle-income countries. When Wright et al.

(2019) conducted a systematic review of positive adjustment in children in residential care, they found some studies used subjective well-being as outcome measures, including one developed with adults (the WHOQOL-BREF), one developed with children in the UK (the Generic Children's Quality of Life scale), and one developed for children in non-parental care are in the UK (the Children's Happiness Scale). No measures of subjective well-being were tailored towards children with the experience of non-parental or residential care in low- and middle-income countries (in fact, only seven of the 38 studies were done in Africa and four in Latin America). The current study is designed to contribute to filling this gap in the literature.

Study Aims and Context

With the ultimate goal of creating a tool for child participation in research and policymaking around the care of vulnerable children (United Nations General Assembly, 2010), this study takes the innovative approach of developing a multidimensional measure of subjective well-being informed by qualitative research with young people with lived experiences of residential care in two low- and middle-income countries.

The data for this study were collected within the context of Changing the Way We Care (CTWWC), an initiative operating in multiple countries, including Kenya and Guatemala, to reform child protection systems and reunify children in residential care with families where possible. The drivers of entering and experiences of living in residential care in Kenya have been previously explored in this dissertation. Guatemala has different factors that affect children's entry into residential care and a different type of system governing residential care, yet similarities also exist across the two countries. Both countries have similar proportions of children living in residential care (Desmond et al., 2020), and family poverty and child maltreatment are reasons children enter residential care in both countries (Changing the Way We Care, 2020; Chege & Ucembe, 2020; Manzo Chávez, 2021). Drivers of residential care more prominent in Guatemala than Kenya include malnutrition, organized crime, and international migration, while issues more salient in Kenya include genital cutting and early marriage (Changing the Way We Care, 2020; Chege & Ucembe, 2020; Kirk et al., 2017; Manzo Chávez, 2021). Children in Guatemala also often enter residential care per order of the judicial system (Changing the Way We Care, 2020). In terms of the effects of living in residential care, research has found that children in Latin America can face psychological problems including aggression and behavioral issues, internalizing symptoms, and delayed physical and cognitive development (Manzo Chávez, 2021). Young people are often also stigmatized as "delinquent" after exiting care in Guatemala (Changing the Way We Care, 2020).

Some international actors, including both researchers and policymakers, view the issue of residential care through a global lens, by drawing conclusions about and making recommendations for residential care that apply regardless of the continent, country, or region (United Nations General Assembly, 2010; van IJzendoorn et al., 2020; Whetten et al., 2014). Creating a standardized data collection tools that can be used across regions, yet is tailored for the specific context of children connected to residential care, will not only potentially aid in making global generalizations about residential care for children, but also allow for comparative analyses that can examine nuances and differences between contexts. Moreover, a measure designed to apply to multiple regions can also be used as a basis from which to adapt in situations where there are not enough time or resources to construct an entirely new measure. For these reasons, this study utilized data from two distinct contexts, Kenya and Guatemala, to construct a measure that captures areas of well-being that are potentially uniquely salient for children who have lived in residential care across multiple low- and middle-income countries.

Method

This study used a multi-step iterative process to create a measure of well-being that captures domains salient for children who have experienced residential care. First, focus groups were conducted with children and young people, and the data were analyzed and informed construction of a measure of subjective well-being for children in residential care. Second, face validity of draft items was assessed via member check-in with focus group participants. Third, cognitive interviewing was conducted with *n*=5 children, before the survey was deployed amongst *N*=180 children ages 11 to 18 who had lived in residential care in Kenya and Guatemala. Finally, we used exploratory factor analysis to determine the factor structure of the scale and create sub-scales.

Development of the Measure

Focus Group Procedure

In Kenya, four focus groups were conducted in each of the three study counties, Kisumu, Nyamira, and Kilifi. Six focus groups were held with *n*=41 children ages 11 to 17 who were reunified with family after living in residential care with post-placement support from CTWWC. These children were sampled via stratified random sampling from CTWWC's roster of children they supported, using strata for county and age. Six focus groups were held with *n*=29 young adults ages 18 to 29 who had lived in residential care during their childhoods more than two years ago. These young people were selected via convenience sampling from networks of young people who had lived in residential care with whom CTWWC had prior connections. In Guatemala, CTWWC served a smaller number of children, many of whom are younger than 11, and did not have existing networks of young adults, so convenience sampling was used to recruit *n*=8 children ages 11 to 17 who had been reunified with families into two focus groups in two locations served by CTWWC, with five children in the Zacapa focus group and three in the Guatemala City focus group.

Figure 1. Sampling strata for focus groups

Kisumu County, Kenya				Nyamira County, Kenya				Kilifi County, Kenya				Guatemala	
Reunified adolescents		Young adults		Reunified adolescents		Young adults		Reunified adolescents		Young adults		Guatemala City group (n=3)	Zacapa group (n=5)
Younger group (*n*=8)	Older group (*n*=8)	Men's group (*n*=8)	Women's group (*n*=6)	Younger group (*n*=3)	Older group (*n*=5)	Men's group (*n*=3)	Women's group (*n*=3)	Younger group (*n*=6)	Older group (*n*=6)	Men's group (*n*=7)	Women's group (*n*=7)		

In the focus groups, participants were asked to reflect on and share their personal experiences of life in residential care and life after residential care. After this, facilitators asked participants, "Use your imagination to make up a child who lives in a residential care institution and is really, really happy—as happy as they could possibly be. What is their life like?" Facilitators were given probes to use if children were stuck on just a few topics; specifically, they were trained to ask about safety, health, food, housing, relationships, emotions and feelings, education, or livelihoods (Betancourt et al., 2010). They were also trained to probe about different types of children (e.g., boys and girls, children with disabilities). Then they asked, "Now use your imagination to make up a child who left a residential care institution and joined a family, who is really, really happy – as happy as they could possibly be. What is their life like?" Probing questions were the same, and in addition they could also ask about children who joined different types of families (e.g., grandparents, foster families).

Finally, facilitators labeled two flip charts with the following headings: "What is important for 'doing well' for children in residential care institutions" and "What is important for 'doing well' for young people in the first five years after leaving residential care". Participants were asked to write what was important for 'doing well' on sticky notes or cards which they then pasted onto each flip chart. This written free-listing process allowed participants to distill the information from their previous discussion into a list, potentially incorporating not just their own ideas but also the ideas raised by fellow participants that resonated with them.

Focus group facilitators audio recorded the groups and transcribed the recordings. In Kenya, the facilitators also translated the audio recording into English where necessary (a mix of languages could be used in the groups), while in Guatemala, the transcriptions were fully in Spanish (since the lead researcher could read Spanish, they were not translated to English).

Analysis of Focus Group Data

The lead researcher conducted a rapid analysis of the focus group transcripts and written lists to have results ready for programmatic use in a timely way. The process was entirely inductive, following grounded theory's process of relying on participants' voices to create a framework of well-being rather than using theories held *a priori* by the researchers (Creswell & Poth, 2018). After reading the transcripts, the lead researcher highlighted everything a participant mentioned as a sign of a good life or important to doing well. Each of these excerpts, whether it came from the discussion or from the participants' written lists, constituted *in vivo* codes which were entered individually into a spreadsheet that also noted the context of the excerpt (Saldaña, 2016). Across the 12 Kenya focus groups, there were 909 excerpts of areas of well-being mentioned by participants, and 170 excerpts came from the Guatemala focus groups.

After finalizing the spreadsheet, the researcher considered the excerpts in their entirety and began to code them, according to common categories and themes. In some cases, once the researcher established a code, it stayed the same throughout the entire analysis (for example, the code "food"). In other cases, as it became clear that some categories were too narrow, or were connected to other categories, categories were changed, renamed, or split. For example, "community acceptance" was eventually merged with "sense of belonging" to be "acceptance/belonging"; on the other hand, while "hygiene" originally encompassed many aspects of sanitation, it became clear that "having sanitary towels" necessitated its own category. There were 42 themes that had more than two excerpts in Kenya, and 18 themes that had more than three excerpts in Guatemala; though not exhaustive, Table 1 and Table 2 illustrate the most common themes from these data.

Table 1. Ten most frequently mentioned themes from Kenya focus groups

Code	Freq.	Example excerpts	Notes
Love/care	86	"He or she will be happy when surrounded by people who show them love"; "There is that love of a family"	Related to love, care, affection, "parental love"
Food	63	"balanced food, good food, changing menus"; "chakula chenya anukuta [sweet food finds me]"; "balanced diet"	
Guidance and counseling	58	"Having mentors for guidance and counseling"; "there are people who can render us pieces of advice…when you are emotionally troubled"; "boy has good relations with father and is guided on the roles of a man"	Participants often mentioned "guidance and counseling" verbatim; this referred to advice from adults
Security	52	"feel safe because they live in a secured compound"; "Protection from people who might not have good intentions with them"; "there should be having good security in the area"	Safety was often introduced by facilitators with probing questions. Participants often understood it as having a watchman or a gate.
Clothes	47	"Has care and basic needs, not going to school with hand stitched cloth and bare foot"; "inner pants and bikers"; "shoes"	
Education	44	"Being taken to school, being taught some skills"; "Provision of all educational requirement for each and every child"	
Health	41	"is taken to hospital for medication"; "are taken to the hospital when they fall sick"	
Being with/having family	39	"girl gets to always go places together with her mother"; "meeting the family after a long time"; "emotional bond with family"	Participants sometimes equated happiness as simply being with or having family.
Play	34	"The child should get enough playing time"; "don't overwork, they have leisure time"; "can climb fruit trees and play with fellow children"	
Hygiene	30	"proper hygiene"; "proper sanitation"; "has washing soap"	Excluding sanitary towels, which had its own category

Table 2. Ten most frequently mentioned themes from Guatemala focus groups

Code	Freq.	Example excerpts	Notes
Good behavior	35	"Ser obediente" *(being obedient); "*Hacerles caso a los abuelitos" *(obey your grandparents); "*No estar mucho tiempo en la calle" *(not spending much time on the street); "*Ayudar a barrer si mama está cansada" *(helping your mom sweep if she is tired)*	Focus group facilitators believed that children mentioned this because if they do not listen, they are punished.
Play	35	"Jugar pelota" *(playing ball*); "columpios" *(swings);* "jugar shuco" *(playing freeze tag);* "ayudándole a papa a pescar" *(helping dad to fish)*	
Harmony and relationships	18	"Amor, Ayuda, Paciencia, Cariño, Sabiduria" *(love, help, patience, care, wisdom)*	This code was used for abstract items that related to positive relationships
Freedom	16	"No estar encerrados" *(not being locked in);* "puede salir" *(can go out)*	
Positive family relationships	13	"Que su familia lo apoyen" *(their family supports them);* "tiene mucho amor, cariño, comprensión" *(they have a lot of love, care, and understanding)*	
Being with family	11	"siempre tiene a su familia con ella" *(always has her family with her);* "Acompañar a la mamá a comprar" *(going shopping with your mom)*	
Food and nutrition	7	"tiene comida" *(has food);* "sus tres tiempos de comida" *(their three meals a day)*	
Education	8	"Graduarse" *(graduating from high school)*	
Shelter	8	"tendrá su cuarto aparte" *(has her own room);* "pila para bañarse" *(outdoor sink to bathe/wash in)*	
Clothing	8	"zapatos" *(shoes)*	

The researcher then compared the codes and ideas from the focus groups with a pre-identified well-being tool, the Catholic Relief Services Orphans and Vulnerable Children Wellbeing Tool (OWT) (Senefeld et al., 2011). The OWT is a self-report measure of well-being for children ages 13 to 18 who may be associated with orphan and vulnerable children (OVC) programs. OVC programs are targeted at children, adolescents, and young people living with or affected by HIV and AIDS. Children captured within the "OVC" category may or may not have involvement in RCIs, and children in RCIs may or may not be "OVC," but the populations overlap and have some sociologically similar characteristics (e.g., with regards to stigma, poverty) and are sometimes conflated (Cheney & Rotabi, 2014). Thus, the research team found the OWT to be a relevant measure from which to build.

We modified existing questions and added questions to the tool until we had a final list of survey questions that encompassed the key themes from the children and young adults, while also being general enough to use as survey questions for all children who have lived in RCIs. Some domains of well-being arose from the data that the OWT did not contain, particularly around play and leisure as well as freedom to go out and personal agency, while others from the OWT remained relevant, such as *"I eat at least two meals a day"*. Some OWT items were dropped because they were not mentioned in the focus group (e.g., *"My belief in God gives me strength to face difficulties").* Several were changed; for example, one OWT item was *"My school attendance is affected by my need to work,"* but because some participants in Kenya noted that it was important for children to have adequate time to study at home (not just to attend class), the statement was broadened to, *"My work or chores impact my ability to do well in school*. We also retained the OWT’s three-point Likert scale response, where respondents could respond whether statements were true for them all of the time, some of the time, or none of the time, which the OWT had adopted because it was simple enough for child respondents.

Member Checking

Member checking is the process of verifying results and interpretation of research with research participants or members of the population being studied (Creswell & Poth, 2018). It is considered a best practice in qualitative and participatory research in particular, and has been utilized as a way of assessing face validity in similar studies that used qualitative data from marginalized groups to create contextually-relevant measures (Ng et al., 2014; Selwyn et al., 2017; Sharma et al., 2013).

In Kenya, facilitators of the original focus groups conducted member checking workshops with a convenience sample drawn from the participants of the original focus groups, excluding the youngest children (as they may not have been able to understand the abstract nature of the discussion); *n*=22 adolescents and young adults participated in the three member checking workshops. Facilitators told participants they were providing them with a list of “the most important things to look at in order to determine if a child who currently lives in a residential care institution, or who used to live in a residential care institution, is doing well and having a good life...” Participants were asked to consider the lists of items, and suggest revisions, additions, or deletions. Facilitators took notes, which the lead researcher analyzed, and incorporated the respondents’ suggestions where appropriate.

In Guatemala, as previously described, it was only possible to hold two in-person focus groups due to the low number of adolescents receiving post-placement services from CTWWC and because these adolescents were spread across various geographic regions. To supplement the focus groups, the facilitators conducted phone calls with n=5 eighteen-year-olds who were reunified with family and receiving post-placement services from CTWWC. The team decided that the abstract nature of the discussion and the phone call format would be challenging for younger children. The phone calls in Guatemala served as both a way to expand the participant pool and collect new data, as well as to conduct member checking. Similar to the focus groups, facilitators first asked participants what life looks like for a child in residential care enjoying well-being, then the same regarding reunified children. Next, facilitators listed preliminary themes from the Guatemala focus groups, and asked participants what they thought about the list, and if they had any changes or additions. The facilitators audio recorded and transcribed these phone calls. Because the phone calls served a dual purpose of member checking and extending the focus group data collection (asking some of the same questions with new participants), the lead researcher analyzed the phone call data alongside the Guatemala focus group data, rather than afterwards.

During member checking, participants largely noted that the list of items resonated with them. The changes that were made based on the member checking process were few; for example, participants suggested combining *"I have a house where I can sleep at night"* and *"Where I sleep at night is comfortable,"* so the revised version of the tool consolidated these items into, *"I have a comfortable place to sleep at night"*.

Translation and Cognitive Interviewing

After completing member checking, and before administering the tool with children in Kenya and Guatemala, we conducted translation and cognitive interviews.

In Kenya, the English version of the items were used, but survey enumerators also had some key terms and phrases pre-translated into Kisii, Luo, and Kiswahili, that they could use if the respondent did not understand terms in English. The tool was translated into Spanish for use in Guatemala.

Cognitive interviewing (Collins, 2003) was conducted in person with *n*=3 child respondents in Kenya (one from each study county) and *n*=2 in Guatemala to assess whether children between ages 11 and 18 would understand and feel comfortable responding to the questions. A substantive change that came as a result of cognitive interviewing was changing two items ("I'm treated differently from the other children in my household" and "I'm treated differently from other children in my village/neighborhood/compound/community") in the Spanish version; cognitive interviewers found that the negative wording was confusing to respondents, and advised revising them into a positive framing (i.e., "I'm treated the same as…"). Thus, while these two items were reverse coded for Kenya respondents, they were not reverse coded for Guatemala respondents.

Table 3. List of items used in exploratory factor analysis and missing data

Item text	Number of missing responses Kenya (*n*=138)	 Guatemala (*n*=42)	 Overall (*N*=180)
At home, I have everything I need to keep myself clean	0 (0.0%)	0 (0.0%)	0 (0.0%)
I am happy with my clothing and shoes	0 (0.0%)	0 (0.0%)	0 (0.0%)
I have the materials I need for school	0 (0.0%)	1 (2.4%)	1 (0.6%)
I like my teachers at school	0 (0.0%)	1 (2.4%)	1 (0.6%)
My teachers treat me with respect	0 (0.0%)	1 (2.4%)	1 (0.6%)
My work or chores impact my ability to do well in school*	0 (0.0%)	1 (2.4%)	1 (0.6%)
I worry about having enough money for my education*	0 (0.0%)	0 (0.0%)	0 (0.0%)
I eat at least two meals a day	0 (0.0%)	0 (0.0%)	0 (0.0%)
I like the food I eat	0 (0.0%)	0 (0.0%)	0 (0.0%)
I can eat until I am satisfied	0 (0.0%)	0 (0.0%)	0 (0.0%)
My diet is well-balanced and nutritious	0 (0.0%)	2 (4.8%)	2 (1.1%)
My health is good	0 (0.0%)	0 (0.0%)	0 (0.0%)
I would be given medicine if I needed it	0 (0.0%)	0 (0.0%)	0 (0.0%)
Someone would take me to the hospital/clinic/doctor if I needed it	0 (0.0%)	0 (0.0%)	0 (0.0%)
If I needed something that my parents/caregivers can’t provide, there are others who would help	0 (0.0%)	0 (0.0%)	0 (0.0%)
I get to play and have fun	4 (2.9%)	0 (0.0%)	4 (2.2%)
I have enough time to study	0 (0.0%)	2 (4.8%)	2 (1.1%)
I have enough time to rest and sleep	1 (0.7%)	0 (0.0%)	1 (0.6%)
I get to pursue my hobbies and interests	0 (0.0%)	0 (0.0%)	0 (0.0%)
I have freedom to go out	1 (0.7%)	0 (0.0%)	1 (0.6%)
I have fun with my friends	1 (0.7%)	1 (2.4%)	2 (1.1%)
If I want something, my parents/caregivers will listen and consider it	0 (0.0%)	0 (0.0%)	0 (0.0%)
I can choose what to eat and when	0 (0.0%)	0 (0.0%)	0 (0.0%)
I am happy with how many friends I have	0 (0.0%)	0 (0.0%)	0 (0.0%)
I get along well with my friends	0 (0.0%)	3 (7.1%)	3 (1.7%)
I have someone to turn to for advice and guidance	0 (0.0%)	0 (0.0%)	0 (0.0%)

I have people I can talk to when I have a problem	0 (0.0%)	0 (0.0%)	0 (0.0%)
I have adults in my life who understand me	0 (0.0%)	0 (0.0%)	0 (0.0%)
The adults in my life teach me how to be successful in the future	1 (0.7%)	0 (0.0%)	1 (0.6%)
I feel I am supported by my relatives	0 (0.0%)	0 (0.0%)	0 (0.0%)
I feel like I'm part of my family	0 (0.0%)	0 (0.0%)	0 (0.0%)
I get love and care from my parents/caregivers	1 (0.0%)	0 (0.0%)	1 (0.6%)
I'm treated differently from [Spanish: the same as] the other children in my household[†]	0 (0.0%)	0 (0.0%)	0 (0.0%)
I'm treated differently from [Spanish: the same as] other children in my village/neighborhood/compound/community[†]	0 (0.0%)	1 (2.4%)	1 (0.6%)
I am as happy as other kids my age	0 (0.0%)	0 (0.0%)	0 (0.0%)
I have a comfortable place to sleep at night	0 (0.0%)	0 (0.0%)	0 (0.0%)
My home has a good environment for studying	0 (0.0%)	1 (2.4%)	1 (0.6%)
I feel safe where I live	0 (0.0%)	0 (0.0%)	0 (0.0%)
My home is peaceful	1 (0.0%)	0 (0.0%)	1 (0.6%)
I have someone to ask for help if I feel unsafe	0 (0.0%)	0 (0.0%)	0 (0.0%)
When I make a mistake, my parents/caregivers help me improve	0 (0.0%)	0 (0.0%)	0 (0.0%)
I am afraid of what will happen if I don't listen to my parents/caregivers*	0 (0.0%)	0 (0.0%)	0 (0.0%)
My parents/caregivers treat me with respect	1 (0.0%)	0 (0.0%)	1 (0.6%)

*Reverse coded in both languages

[†] Reverse coded in English only

Psychometric Testing of the Measure

Using data from *N*=180 children in Kenya and Guatemala, the psychometric properties of the measure were evaluated by (1) conducting an exploratory factor analysis to create sub-scales in the measure, (2) evaluating the internal consistency of sub-scales with Cronbach's alpha, and (3) evaluating the convergent validity of the subscales with their correlations with a unidimensional measure of life satisfaction.

Sample and Participants

The measure was deployed in household surveys of all CTWWC participants in Kenya and Guatemala, the purpose of which was to evaluate CTWWC's programming. Exploratory factor analysis was conducted on *N*=180 responses from young people in Kenya and Guatemala who were reunified with family after living in residential care, or who were assessed to be at risk of entering residential care.

Children were eligible to complete the child-informed well-being measure if they were between the ages of 11 to 18. In Kenya, there were 295 households eligible to participate in the household survey, and 89.2% (*N*=263) did so (reasons for non-participation included relocation, inability to contact the family, and illness). Within these households, 55.3% of eligible children (i.e., children ages 11 to 18 receiving CTWWC case management) completed the child measures (*n*=142); 76 (29.6%) children did not participate because they were away at boarding school, some had returned to residential care or moved to a different household, and some had run away. In Guatemala, 61 households were recruited to participate, and *N*=59 (96.7%) did so while two declined to participate; the households contained 57 eligible children, of which *n*=50 completed a child survey (87.7%) (three children could not participate and four children no longer lived in the household at the time of the survey).

During the process of data collection, some questions were only presented to children if they were enrolled in school, so for the purposes of this study, we excluded children who were not in school from the analysis (*n*=8 in Guatemala and *n*=4 in Kenya). Thus, we used data from *n*=138 children in Kenya and *n*=42 children in Guatemala.

Most items did not have any missing data; 17 out of the 43 items had between 1 and 4 missing cases (Table 3). For example, four responses were missing for *I get to play and have fun* (2.2% of the overall sample), and three from *I get along well with my friends* (1.7%).

Quantitative Analysis

Because the researchers had no *a-priori* theory guiding or expectation for what sub-domains may have existed within the measure, exploratory factor analysis (EFA), a method for uncovering the way in which latent variables (i.e., underlying concepts) are related to observed variables (i.e., survey items), was used to identify the factor structure of the scale (Watkins, 2018).

Since missingness in the sample was relatively low, missing data was handled via listwise deletion. In order to determine the optimal number of factors, the researcher visually examined scree plots and noted how many eigen values were greater than 1. The EFA was based on polychoric correlations (as the items are ordinal with fewer than five response options), used an iterated principal axis factor extraction (which is better suited for small sample sizes than maximum likelihood estimation), and used oblique (*promax*) rotation (Watkins, 2018). The “simple structure” concept guided interpretation of the

EFA results, which suggests that "(a) each factor should be saliently loaded by at least three variables (i.e., overdetermined), (b) each variable should load saliently on only one factor (no complex or cross-loadings), (c) each factor should demonstrate internal consistency reliability ≥.70, and (d) all factors should be theoretically meaningful" (Watkins, 2018, pp. 234–235). A variable was considered loaded on a factor if its factor loading was .40 or greater, and internal consistency was assessed by calculating Cronbach's alpha.

Finally, the measure's convergent validity was gauged by examining the factors' correlations with the unidimensional measure Overall Life Satisfaction (OLS), in which respondents were asked to rate how happy or satisfied they were with their life overall on a scale of 0 to 10, where 0 represented not at all satisfied and 10 completely satisfied. A visual aid was provided to help respondents understand the scale. The wording of this question, which is originally from Campbell (1976), is now widely used in the Personal Well-being Index – School Children (Cummins & Lau, 2005), and this question is used with a similar visual aid in the Children's Worlds International Survey of Children's Well-Being (Children's Worlds, n.d.).

Results

Table 4. Exploratory factor analysis dataset sample characteristics

		n (%) or M (SD)	
	Kenya (*n*=138)	Guatemala (*n*=42)	Overall (*n*=180)
Case type			
At-risk	16 (11.6%)	7 (16.7%)	23 (12.8%)
Reunified	122 (88.4%)	35 (83.3%)	157 (87.2%)
Female	59 (42.8%)	21 (50.0%)	80 (44.4%)
Living arrangements			
Both biological parents	12 (8.7%)	17 (40.5%)	29 (16.1%)
One biological parent	68 (49.3%)	18 (42.9%)	86 (47.8%)
Neither biological parent	58 (42.0%)	7 (16.7%)	65 (36.1%)
Mean age (years)	14.1 (2.0)	14.8 (2.0)	14.3 (2.0)

The mean age of participants in the dataset was 14.3 years (*SD*=2.0), and almost half (44.4%) were girls. Most participants (87.2%) had been reunified with family after living in residential care, while the others were identified as being at risk of entering residential care. About a third (36.1%) of participants were cared for by someone other than their biological parents, and this was more common in Kenya than Guatemala.

Bartlett's test of sphericity was $\chi2(903) = 3086.791$, $p < .001$ (Bartlett, 1954), and the KMO statistic was .833 (Kaiser, 1974), indicating that the data were appropriate for exploratory factor analysis. Visual analysis of scree plots suggested between 3 and 5 factors should be retained, while 11 eigenvalues were greater than 1, and Horn's parallel analysis of factors suggested 5 factors be retained. Thus, factor structures with six, five, four, and three factors were sequentially examined. Solutions with five and six factors resulted in multiple factors that had only one or two items saliently loaded onto the factor. The four-factor solution was inadequate, with four cross-loaded items, and with the fourth factor having an internal consistency of α<.60; the four factors also were determined to be insufficiently distinct in terms of subject matter.

The three-factor solution was judged to be adequate, with factors covering distinct content areas and having only two cross-loadings. All loadings from this solution are displayed in Table 5. We named factor 1 *care and safety* (12 items)*,* factor 2 *basic needs* (13 items)*,* and factor 3 *leisure and freedom* (7 items)*.* Seven items did not load saliently onto any factor, so they were removed (*I like my teachers at school; I'm treated differently from other children in my community; I'm treated differently from the other children in my household; If I needed something that my parents/caregivers can't provide, there are others who would help; I would be given medicine if I needed it; I have enough time to study; I am afraid of what will happen if I don't listen to my parents/caregivers*). Three items were removed because it was determined that they did not match the theoretical meaning of the factors onto which they loaded (*I am as happy as other kids my age; My health is good; My teachers treat me with respect*). Two items loaded saliently onto more than one factor (*At home, I have everything I need to keep myself clean; I feel I am supported by my relatives*), but because the *clean* item was theoretically relevant to the rest of the *basic needs* factor, it was retained on factor 2 despite the cross-loading; as the *relatives* item was related to both provision of basic needs as well as care from family, this item was dropped. The internal consistency of the *care and safety* factor was α=.88, *basic needs* was α=.85, and *leisure and freedom* was α=.72; all items improved the alpha values of their respective scales.

Table 5. Results of exploratory factor analysis

Item	Loadings onto each factor Factor 1: Care & safety	Factor 2: Basic needs	Factor 3: Leisure & freedom	Decision
When I make a mistake, my parents/caregivers help me improve	**.84**	.07	-.16	Retained as factor 1
I have someone to turn to for advice and guidance	**.83**	-.10	.01	Retained as factor 1
I have people I can talk to when I have a problem	**.82**	.13	-.05	Retained as factor 1
My parents/caregivers treat me with respect	**.78**	-.18	.15	Retained as factor 1
I get love and care from my parents/caregivers	**.76**	.15	.02	Retained as factor 1
I have adults in my life who understand me	**.68**	.00	.21	Retained as factor 1
The adults in my life teach me how to be successful in the future	**.67**	.03	.08	Retained as factor 1
I feel like I'm part of my family	**.64**	.33	-.01	Retained as factor 1
If I want something, my parents/caregivers will listen and consider it	**.62**	.09	-.03	Retained as factor 1
I have someone to ask for help if I feel unsafe	**.62**	.29	.07	Retained as factor 1
Someone would take me to the hospital/clinic/doctor if I needed it	**.57**	.06	.06	Retained as factor 1
My home is peaceful	**.50**	.28	.11	Retained as factor 1
I like my teachers at school	.36	-.21	.27	Dropped as loadings <.40
I'm treated differently from [Spanish: the same as] other children in my village/neighborhood/compound/community	.34	-.13	.29	Dropped as loadings <.40
If I needed something that my parents/caregivers can't provide, there are others who would help	.31	.29	-.19	Dropped as loadings <.40
I would be given medicine if I needed it	.29	.28	.24	Dropped as loadings <.40
I like the food I eat	.01	**.83**	-.07	Retained as factor 2
My home has a good environment for studying	.06	**.75**	.05	Retained as factor 2
I have a comfortable place to sleep at night	-.19	**.74**	.22	Retained as factor 2
I can eat until I am satisfied	.03	**.71**	.09	Retained as factor 2
My diet is well-balanced and nutritious	.12	**.70**	.05	Retained as factor 2
I worry about having enough money for my education	-.22	**.68**	.06	Retained as factor 2
I can choose what to eat and when	.26	**.66**	-.32	Retained as factor 2
I feel safe where I live	.10	**.61**	.32	Retained as factor 2
I eat at least two meals a day	.17	**.58**	.02	Retained as factor 2

I am happy with my clothing and shoes	.29	**.56**	-.02	Retained as factor 2
At home, I have everything I need to keep myself clean	.44	**.53**	-.20	Retained as factor 2
I have the materials I need for school	.31	**.45**	-.01	Retained as factor 2
I am as happy as other kids my age	.24	.44	.25	Dropped as not theoretically matched to factor
I feel I am supported by my relatives	.42	.44	-.08	Dropped due to cross-loading
My work or chores impact my ability to do well in school	-.29	**.40**	.19	Retained as factor 2
I have enough time to study	.19	.39	.29	Dropped as loadings <.40
I am afraid of what will happen if I don't listen to my parents/caregivers	-.26	.35	-.02	Dropped as loadings <.40
I have fun with my friends	-.06	-.18	**.75**	Retained as factor 3
I get along well with my friends	.02	.04	**.73**	Retained as factor 3
My health is good	-.13	.15	.72	Dropped as not theoretically matched to factor
I am happy with how many friends I have	.15	-.01	**.72**	Retained as factor 3
I get to play and have fun	.11	.17	**.59**	Retained as factor 3
I get to pursue my hobbies and interests	.00	.39	**.52**	Retained as factor 3
I have enough time to rest and sleep	.09	.28	**.52**	Retained as factor 3
I have freedom to go out	-.12	.14	**.50**	Retained as factor 3
My teachers treat me with respect	.31	.00	.44	Dropped as not theoretically matched to factor
I'm treated differently from [Spanish: the same as] the other children in my household	.33	-.35	.39	Dropped as loadings <.40

Note: Bolded statistics indicate items retained on their respective factors; italics indicate dropped items.

As a sensitivity analysis, we evaluated the factor loadings onto a three-factor solution using only data from Kenya. The items that loaded <.40 onto the three factors results were similar, but not exactly the same, to those that used both countries' samples pooled together. For factor 1, there was 72.1% match in loaded items between the Kenya-only and the pooled sample. For factor 2, the match was 81.4%, and for factor 3, the match was 88.4%. We determined that the coherence between items in the factors using the pooled sample was more logical than in the one using a Kenya-only sample.

As another sensitivity analysis, another three-factor exploratory factor analysis was run for the pooled sample with the dropped items excluded. For the three-factor solution, the same items loaded saliently onto the same factors as in the original solution. The proportion of variance of all these items explained by the *care and safety* factor was 33.2%, by *basic needs* was 31.5%, and by *leisure and freedom* was 19.4%.

Finally, scale scores were created of each of the three factors by calculating the mean of their items. The *care and safety* scale correlated significantly with overall life satisfaction (r=.42, p<.001), as did *basic needs* (r=.51*, p<.001*)*,* and *leisure and freedom* (r=.23, p=.002).

Discussion

The utility of well-being measures that are tailored to the needs and priorities of diverse populations is well recognized (McGregor et al., 2015; Sharma et al., 2013). Although policymakers rely heavily upon research about children's development and well-being to shape policy and practice around the use of residential care institutions for children in low- and middle-income countries (Goldman et al., 2020; van IJzendoorn et al., 2020), and although qualitative research suggests that the salient experiences of children in residential care are unique (Roche, 2019), we could not identify any measures of well-being specifically tailored to the priorities of children who have experienced residential care. This study attempts to fill this gap by constructing survey questions about children's subjective well-being based on qualitative analysis of focus groups with children and young people who have lived in RCIs in Kenya and Guatemala, resulting in a child-informed measure is specifically designed for use with children in RCIs, who have left RCIs, who are at risk of entering RCIs, and any potential comparison groups. Exploratory factor analysis suggested that the measure assessed three underlying constructs, which we call *care and safety, basic needs,* and *leisure and freedom.*

Analysis of data from the focus groups reinforce prior literature's findings that children in RCIs care about the level of agency and decision-making power they have over their own lives (Roche, 2019). This theme of autonomy, and ability to decide how to spend one's time, freedom of movement, and freedom to play, was important to young people, yet seems to be relatively unexplored in quantitative research. Indeed, although the Convention on the Rights of the Child recognizes "the right of the child to rest and leisure, to engage in play and recreational activities" (United Nations General Assembly, 1989, art. 31), none of the child well-being measures or quantitative studies of children in RCIs that we reviewed mentioned this as an aspect of child well-being. Thus, one of the current study's significant contributions is the construction and validation of a quantitative sub-scale that assesses children's subjective perspective on leisure and freedom in their lives.

Prior literature on RCIs also confirms the importance of having their basic, material needs met. Poverty is a significant driver of children entering residential care, and caregivers may choose to place children in RCIs so that they can access food, healthcare, and education (van IJzendoorn et al., 2020). One study in Ghana found that children in RCIs had better access to material resources than children who had been reunified with family after living in RCIs (James et al., 2017). Thus, it is important that research and evaluation assess child poverty, food security, access to education, and other dimensions of basic needs, in order to inform policies around the use of RCI and support services that may need to be provided to children's families after family reunification. While other measures can provide more robust, objective measures of household economic status, such as those employed in the Demographic and Health Surveys (Staveteig & Mallick, 2014), the basic needs subscale of this measure provides an important complementary perspective, which is children's own perceptions on whether their material needs are being met in areas they prioritize.

For children who have lived in RCIs or who are at risk of entering RCIs, their experience of being parented and receiving care is particularly important. Children may enter RCIs due to abuse or neglect or the presence of violence or dysfunction in their family. At the same time, literature suggests that abuse, violence, neglect, and lack of individualized attention, can also characterize RCIs across low- and middle-income countries (Dozier et al., 2012; Rus et al., 2017). A study of five low- and middle-income countries found that over half of children who had lost a parent or were separated from their parents had experienced physical or sexual abuse by age 13, and this was true whether they lived in RCIs or families; 31% of children in RCIs had experienced violence in their RCI and 37% of children in families had experienced violence in the family home (Gray et al., 2015). Thus, the care and safety subscale of this measure is a tool for assessing whether children feel they are receiving love and care, receiving the parenting or caregiving they need, and whether they feel safe in their homes.

Limitations

One limitation of this study is that only one person conducted the rapid coding of the focus group data, with no second coder to enhance the reliability and validity of the procedures; however, the member checking process with participants mitigated some of this potential source of bias. The psychometric analysis in this study was also limited by its small sample size, which precluded our ability to do a split sample analysis (i.e., conducting exploratory factor analysis on one half of the sample and assessing the fit of the best-fitting model with confirmatory factor analysis in the other). Another limitation is that an item that was developed from the focus group data, "I am happy with how much time I get to spend with my family," was not used in Kenya due to a survey programming error, despite this item being relevant to the population's subjective well-being. Although the study aimed to recruit all children ages 11 to 18 who were enrolled in CTWWC's programming, children who were not enrolled in school were excluded from this analysis, and many children in Kenya could not be surveyed because they were away at boarding school; these could have introduced bias to the sample. In addition, since two items were not reverse-coded in Spanish, there could have been measurement differences between the two languages. Finally, and crucially, this study only used data from only two countries, Kenya and Guatemala, and repeating this process in more contexts could enhance its applicability worldwide.

Implications and Future Directions

This study adopted an innovative approach to the measurement of outcomes for vulnerable children, using participatory, qualitative methods with children and young people to inductively construct a new quantitative measure. The results of this study integrate child participation in multiple layers: as this is a child-report tool, the *answers* children give to this survey embody child participation, and the tool was designed via participatory methods, the *questions* asked of children also represent children's priorities.

It should be noted that there is a tension in developing measures contextualized for diverse populations: that is, how specific is too specific, and how general is too general? If a measure is too finely tailored to a specific group, its applicability can be impractically narrow. If a measure is developed to be used too broadly, then it can fail to measure nuances that are important to the population of interest. Recognizing that much of the influential discourse on children's care happens at a global level, we aimed to create a measure that can be useful for research across various low- and middle-income countries by pooling the common experiences of participants in the very different countries of Kenya and Guatemala. However, researchers, practitioners, and policymakers may disagree about what balance between specificity and generalizability is ideal for measures used to inform policymaking. This question cuts to the core of global research, and those working in global development and human rights must elevate and grapple with this issue in future research.

Certain research on children's cae that aims to be highly localized may find it more useful to have a measure specifically tailored to their particular cultural context, because the experiences of residential care can indeed differ greatly from country to country. In these cases, this study offers useful contributions as well, as it can either provide a replicable methodology that another researcher could use to construct their own child-informed, contextual measure of child well-being from their own focus groups, or they could take these questions or sub-scales as a starting point for further cultural adaptation and contextualization.

It is critical that both qualitative and quantitative research on children's care uplifts the perspectives of children and young people with the lived experience of residential care. This study provides a useful tool and example methodology for embedding child participation in research, ensuring that when such research influences policy making on the use of RCIs in low- and middle-income countries, children's perspectives are at the table.

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Chapter IV. Subjective Well-being of Kenyan Children Reunified with Families from Residential Care Institutions: The Role of Disability

Introduction

Estimates suggest that around 50,000 to 60,000 children live in residential care institutions (RCIs) in Kenya (Desmond et al., 2020). Children in Kenya generally enter institutional care due to poverty, violence and maltreatment, and the stigmatization of HIV and disability (Chege & Ucembe, 2020; Morantz et al., 2013). Many children with disabilities live in residential care institutions in Kenya (UN Committee on the Rights of Persons with Disabilities, 2015). Changing the Way We Care (CTWWC) explicitly includes children with disabilities in their programming in Kenya, and identifying, utilizing, and advocating for supportive policies and services for children with disabilities is part of CTWWC's advocacy work in Kenya (Changing the Way We Care, 2021).

Outcomes of Living in Residential Care

The harms of living in RCIs have been well documented, particularly in Europe. A systematic review by the 2020 Lancet Group Commission on Institutionalisation and Deinstitutionalisation of Children found strong links between living in RCIs and poor developmental outcomes in cognition, attention, and physical growth, and moderate links with socioemotional, mental health, and attachment difficulties (van IJzendoorn et al., 2020). Fortunately, when children in RCIs join families, they can show rapid developmental catch-up in growth and cognition and improvements in adaptive functioning (Humphreys et al., 2018; van IJzendoorn et al., 2020). Research on children who have joined families has focused on children who have been internationally adopted into high-income countries (van IJzendoorn & Juffer, 2006) and children who have entered local foster care (Zeanah et al., 2017), but rarely on children who have been reunified with their original families (James et al., 2017). The Lancet Commission noted that broadly, across studies, the duration of time children lived in RCIs, and living in RCIs during their earliest years of life, was linked to more developmental delays and poorer rates of developmental catch-up (van IJzendoorn et al., 2020). However, these studies are largely of infants and very young children and of contexts outside Sub-Saharan Africa. Studies that try to untangle the impacts of living in and leaving residential care on child well-being in Kenya and in other Sub-Saharan African nations are more limited, and have shown varied results.

While we could not identify any quantitative studies of children who have reintegrated with local families after living in residential care in Kenya, a few in other Sub-Saharan African nations have been conducted. Children reunified with families after living in RCIs in Ghana had higher levels of hope compared with their peers who remained in institutions, but generally speaking, children in institutions had better access to resources, including education, health care, nutrition, and shelter, than those in family care (James et al., 2017; James & Roby, 2019).

More commonly, research has compared children currently living in residential care with children who have not lived in residential care and reside in families. A study in Uasin Gishu county, western Kenya, compared children in residential care institutions with orphaned and foster children living in families. It found that children in RCIs had better outcomes in terms of nutrition, mental health, resilience, having their basic materials needs met, experiences of sexual abuse and transactional sex, and completing primary school, while the children in families have better outcomes in secondary school completion and fewer experiences of traumatic events (Apedaile et al., 2022; Atwoli et al., 2014; Braitstein et al., 2013; Embleton et al., 2014, 2017; Omari et al., 2021; Sutherland et al., 2022).

Emerging qualitative work suggests additional domains of well-being may be affected by living in residential care. For example, a scoping review of children's experiences in RCIs in low- and middle-income countries found that children enjoyed material benefits of orphanages, struggled with favoritism by orphanage staff, wished to have greater autonomy and decision-making over their lives, sought greater connection to their communities and biological families, and struggled with identity, sense of belonging, and being stigmatized as an orphan (Roche, 2019). Similar themes arose in interviews with youth in Uasin Gishu (Gayapersad et al., 2019). These phenomena, and children's first-hand perspectives on their well-being in general (i.e., "subjective well-being"), have rarely been assessed in quantitative studies. This study aims to address these gaps by examining, among a sample of children who have been reunified with family after living in residential care institutions in Kenya, correlates of child subjective well-being, as well as their perspective on whether their life was better in residential care or after reunification.

Child Disability and Residential Care

Globally, disability is both a risk factor for entering residential care, and residential care can also cause children to become disabled, although data on these issues are scarce (Berens & Nelson, 2015; Browne, 2009; Sherr et al., 2017). Disability Rights International found that in Kenya, poverty, stigma, and lack of social services drove parents to place their children with disabilities in residential care (Rodríguez et al., 2018).

They quoted one government official as saying, “culture still plays a role as having a child with a disability is said to be taboo and there are also financial constraints for most families. Unable to take care of their children, some parents place the children in institutions” (Rodríguez et al., 2018, p. 18).

Residential care can also cause child disability, although it is difficult to definitively disentangle causes and effects (Sherr et al., 2017). Researchers theorize that the physical and socioemotional deprivation and lack of individualized attention in RCIs can cause deficits in cognitive development, attention, attachment, and other domains of functioning (Dozier et al., 2012; van IJzendoorn et al., 2020). Trauma can cause disabilities (Schüssler-Fiorenza Rose et al., 2014), especially childhood disabilities in emotions and attention (La Greca et al., 2008). Arguably, all children in RCIs have experienced the traumatic event of family separation in order to enter residential care, and in addition, they may experience other traumas in residential care such as abuse (Gray et al., 2015). For these reasons, it is very likely that entering and living in residential care has a causal relationship with developing cognitive, behavioral, attention, and emotional disabilities, if not others.

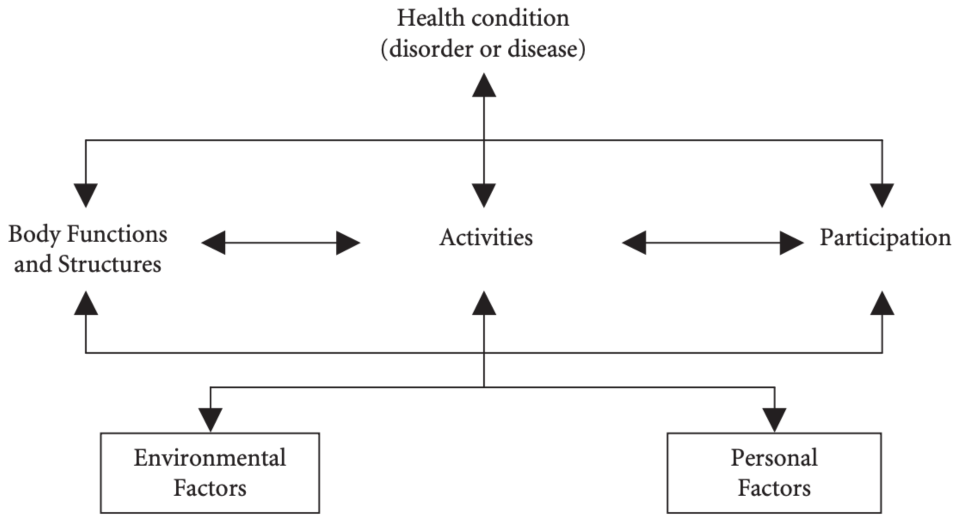
To our knowledge, little research has measured the prevalence of disability amongst children in Kenya or elsewhere in Africa who are entering residential care, living in residential care, or leaving residential care, or examined outcomes for such children. A notable exception is a study of Ghana, which found using representative sampling techniques that 20% of children in RCIs had a disability; the most common domain of disability was learning difficulties (Ghana Department of Social Welfare & UNICEF, 2021). Additionally, according to the 2001 South African census, 5% of children with disabilities lived in RCIs compared to only 0.5% of children without disabilities, and 20% of children in RCIs had severe disabilities compared to only 2% of children in families (Department of Social Development et al., 2012). However, these analyses measured disability in different ways. The conceptualization and measurement of child disability must be done with care in order to ensure comparability between studies.

Theoretical Framework and Measurement of Child Disability

This study uses the World Health Organization's International Classification of Functioning, Disability, and Health (ICF) to conceptualize disability (World Health Organization, 2007). Disability has traditionally been framed through a medical model, which conceptualizes disabilities as being caused exclusively by impairments in individuals' bodies. The ICF, on the other hand, is a bio-psychosocial model of disability, which conceptualizes disability as a phenomenon that arises from the interaction between an individual's health conditions and their environment. That is, a person can only "disabled" to the extent that their physical environment, social context, or local laws limit their ability to function effectively in society—barriers in society, not just the condition of a person's body, cause disability (World Health Organization, 2007).

Specifically, the ICF posits that an individual's health conditions interact with environmental factors (e.g., laws, infrastructure, cultural attitudes) and personal factors (e.g., age, gender) to affect their body structures and functions (e.g., limbs, breathing, seeing) and their ability to complete activities and participate in life situations (e.g., self-care, walking, communicating with others, completing household tasks). These dynamics are illustrated in Figure 1.

Figure 1. The ICF Model



Note. From *International classification of functioning, disability and health: Children & youth version* (17) by World Health Organization, 2007. Copyright 2007 by World Health Organization.

Since this study uses this bio-psychosocial model of disability, it does not rely on medical diagnoses, cognitive tests, or the Diagnostic and Statistical Manual of Mental Disorders to determine if a child has a disability. Rather, we focus on the *activities* portion of the ICF model; children are considered as having a disability depending on the extent to which they have difficulties doing activities, if those activity limitations put them at greater risk than other children of the same age of “experiencing limited participation in an unaccommodating environment” (UNICEF/Washington Group on Disability Statistics, 2017, p. 2). Specifically, this study employed a widely-used tool for assessing child disability, the Washington Group/UNICEF Child Functioning Module (CFM), which is based on the ICF model (Washington Group & UNICEF, 2016). The CFM assesses whether children have functional difficulty in the domains of vision, hearing, mobility, self-care, communication, learning, concentration, accepting change, controlling behavior, making friends, anxiety, and depression.

Study Aim

The aim of this study is to examine, among a sample of children who have been reunified with family after living in residential care institutions in Kenya, how child characteristics and experiences correlate with their subjective well-being. In particular, we hypothesize, when controlling for child sex, age, and time since family reunification, that children with disabilities will have worse subjective well-being, and more negative experiences of reunification, than children without disabilities.

Method

Sampling and Recruitment

This study draws on data from a household survey of CTWWC participants in Kenya who were either receiving services because a child had been reunified with family after living in an RCI or because the child was considered at risk of entering an RCI. A family was considered eligible if they had begun receiving services from CTWWC before June 1, 2021, and data were collected in October 2021.

The primary caregiver within each family completed a survey about himself or herself and the household (*caregiver survey*). Primary caregivers were identified as the individual already listed as such in CTWWC's case management and monitoring systems. They also completed a survey about each child in their care who had been reunified from residential care or was receiving individualized case management due to being at risk of entering residential care (*caregiver report on the child*). It was possible for one household to have more than one child receiving individualized case management; in these cases, the caregiver completed a report on the child for each child.

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

A total of 295 caregivers with children receiving services from CTWWC were eligible to be surveyed in Kenya, and 89% (*n*=263) of these completed a survey. The reasons caregivers were unable to be surveyed were relocation to outside the county (*n*=15 caregivers), unable to be contacted (*n*=4), illness/disability (*n*=5), and other (*n*=8). These caregivers had 257 children ages 11 and above eligible to complete a child self-report survey, of whom 55% (*n*=142) did so. Multiple reasons existed as to why these response rates were lower compared to caregivers, with the most common being living at a boarding school (*n*=76 children), relocation or no longer living with the caregiver (*n*=12), having returned to residential care without the knowledge of the case worker (*n*=6), found to not meet eligibility requirements upon visiting the household or other data error (*n*=6), having run away/not being traceable (*n*=5), disability/illness (*n*=5), having been married (*n*=2), and unable to be reached due to being in day school (*n*=2).

Participants

We limited our analysis to the 126 children who had been reunified after living in residential care, excluding those who had only been assessed as at risk of entering residential care. These 126 children, ages 11 to 18, lived in 106 households. Ninety households (84.9%) contained one surveyed child, 14 households (13.2%) contained two, and two households (1.9%) had three children surveyed.

Measures

Independent Variables

Orphanhood, parental care status, time since reunification, years in residential care, household hunger, and disability status were included as independent variables. Covariates also included child age (0% missing) and sex (0% missing).

Orphanhood. The child's primary caregiver was asked in the report on the child if the child's biological mother and father were alive. These data were recoded into a categorical variable of orphanhood in which 0, the reference group, represented non-orphan (both parents alive), 1 was single orphan (deceased father or mother), and 2 was double orphan (both parents deceased). Five cases were missing (4.0%), usually because the caregiver did not know if one of the parents was alive.

Parental Care. The primary caregiver was also asked whether the child lived with his biological mother or father. These data were re-coded into a categorical variable of parental care status in which 0 (the reference group) represented living with both parents, 1 was living with one parent, and 2 was living with both parents. No cases contained missing data.

Days Since Reunification. The date that the child was reunified, in day-month-year format, was obtained from CTWWC's case management database. This date was subtracted from the date of the survey to calculate a variable of the number of days that had elapsed since reunification. There were no missing cases.

Years in RCI. Caregivers reported how old the child was when they first entered residential care and how old they were when they most recently came to live with them. The difference between these variables was calculated to create a variable of the approximate number of years the child spent in residential care. Thirteen cases were missing (10.3%).

Household Hunger. The Household Hunger Scale was used as a proxy for economic deprivation (Ballard et al., 2011). As part of the caregiver survey, caregiver respondents were asked if over the past four weeks their household ever lacked food entirely, if anyone in their household went to sleep hungry, or if anyone in their household ever went a whole day and night without eating. Each question was scored as 0 for no, 1 for rarely or sometimes, and 2 for often. The three questions were summed into a score in which 0-1 represented little or no household hunger, 2-3 represented moderate hunger, and 4-6 severe hunger. There was no missing data.

Disability Status. Caregiver respondents completed the Washington Group/UNICEF Child Functioning Module (CFM) about each child (Washington Group & UNICEF, 2016). The CFM, based on the World Health Organization ICF model, assesses whether children have functional difficulty in the domains of vision, hearing, mobility, self-care, communication, learning, concentration, accepting change, controlling behavior, making friends, anxiety, and depression. Caregivers were asked to rate children's level of difficulty in each domain (e.g., "Does [name] have difficulty concentrating on an activity that he/she enjoys doing?"), with options "no difficulty," "some difficulty," "a lot of difficulty," or "cannot do at all." For anxiety, caregivers were asked how often the child seemed "very anxious, nervous, or worried," and for depression, "very sad or depressed," with options "daily," "weekly," "monthly," "a few times a year," and "never." A child was considered as having a disability if they had a "a lot of difficulty" or "could not [function] at all" in at least one domain of functioning or if they seemed anxious or depressed every day. There were four cases of missing data (3.2%).

Dependent Variables

Overall Life Satisfaction (OLS). As part of the child survey, child respondents were asked “How satisfied (or ‘happy’) are you with your life as a whole?” on a scale of 0 to 10, where 0 represented not at all satisfied and 10 completely satisfied (“current OLS”, 2 missing cases [1.8%]). The wording of this question, which is originally from Campbell (1976), is now widely used in the Personal Well-being Index – School Children (Cummins & Lau, 2005), and is also used with a visual aid in the Children’s Worlds International Survey of Children’s Well-Being (Children’s Worlds, n.d.). A similar visual aid was added in this study to help respondents understand the scale. The child was also asked to think about when they lived in residential care, and rate how happy or satisfied they were with their life at that time on the same scale (“OLS in RCI”, 2 missing cases [1.8%]).

We subtracted OLS in RCI score from their current OLS score to produce a score that represented a change in life satisfaction (“change in OLS”, 4 missing cases [3.2%]). Change in OLS could range from -10 to 10, where -10 represented the greatest possible decrease in life satisfaction, 0 represented no change in life satisfaction, and 10 represented the greatest possible increase in life satisfaction. This variable allowed us to assess to children’s experience of reunification, in the sense that it measured whether children felt their life was better or worse, and to what degree, after reunification, compared to their life in residential care.

Figure 2. Visual aid for OLS questions

Note. Adapted from *12 Years-old questionnaire,* by Children's Worlds (n.d.), *8 Years-old questionnaire,* by Children's Worlds (n.d.), https://isciweb.org/the-questionnaire/using-the-questionnaires/, and from Pain scale chart consisting of eleven levels of pain, in *Shutterstock,* n.d., from https://www.shutterstock.com/image-vector/pain-scale-chart-consisting-eleven-levels-538565311.

Child-Informed Subjective Well-Being. Three measures of subjective well-being, which were developed through focus groups with children and young people who had lived in RCIs in Kenya and Guatemala, were also used. All of the items were statements to which respondents responded with how true the statements were for them (0=none of the time, 1=some of the time, 2=all of the time). The mean across answers was calculated to serve as the subscale scores, wherein values could range from 0 to 2 and higher scores indicated greater well-being. The first subscale was "care and safety," which contained 12 items such as "I have someone to turn to for advice and guidance," "My parents/caregivers treat me with respect," and "I have someone to ask for help if I feel unsafe" (α =.88, 0 missing). The second was "basic needs," which contained 12 statements including "I have a comfortable place to sleep at night, "I can eat until I am satisfied," and "At home, I have everything I need to keep myself clean"; two items were reverse coded in this subscale (α=.80, 0 missing). Finally, the "leisure and freedom" subscale contained seven statements, including "I get to play and have fun", "I get along well with my friends," and "I have freedom to go out" (α=.79, 0 missing).

Analysis

Statistical analyses were completed in Stata 17 BE (StataCorp, 2021). First, univariate descriptive statistics (i.e., means, counts, and percentages) were used to describe the characteristics of the sample and the mean scores on dependent variables. In terms of bivariate statistics, we used Pearson's correlations to analyze relationships amongst continuous variables, *t*-tests to examine differences in means on continuous variables by child sex and disability status, and chi-squared tests to examine relationships between categorical variables. One-way ANOVAs were also used to compare means on continuous variables by orphanhood and parental care status, using Tukey post-hoc tests to examine significant differences. We used ordinary least squares regressions to analyze predictors of well-being, with standard errors adjusted for clustering at the household level. In all analyses, missing values were managed via listwise deletion (Schafer, 1999).

Results

Univariate Results

Univariate statistics are presented in Table 1. Boys were slightly overrepresented in the sample (57.9%), and 73.6% of children had lost one or both parents. Almost half of children only lived with one of their biological parents, and 41.3% of children were living with neither of their parents.

The average change in life satisfaction was 0.1 points (*SD*=1.2). In the sample, 37.7% of respondents had a negative change in OLS, meaning that they rated their satisfaction with life in the RCI higher than their current life satisfaction, while 40.2% had a positive change in OLS, and 22.1% gave them the same rating (data not shown).

Seventeen children (13.9%) had a disability. Twelve of these children had functional difficulties in only one domain, while five had difficulties in multiple domains (not shown). Eleven children's difficulties were only in behavioral domains (depression, anxiety, controlling behavior, or making friends). Three children had difficulty in only a physical domain (seeing or hearing), and one child only had difficulties in cognitive domains (learning, communication, remembering, and concentrating). One child had both cognitive and behavioral difficulties, and another child had physical and cognitive difficulties.

Table 1. Descriptive statistics on sample (*N*=126)[1]

	M (SD)	N (%)
Age	14.3 (2.0)	
Sex		
Female		53 (42.1%)
Male		73 (57.9%)
Orphanhood		
Non-orphan		32 (26.5%)
Single orphan		66 (54.6%)
Double orphan		23 (19.0%)
Parental care status		
Both parents		12 (9.5%)
Single parent		62 (49.2%)
Neither parent		52 (41.3%)
Days since reunification	532.1 (145.6)	
Years in residential care	5.0 (4.0)	
Household Hunger Score	1.1 (1.2)	
Disability status		
No disability		105 (86.1%)
Has disability		17 (13.9%)
Current life satisfaction	7.6 (2.3)	
Retrospective life satisfaction	7.5 (2.5)	
Change in life satisfaction	0.1 (3.1)	
Care and safety	1.7 (0.4)	
Basic needs	1.4 (0.3)	
Leisure and freedom	1.7 (0.4)	

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[1] Sample sizes differ by variable in tables 1, 2, 3, and 4.

Bivariate Results

Correlations among continuous independent and dependent variables (Table 2) showed that children living in households with higher Household Hunger Scores had lower well-being in the basic needs domain (*r*=-.38, *p*<.001), and older children tended to have spent more years in residential care (*r*=.33, *p*<.001; not shown).

Table 2. Pearson's *r* correlations (*N*=126)

	Current OLS	OLS in care	Change in OLS	Care & safety	Basic needs	Leisure & freedom
Age	.03	.03	.00	.01	-.15	-.04
Days since reunification	-.12	.01	-.10	.06	-.14	-.13
Years in RCI	.01	-.03	.04	.06	-.14	-.13
Household hunger	-.08	-.05	-.01	-.11	-.38***	-.05

Note: Correlation statistically significant at * *p*<.05, ** *p*<.01, *** *p*<.001.

Children with disabilities had significantly worse outcomes on change in OLS (*t*(116)=2.63, *p*<.01), care and safety (*t*(120)=3.62, *p*<.001), basic needs (*t*(120)=2.77, *p*<.01), and leisure and freedom (*t*(120)=3.77, *p*<.001) (Table 3), but did not differ significantly on independent variables or covariates (not shown). No study variables differed significantly by child sex (not shown).

Table 3. Comparison of means of study variables by disability status, M (SD) (*N*=126)

	No disability	Disability
Current OLS	7.8 (2.2)	6.6 (2.6)
OLS in care	7.4 (2.5)	8.1 (2.0)
Change in OLS**	0.4 (3.2)	-1.8 (2.6)
Care and safety***	1.7 (0.3)	1.4 (0.5)
Basic needs**	1.4 (0.3)	1.2 (0.5)
Leisure and freedom***	1.7 (0.3)	1.3 (0.5)

Note: T-test statistically significant at * *p*<.05, ** *p*<.01, *** *p*<.001.

About two thirds of the single orphans in the study were living with a biological parent (Table 4). Out of the 32 participants who had two living parents, 19% were not living with either of their parents.

Table 4. Cross-tabs of orphanhood and parental care status (*N*=126)

	Non-orphan	Single orphan	Double orphan
Both parents	12 (37.5%)	0 (0%)	0 (0%)
Single parent	14 (43.8%)	45 (68.2%)	0 (0%)
Neither parent	6 (18.8%)	21 (31.8%)	23 (100%)
Total	32 (100%)	66 (100%)	23 (100%)

One-way ANOVAs (not shown) found that the number of years a child lived in an RCI varied significantly by orphanhood (*F*(2)=7.45, p<.001) and parental care status (*F*(2)=4.09, *p*<.05). Specifically, single orphans spent significantly more time in residential care than non-orphans (*t*=3.86, p<.01) and children living with both parents spent significantly less than children living with neither parents (*t*=-2.85, *p*<.05). Orphanhood was also linked to change in OLS (*F*(2)=4.29, p<.05); non-orphans had significantly worse changes in OLS than single (*t*=2.69, *p*<.05) and double orphans (*t*=2.41, *p*<.05). Care and safety scores varied significantly by orphanhood as well (*F*(2)=6.00, p<.01), with non-orphans having significantly worse care and safety scores than single orphans (*t*=3.42, *p*<.01).

Multivariate Results

Multiple linear regression models for predicting current Overall Life Satisfaction (OLS), OLS in RCI, and change in OLS can be found in Table 5. When controlling for all covariates, double orphans had significantly better current OLS scores than non-orphans (*p*<.05). None of the predictors were significantly associated with OLS in RCI scores. For change in OLS scores, when controlling for all covariates, girls had worse change scores than boys (*p*<.05), single orphans (*p*<.05) and double orphans (*p*<.01) had better change scores than non-orphans, and children with disabilities had worse change scores than children without disabilities (*p*<.05).

Table 5. Regressions for overall life satisfaction (OLS) (b, Robust SE)

	Current OLS	OLS in RCI	Change in OLS
Female	-0.81 (0.48)	0.32 (0.48)	-1.27 (0.61)*
Age	0.08 (0.13)	0.00 (0.14)	0.07 (0.18)
Orphanhood (ref=non-orphan)			
Single orphan	1.18 (0.78)	-0.67 (0.72)	2.09 (0.81)*
Double orphan	1.74 (0.85)*	-0.44 (1.10)	2.64 (0.99)**
Parental care (ref=both parents)			
Single parent	-0.85 (1.05)	-0.35 (0.95)	-0.72 (1.12)
Neither parent	-0.79 (1.08)	-0.69 (1.19)	-0.60 (1.11)
Days since reunification	-0.002 (0.001)	-0.001 (0.002)	-0.001 (0.002)
Years in RCI	-0.02 (0.08)	-0.02 (0.08)	0.01 (0.11)
Has disability	-1.19 (0.74)	0.61 (0.70)	-2.18 (0.97)*
Household hunger	0.01 (0.17)	-0.21 (0.20)	0.27 (0.26)
N	103	105	103
R^2	.128	.051	.190
F	1.72	0.54	2.81**

Note: Statistically significant at * *p*<.05, ** *p*<.01, *** *p*<.001.

Table 6 displays multiple linear regression results for the child-informed subjective well-being subscales. Controlling for all covariates in the model, single orphans had higher care and safety scores than non-orphans (*p*<.05) and children with disabilities had lower care and safety scores than those without disabilities (*p*<.01). For the basic needs domain, more years in RCI was associated with lower basic needs well-being (*p*<.01), children with disabilities had worse basic needs scores than those without disabilities (*p*<.01), and Household Hunger Scores were linked to lower basic needs subscale scores (*p*<.001). Finally, in our regressions predicting leisure and freedom scores, years in RCI predicted worse outcomes (*p*<.01) and children with disabilities had lower scores than those without disabilities (*p*<.01).

Table 6. Regressions for child-informed subjective well-being measures (b, Robust SE)

	Care and safety	Basic needs	Leisure and freedom
Female	0.02 (0.08)	0.02 (0.06)	-0.06 (0.08)
Age	0.01 (0.02)	-0.01 (0.02)	-0.01 (0.02)
Orphanhood (ref=non-orphan)			
Single orphan	0.33 (0.15)*	0.16 (0.11)	0.26 (0.13)
Double orphan	0.30 (0.18)	0.21 (0.13)	0.30 (0.16)
Parental care (ref=both parents)			
Single parent	-0.08 (0.20)	-0.03 (0.12)	-0.21 (0.16)
Neither parent	-0.19 (0.21)	-0.06 (0.13)	-0.28 (0.17)
Days since reunification	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Years in RCI	-0.01 (0.01)	-0.02 (0.01)**	-0.03 (0.01)**
Has disability	-0.31 (0.11)**	-0.23 (0.08)**	-0.42 (0.12)**
Household hunger	-0.01 (0.03)	-0.11 (0.03)***	-0.03 (0.03)
N	105	105	105
R^2	.198	.265	.263
F	1.72	5.57***	4.06***

Note: Statistically significant at * *p*<.05, ** *p*<.01, *** *p*<.001.

Discussion

Very little is known about the well-being of Kenyan children with disabilities in residential care or after reunification. One of the first studies to examine this population, this study found that, in a sample of children who reunified with families after living in residential care in Kenya, children with disabilities—who constituted 14% of the sample—reported lower subjective well-being than children without disabilities. These diminished well-being outcomes were found in three domains uniquely important to children who have lived in residential care: basic needs, leisure and freedom, and care and safety. In addition, children with disabilities reported decreased satisfaction with their lives in families compared to their previous lives in residential care, while children without disabilities reported a small increase, a statistically significant difference between the two groups. These differences in outcomes existed in simple comparisons between groups as well as when controlling for a number of demographic characteristics, including length of time in residential care, time since reunification, and household hunger. Children with disabilities did not have significantly lower satisfaction with their life in the RCI than children without disabilities, nor did they have lower satisfaction with their current lives; rather, they had a significantly larger discrepancy between the two—a more negative change in life satisfaction since reunification. As our study was unable to ascertain when the sampled children had developed their disability, two possible explanations for these findings could be as follows. First, perhaps children who had disabilities both while in the RCI and after leaving the RCI had been receiving better support for their disabilities in the RCI than in their families. This is plausible because prior literature has found that children can enter residential care because they have a disability (Berens & Nelson, 2015; Rodríguez et al., 2018), or can develop disabilities as a result of living in residential care (Berens & Nelson, 2015; Dozier et al., 2012; van IJzendoorn et al., 2020). However, there is scant information on the quality of care children with disabilities receive in residential care or after reunification. A second possible explanation is that children who had relatively negative experiences of reunification, or who were happier with life in their RCI than family, developed disabilities, perhaps internalizing or externalizing symptoms, as a result of this negative reunification experience. Indeed, as many of the children in this study reunified unexpectedly and hastily due to COVID-19, it is possible that reunification itself was traumatic and caused behavioral or emotional disabilities. While there is scant information about whether family reunification can indeed be traumatic, it is well-established that trauma can cause disabilities (La Greca et al., 2008; Schüssler-Fiorenza Rose et al., 2014), and studies have raised concerns about the well-being of children and families around the globe who were rapidly reunified by government entities due to COVID-19 without adequate planning and preparation (Howard et al., 2022; Wilke et al., 2020).

Our analyses did not find significant differences in well-being outcomes for children based on child sex, age, time since reunification, or parental care status. However, we caution against concluding that children's well-being does not differ based on the type of family relationship they have with the caregiver with whom they reunify. Our study included children who had reunified with single parents, two parents, grandparents, aunts and uncles, and other kin, but it is likely that our sample size was too small to detect differences between all of these groups. Previous research on the sub-continent has found that within family-based care, child outcomes can differ by type of relation between the child and caregiver (Beegle et al., 2010; Nduwimana et al., 2017; Neville et al., 2022), and more research is necessary to determine how this plays out in the context of reunification from residential care.

In this sample, spending more time in residential care was associated with worse outcomes on having basic material needs and on having leisure and freedom when controlling for the other variables in our model. Duration of stay in RCIs has been linked with developmental delays in children globally (van IJzendoorn et al., 2020), but it is unclear why in our study, these outcomes were the ones affected, especially since length of time that children spent in residential care was not correlated with household hunger or life satisfaction measures. One possible explanation is that children who had lived in residential care for longer were more accustomed to having more material resources in residential care, and were less satisfied with their material resources after reunification as a result. This is reinforced by qualitative literature that has found that children in Kenya and other Sub-Saharan African countries often enjoy better material well-being in residential care (Johnson & Vindrola-Padros, 2014; Ucembe, 2013) and report sometimes struggling with poverty after family reunification (Frimpong-Manso, 2018; Mahuntse, 2015; Walakira et al., 2022). In terms of leisure and freedom, prior literature has found that children in Kenya often enjoy greater freedom after reunification and dislike the rigidity of residential care (Gayapersad et al., 2019; Ucembe, 2013). One reason that our study found that more time in residential care was associated with lower leisure and freedom scores could be that children whose stays in residential care were shorter had been less accustomed to the rigidity of residential care, and thus more satisfied with freedom after returning to family life. Additional research amongst reunified children is necessary to explain these findings more thoroughly.

Orphaned children also tended to have higher subjective well-being than their non-orphaned counterparts, both in bivariate analyses and when controlling for variables including household hunger and whether or not they lived with their parents. This finding is also counter-intuitive, and contradicts evidence that children in Sub-Saharan Africa who have lost one or both parents could be at risk of mental health problems (Atwine et al., 2005; Cluver & Gardner, 2007; Puffer et al., 2012; Thurman et al., 2015). However, many such studies focus specifically on orphaned children affected by HIV/AIDS, and additional research is necessary to determine how parental death may play a different role in outcomes for children reunified from residential care, especially in Kenya.

To our knowledge, this is the first quantitative study that has asked children who have reintegrated with family to reflect on their well-being when they lived in residential care in Kenya. It is notable how diverse children's answers were on these questions; about 20% reported they were equally satisfied with life in the RCI and their current life with family, and the rest of the respondents were about evenly split between those who were happier in the RCI and those who were happier with their current life. For comparison, in Ghana, 73% of a sample of reunified children reported that they preferred living with their families than in residential care (Frimpong-Manso et al., 2022), and in Zimbabwe, 83% of reunified children preferred family life to residential care (Mahuntse, 2015). Although their ratings of their satisfaction with life in the RCI was retrospective—in this cross-sectional study, we were not able to ask children to rate their life satisfaction before they reunified with their family—it is still important to listen to children's first-hand perspectives, even reflections on the past. Indeed, the children in this sample had reunified with their families a year and a half ago on average, so the memories of their time in residential care were recent and likely quite strong.

Limitations

There are several limitations of this study. Importantly, data were collected during a time of year when many children were at boarding schools, resulting in a diminished response rate. This factor could have introduced bias to the sample, as children who attend boarding schools could systematically differ from those who live at home and were available to be surveyed. As a cross-sectional study, this survey could not ascertain at what point children had developed a disability (i.e., before entering the RCI, as a result of living in the RCI, or upon reunification), so it was not possible to determine why there were differences in well-being between children with and without disabilities. Although survey enumerators were trained to speak to children out of earshot of other adults, and it was explained in the assent process that their responses would not affect the support they received from CTWWC, child respondents may not have answered survey questions honestly if they felt nervous, that it would reflect badly on their caregivers, or if they believed the enumerators were associated with the residential care institutions. Finally, although this study provides valuable insights into child characteristics that may be linked with well-being amongst reunified children, there was no comparison group or wider sampling strategy that would allow for the results of this study to be generalized to other children who have lived in residential care or to make comparisons between reunified children and other types of children.

Directions for Further Research

Despite many years of practitioners and advocates calling attention to the issues faced by children with disabilities in residential care (Rodríguez et al., 2018; Sherr et al., 2017; United Nations General Assembly, 2006), a dishearteningly small amount of research has analyzed how residential care and disability are intertwined in Sub-Saharan Africa to date. Rigorous, longitudinal research is necessary to elucidate the outcomes of residential care and family reunification on children with disabilities, and to describe the quality of services and barriers to service access that children with disabilities experience in various care settings. Such research could inform specific policy recommendations for how to serve children with disabilities in residential care and after family reunification, for example by providing access to quality healthcare, trauma-informed parenting education, provision of adaptive equipment, access to accommodating schools, or advocacy campaigns for increasing community acceptance of disabilities.

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Chapter V. Conclusion and Implications

Overview

In Kenya, an estimated 60,000 children live separated from their families in residential care institutions (Desmond et al., 2020). Generally, children in Kenya enter residential care not because they have no living family members, but due to poverty and poverty-related issues like violence and abandonment (Chege & Ucembe, 2020). Although it is unknown how many children in Kenyan residential care institutions have living family members, studies of other African countries have shown that 60% to 90% of children in residential care have a living parent, and many more may have extended family or community members who could be available to care for them.

As the family is "the fundamental group of society and the natural environment for the growth, well-being and protection of children" (United Nations General Assembly, 2010, p. 2), UN frameworks assert that family care should be prioritized for children over residential care institutions. The UN Guidelines for Alternative Care states:

> Financial and material poverty, or conditions directly and uniquely imputable to such poverty, should never be the only justification for the removal of a child from parental care, for receiving a child into alternative care, or for preventing his/her reintegration, but should be seen as a signal for the need to provide appropriate support to the family. (United Nations General Assembly, 2010 para. 15)

Recognizing this, the Changing the Way We Care (CTWWC) initiative by Catholic Relief Services aims to reunify children with their families and provide the support, financial or otherwise, that their family needs to successfully care for them, in order to fulfill their human right to grow up in a family. This dissertation was conducted within the context of this initiative. Guided by child participation and the voices of those who have lived in residential care, we explored three topics in the papers of this dissertation, detailed below.

First, we asked, how do young people in Kenya who have lived in residential care institutions describe and conceptualize their experiences of life in residential care and life after leaving residential care? This paper analyzed focus groups with children who had been reunified with family under CTWWC (*n*=39) and young adults who exited residential care outside of this initiative (*n*=29). Using a deductive approach, we relied on the voices of participants rather than existing theories, in order to capture participants' own conceptualizations of their experiences and limit influence from researchers' preconceived notions. There was a wide diversity of experiences, but generally speaking, many reported that their tangible, material needs were better met in residential care, but they gained a special sense of belonging support by being with their family. This reinforces prior research that found that young people in Kenya, Ghana, and Uganda reported having better access to material resources in residential care than afterwards in families (Embleton et al., 2014; James et al., 2017; Walakira et al., 2022). The young people in our study often found that life was too rigid and they had little agency in residential care, although this also came with physical safety, and though they enjoyed freedom outside of residential care, it also came with risks (for example, of falling into bad company). Likewise, previous research with young people in Kenya, Uganda, and across other low- and middle-income countries has also found children are dissatisfied with their lack of freedom in residential care (Gayapersad et al., 2019; Roche, 2019; Walakira et al., 2022).

Second, we aimed to create a quantitative measure of well-being specifically tailored to the aspects of well-being that are salient for young people who have lived in residential care. We analyzed the same focus group dataset, supplemented by data from Guatemala, in which young people were directly asked about the indicators of well-being for children in residential care and children who have left residential care, and created a survey measure including 43 items about subjective well-being that were drawn from the participants' words and ideas. This survey was administered to children reunified under CTWCW in Kenya and Guatemala. We then conducted an exploratory factor analysis on the N=180 survey responses to identify more specific domains of well-being that emerged from the overall measure, and found that three factors emerged. These included a factor measuring a construct we called *care and safety,* which captures the extent to which children feel they receive respect and care from their caregivers and are emotionally and physically safe*,* one assessing children's perspectives on their *basic needs*, such as nutrition, shelter, clothing, and education, and finally a construct we termed *leisure and freedom,* which captures children's freedom of movement, agency and decision-making over their own lives, and time to play and rest*.* This resonated with the findings of the first paper, in that the young people said that the things that were important to well-being in and out of residential care were whether or not they had love, care, tangible support, freedom, and the ability to play and rest. Research has found that children may enter residential care due to violence and neglect, that children can experience abuse in residential care, and that family disfunction sometimes persists after reunification(Dozier et al., 2012; Gray et al., 2015; Rus et al., 2017); thus, *care and safety* is an important area of well-being to assess in children who have experienced residential care. Second, it is well-documented that poverty is a significant driver of entrance to residential care (van IJzendoorn et al., 2020), so it follows that children's perceptions of their basic needs is important to assess. Third, research on young people who have lived in residential care Kenya, other areas of Sub-Saharan Africa, and other low- and middle-income counties, have found that young people often find they lack freedom, decision-making power, and flexibility in residential care (Gayapersad et al., 2019; Roche, 2019; Walakira et al., 2022), confirming the resonance of a sub-scale on leisure and freedom.

Third, we employed this newly developed measure of subjective well-being in a sample of children in Kenya who were reunified with family under CTWWC after living in residential care (*N*=126) in order to examine child and family characteristics associated with the previously identified components of well-being. We also examined which subscales were linked to children's overall life satisfaction in residential care and in their families. We found that children with disabilities reported lower subjective well-being in basic needs, leisure and freedom, and care and safety, than children without disabilities. They also reported decreased satisfaction with their lives in families compared to their previous lives in residential care, while children without disabilities reported a small increase. These differences in outcomes existed in simple comparisons between groups as well as when controlling for a number of demographic characteristics, including length of time in residential care, time since reunification, and household hunger. Our analyses did not find significant differences in well-being outcomes for children based on child sex, age, time since reunification, or parental care status. This contradicted previous studies that have found that children living with their biological parents often have better outcomes than those in kinship care or non-relative families (Beegle et al., 2010;

Nduwimana et al., 2017; Neville et al., 2022). Overall, about 20% of the sample reported they were equally satisfied with life in residential care and their current life with family, while the remaining respondents were about evenly split between those who were happier in residential care and those who were happier with their current life. These rates were also quite different from two similar studies we identified: in Ghana, 73% of a sample of reunified children reported that they preferred living with their families than in residential care (Frimpong-Manso et al., 2022), and in Zimbabwe, 83% of reunified children preferred family life to residential care (Mahuntse, 2015).

Implications

These findings have many implications for social work practice with children reunifying with family after living in residential care institutions in Kenya. About 40% of children in the sample reported that they were more satisfied with their current life with family than they had been in the residential care institution. The focus group data uncovered factors that could contribute to this preference, namely that some children placed a very high value on being able to spend time and live with their family members, on having freedom, and on being able to have a voice in decisions that affected their lives. However, another 40% of children had higher overall life satisfaction in residential care than in their current life in families. The most commonly voiced positive thing about residential care was that children had better access to food, shelter, clothes, school fees, and other material resources in residential care.

Despite these general trends, there was a great diversity of experiences in residential care and in families. A minority of children reported their basic needs were better met in their families. There were also children who said that they enjoyed "freedom" in residential care because they did not need to work as hard to meet their basic needs. These conflicting experiences underscore the importance of customizing the type of support provided to each child using individualized case management, rather than adopting a one-size-fits-all approach.

Finally, one clear difference in well-being outcomes in reintegrated children was related to disability status. Children with disabilities had diminished outcomes compared to children without disabilities.

Therefore, our recommendations for practice are as follows:

(1) Individualized case management is crucial for children reunifying with families after living in residential care.

(2) Children leaving residential care are at risk of not having their basic, material needs met after reunification with families. When carrying out reunification, special attention must be paid towards household economic strengthening, financial assistance for families, and ensuring children's school fees are paid.

(3) As children with disabilities are at risk of having diminished well-being after reunification, special attention must be paid to this population. They must receive adequate support to care for their disabilities after reunification, such as provision of adaptive equipment and educating their caregivers on supporting their disabilities (Changing the Way We Care, 2021; Rodríguez et al., 2018).

These findings also have important implications for policymaking at the national and international levels, which are as follows:

(1) National governments and international organizations must invest in systems that enable effective case management for children. This includes strengthening social work education in Kenyan universities and providing more funding for government actors (e.g., child protection offices) to hire qualified case managers to oversee family reunification and reintegration.

(2) National governments and international organizations must invest in providing a social safety net for ensuring families' short- and long-term economic stability. Many children enter residential care due to poverty-related reasons, so these reasons must be addressed in order for successful re-unification. These financial initiatives could include, for example, cash transfers and direct material assistance to families upon reunifying with their child, as well as microfinance, savings and loans groups, financial literacy, and business start-up assistance to foster sustainable, long-term financial stability (Chaffin & Ellis, 2015).

(3) Investments must be made in systems to support children with disabilities, including in access to quality healthcare, trauma-informed parenting education, access to accommodating schools, and advocacy campaigns for increasing community acceptance of disabilities.

Limitations and Future Research

This dissertation has both strengths and limitations. To our knowledge, this dissertation includes the first quantitative study that has asked children who have reintegrated with family to reflect on their well-being when they lived in residential care in Kenya, and the first qualitative study on children who have reunified with family from residential care as minors in Kenya. Moreover, we conducted our focus groups and household surveys in three different counties which represent varied regions of the country (i.e., different cultural, ethnic, and linguistic groups). In addition, we used an innovative, child-informed approach to design measures that were uniquely relevant to the experiences of young people who have lived in residential care. To our knowledge, no other study has collected a qualitative data in orde to develop a quantitative measure tailored for those who have been in residential care in low- and middle-income countries. This process resulted in a survey instrument that can be used to promote child participation in policymaking, a key tenant of the Convention of the Rights of the Child (United Nations General Assembly, 1989). Notably, the measure ultimately included questions to assess children's satisfaction with leisure, freedom, and agency in their lives, and though the Convention of the Rights of the Child explicitly asserts that children have a right to play and participation (United Nations General Assembly, 1989), we have not been able to identify any other quantitative tools that measure these aspects of children's lives.

In terms of the measurement of the well-being of children who are at risk of entering residential care, living in residential care, or have left residential care, this dissertation makes two key contributions. First, for situations where researchers investigating such children do not have the time or resources to create a contextually-dependent measure, our child-informed measure of subjective well-being can be used in its current form or with small adaptations, given that it was informed by commonalities between children in two distinct contexts (Kenya and Guatemala). Second, this dissertation also details a method that researchers can follow in order to create a measure of well-being of that is tailored to their cultural context or specific population.

However, these findings may not be entirely generalizable outside Kenya, and may have limited generalizability to the rest of Kenya, which contains 47 counties. In an ideal situation, we would have had a larger sample size for both our focus groups—so that we could sample by other strata, like disability status, reason for entering residential care, and type of family care—and for the household survey, so we would have greater power to detect relationships between variables in multivariate analyses. The psychometric analyses of the second paper were also limited by the small sample size, which precluded the ability to do a split sample analysis, wherein exploratory factor analysis is conducted on one half of the survey responses and a confirmatory factor analysis on the other. One of the reasons our sample size was limited is because 45% of our target population, i.e., children ages 11 to 18 who were enrolled in CTWWC's programming, were away at boarding school. This could have introduced bias to the sample, as children who attend boarding schools could systematically differ from those who live at home and were available to be surveyed.

Future research should be conducted to fill in the gaps that remain due to the limitations of this dissertation. First, there is an urgent need for longitudinal and comparative research on care reform in Kenya and Sub-Saharan Africa. Currently, most rigorous research that looks at reunified children (James et al., 2017; James & Roby, 2019) and compares vulnerable children in families with those in residential care (Omari et al., 2021; Whetten et al., 2014) do not look at children who are reunified while receiving the types of family support recommended by child rights frameworks and guidelines (Cantwell et al., 2012). Only research that includes comparison groups will provide the sort of rigorous evidence needed to suggest what specific services should be provided and which best practices should be utilized when children reunify with families. Longitudinal research is also especially important to examine outcomes for children with disabilities; disabilities can arise at different points throughout childhood, sometimes as a result of trauma or neglect, and by tracking children over time, causality can be more easily inferred. This is one of the few quantitative studies that has examined disabilities and children's care in Sub-Saharan Africa, and our finding that children with disabilities have diminished well-being outcomes requires further research to determine why this is the case, where else this is true, and how it can be mitigated.

Conclusion

It might be argued that children should remain in residential care if their material needs can be better met there (Braitstein, 2015). However, poverty alone cannot justify family separation (United Nations General Assembly, 2010, para. 15). While it is possible to invest in supportive social services that ensure that children enjoy all of their rights within families, it will never be possible for residential care institutions to adequately ensure children's right to "be cared for by his or her parents" (United Nations General Assembly, 1989 art. 7) or to "grow up in a family environment" (United Nations General Assembly, 1989, pmbl.). Allowing private residential care institutions to proliferate is an understandably attractive option in the face of entrenched poverty and weak social services that need incredible amounts of investment and reform. However, these sorts of transformative investments and systemic changes are worth fighting for, daunting as they may be, as all children deserve to enjoy their right to thrive in families.

Most importantly, all efforts, whether they be in practice, policy making, or research, must consider, if not center, the voices of young people who have lived in residential care.

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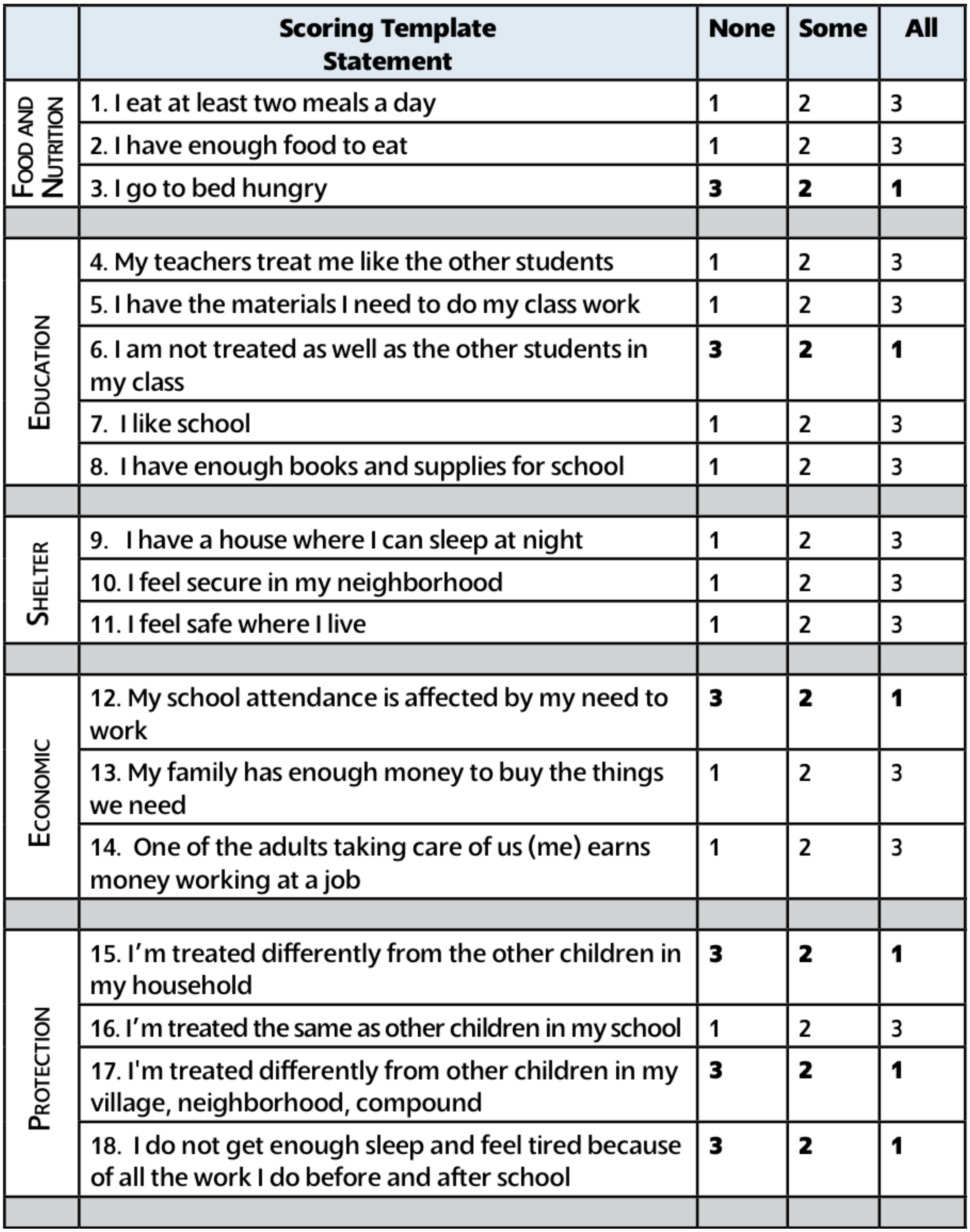
Appendix

CRS OVC Wellbeing Tool



	Scoring Template Statement	None	Some	All
Food and Nutrition	1. I eat at least two meals a day	1	2	3
	2. I have enough food to eat	1	2	3
	3. I go to bed hungry	**3**	**2**	**1**
Education	4. My teachers treat me like the other students	1	2	3
	5. I have the materials I need to do my class work	1	2	3
	6. I am not treated as well as the other students in my class	**3**	**2**	**1**
	7. I like school	1	2	3
	8. I have enough books and supplies for school	1	2	3
Shelter	9. I have a house where I can sleep at night	1	2	3
	10. I feel secure in my neighborhood	1	2	3
	11. I feel safe where I live	1	2	3
Economic	12. My school attendance is affected by my need to work	**3**	**2**	**1**
	13. My family has enough money to buy the things we need	1	2	3
	14. One of the adults taking care of us (me) earns money working at a job	1	2	3
Protection	15. I'm treated differently from the other children in my household	**3**	**2**	**1**
	16. I'm treated the same as other children in my school	1	2	3
	17. I'm treated differently from other children in my village, neighborhood, compound	**3**	**2**	**1**
	18. I do not get enough sleep and feel tired because of all the work I do before and after school	**3**	**2**	**1**

Mental Health	19. I have people I can talk to when I have a problem	1	2	3
	20. I am able to do things as well as most other people	1	2	3
	21. I am as happy as other kids my age	1	2	3
	22. I feel I live in a safe place	1	2	3
Family	23. At home, I have someone to look after me if I get hurt or feel sad	1	2	3
	24. I have adults that I can trust	1	2	3
	25. I get the emotional help and support I need from my family	1	2	3
	26. I feel I am supported by my extended family	1	2	3
HEALTH	27. I feel strong and healthy	1	2	3
	28. I worry about my health	**3**	**2**	**1**
	29. My health is good	1	2	3
	30. I am growing as well as other kids my age	1	2	3
Spirituality	31. My belief in God gives me strength to face difficulties	1	2	3
	32. My belief in God gives me comfort and reassurance	1	2	3
	33. My faith community is important to me	1	2	3
Community	34. People in my community try to help me	1	2	3
	35. I feel welcome to take part in religious services	1	2	3
	36. My household receives free support to care for the children who live here	1	2	3

Changing the Way We Care
Year 3 Review
Focus Group Discussion (FGD) Guide

Materials to bring:

- Audio recorder
- Extra batteries
- Phone, tablet, or other device with camera
- Consent forms
- Drawing paper for participants
- Large flip chart paper and tape
- Sticky notes or cards and tape
- Writing and drawing materials (markers, pencils, crayons)
- Clipboards or notebooks for facilitators
- Name tags
- Masks
- Hand sanitizer
- Materials for providing transportation stipend

Setting up:

- Ensure that the audio recorder is functioning and has sufficient battery.
- Arrange the chairs so everyone is 2 meters apart (following COVID-19 safety guidelines).
- Please do not allow anyone to eat indoors, for the sake of COVID-19 safety. Participants may take their refreshments home as take-away.
- Fill out the FGD Cover Sheet with information about the date, time, location, etc.
- Ensure consent forms have been pre-filled with participants' real names.
- If any participants are late, in order to respect others' time, do not wait longer than 15 minutes after the designated start time to begin the FGD.

FGD script

Facilitator 1: Welcome everyone! We are so happy that you are able to come here today. We're going to start by making sure you understand the risks and benefits of participating in this study. I'm going to read this consent form to you now.

[Please read the consent or assent form appropriate for this participants' age group.]

Do you have any questions? *[answer any questions they may have]*

Do you agree to participate? *[if they say yes, **Facilitator 2** will check the box on their consent form.]*

*[**Facilitator 2** starts the recorder.]*

Facilitator 1: For this talk, we are asking each of you to come up with a special name. It can be any name that you want. Like [insert cultural names or known celebrities]. Take a minute to come up with your name and write it on your name card.

[Move on once everyone has written a name on their nametag.]

Facilitator 1: To start off, we are all going to go around and introduce our new names.

*[**Facilitator 2** takes note of where everyone is sitting on the FGD cover sheet.]*

[Do an ice breaker activity that you believe is suitable for the group. For example, each participant can do a dance while they say their pseudonym, then the next person copies the dance and adds a new part to the dance while saying their own name, and it goes on and the dance gets longer until it reaches the last participant.]

Facilitator 1: Great job everyone! Let's get started. So today we would like your assistance with a research project about the well-being of people who have lived in CCIs. As someone who has lived in a CCI, your perspective is very important to us.

Eventually, in this research project, we want to understand *how well children do* when they leave a CCI and start living with a family. The ultimate goal is to understand how happy or unhappy they are with all the different areas of their lives. So right now, we need your help in identifying what, specifically, are the important areas of their lives to ask about, because we're going to use the information from this discussion to help us make a survey for young people who have reunified with their families. The survey will measure what parts of children's lives are going well, and what parts are not, which will help us decide what sort of help and support we should provide to these children.

A lot of research in the past has failed to measure the things in life that are really important to young people who have lived in CCIs. Research sometimes focuses on measuring one or two aspects of these young persons' lives, but not others. For example, sometimes research looks at young people's physical health and nutrition but not any other areas of their life. We don't want to make the same mistakes in this study. It's important that we ask about *every area of life that matters to people leaving care.*

Do you have any questions?

Facilitator 1: Today, we will be asking you to share your thoughts and experiences about your life and childhood. Our talk will have four parts: First, we will start with a drawing activity, second, we will share our drawings with each other, third, we will imagine a situation together, and fourth, we will make a list together.

First let's set some rules we will follow during our time together.

1. Keep the information and stories that we share private. What is said this this room stays in this room.
2. We should all respect each other. Don't laugh at or mock what other people say. Don't doubt other people's experiences or question their actions. We are here to listen to each other.
3. Speak loud enough for everyone to hear you and for the voice recorder to capture your voice. Please say your chosen name each time you speak, so we know whose voice belongs to who when we listen to the recording.
4. Please keep your mask on and remain 2 meters apart.

[Add other rules that are appropriate for the group. For example, what participants should do if they would like to speak, or if they would like to take a break, or use the restroom. If you'd like, you can involve participants in setting the rules.]

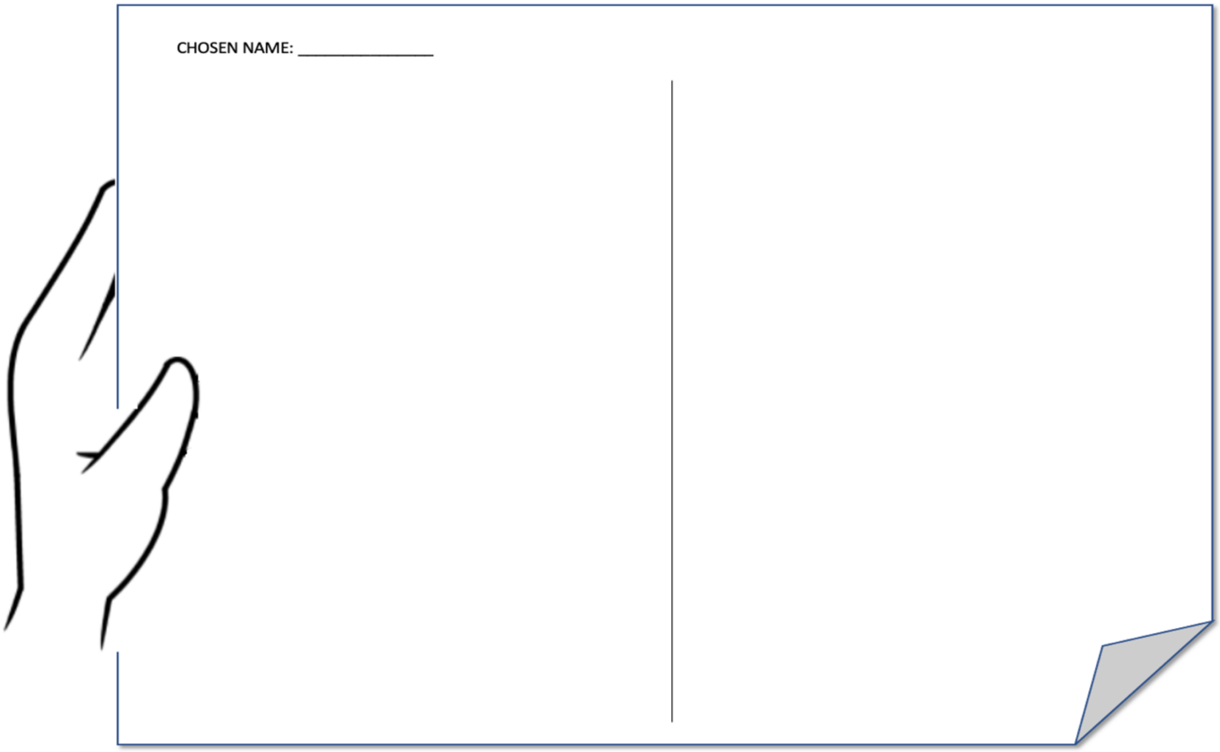
1. DRAWING LIFE EXPERIENCES
(10 minutes)

Facilitator 1: I'd like to start by having a discussion about life in the CCI and life after leaving the CCI.

If you'd like, you can make a drawing to help you tell your story. If you'd prefer not to draw, you can write a story or create a list.

*[**Facilitator 2** hands out papers, pencils and crayons to each participant.]*

Facilitator 1: Please write the name you chose here *[point to space for chosen name]* of your paper so we know it belongs to you.



On the left side, draw a picture of what life was like in the CCI, or write about life in the CCI. On the right side, draw a picture or write about what life was like after leaving the CCI.

The drawing does not need to be a beautiful picture – this is not an art class – it just needs to help you tell your story.

[Allow participants to draw for 10 minutes.]

*[Please also use this time for **Facilitator 2** to fill out the **FGD Cover Sheet** by quietly asking each participant the information for this sheet.]*

SUGGESTED PROBES	*[If participants get "stuck," and can't think of what to draw/write, you can encourage them with phrases like:]* ● What are some of the similarities between life before and after leaving the CCI? ● What are some of the differences between life before and after leaving the CCI? ● What has been good about your life? ● What has not been so good about your life? ● Who was important to your story?

[If everyone is finished, you can move on, even if 10 minutes have not yet passed.]

[When there are 2 minutes left, **Facilitator 1** *should say:]* Please begin to finish up your work. We will just take 2 more minutes.

Reminder:

Refer to the *__Safeguarding Protocols__* document
if any safeguarding concerns arise.

Safeguarding concerns include children becoming upset,
or children disclosing past/current risk of harm/maltreatment to self or others.

2. SHARING LIFE EXPERIENCES
(2-3 minutes per participant)

Facilitator 1: Now let's present our drawings or lists to each other. If you do not want to share, though, that's fine too. Hold up your drawing like this *[hold it up]* so we can all see it, and tell us about your work. You'll have 3 minutes to tell your story, and we'll give you a warning when you have 1 minute left.

*[**Facilitator 2** will keep time.]*

SUGGESTED PROBES	*[If participants do not give lots of details, please encourage them by asking questions like:]* ● Can you tell me more about this *[point to part of a drawing]*? ● Could you explain this further? ● What is it about…that makes you say that? ● Could you share an example of what you mean? ● Could you tell me a little bit more about…? ● Please describe what you mean.

Facilitator 1: Thank you all for sharing your stories. Let's have a round of applause!

[Take a short break, or ask participants if they'd like to take a break, depending on what you believe is appropriate.]

3. DISCUSSION: WHAT DOES WELL-BEING LOOK LIKE

Facilitator 1: Now that we've heard about each other's experiences, let's use them to imagine a situation. Use your imagination to make up a child who lives in a CCI and is really, really happy - as happy as they could possibly be. What is their life like?

SUGGESTED PROBES

[If participants are confused about the question, you can say:]

- What might you see if a child lives in a CCI who is having the best possible experience? The best life you can imagine? Who is doing extremely well?
- What makes them happy? What do they need to be happier?
- Try to be as specific as you can.
- It's okay if you say something that only applies to one type of child and not others. (E.g., only relevant for girls but not boys.)
- We want to think about children around ages 11 to 17.

[If participants aren't saying much - or are stuck on just a few topics - you can say:]

- What about in terms of…
    - Safety
    - Health
    - Food
    - Housing
    - Relationships (family, friends, community)
    - Emotions and feelings (mental health)
    - Education
    - Livelihoods (money, jobs)
- Are there important things in particular to know about for…
    - girls? boys?
    - children with disabilities?
    - children in different ethnic groups or tribes?
- Could you explain this further?
- What is it about…that makes you say that?
- Could you share an example of what you mean?
- Could you tell me a little bit more about…?

Facilitator 1: Now use your imagination to make up a child who left a CCI and joined a family, who is really, really happy – as happy as they could possibly be. What is their life like?

SUGGESTED PROBES

[If participants are confused about the question, you can say:]

- What might you see in a child who left a CCI and joined a family, who is having the best possible experience? The best life you can imagine? Who is doing extremely well?
- What makes them happy? What do they need to be happier?
- Just think about the first 5 years after this child left the CCI. (Not when they are elderly!)
- Try to be as specific as you can.
- It's okay if you say something that only applies to one type of child and not others. (E.g., only relevant for girls but not boys.)
- We want to think about children around ages 11 to 17.

[If participants aren't saying much - or are stuck on just a few topics - you can say:]

- What about in terms of…
    - Safety
    - Health
    - Food
    - Housing
    - Relationships (family, friends, community)
    - Emotions and feelings (mental health)
    - Education
    - Livelihoods (money, jobs)
- Are there important things in particular to know about for…
    - girls? boys?
    - children with disabilities?
    - children in different ethnic groups or tribes?
- What about when a child leaves a CCI to live with…
    - their biological parents?
    - grandparents or other elder relatives?
    - aunts, uncles, siblings, or other kin?
    - a foster family? (A foster family is a family they aren't related to, who maybe they are meeting for the first time.)
- Could you explain this further?
- What is it about…that makes you say that?
- Could you share an example of what you mean?
- Could you tell me a little bit more about…?

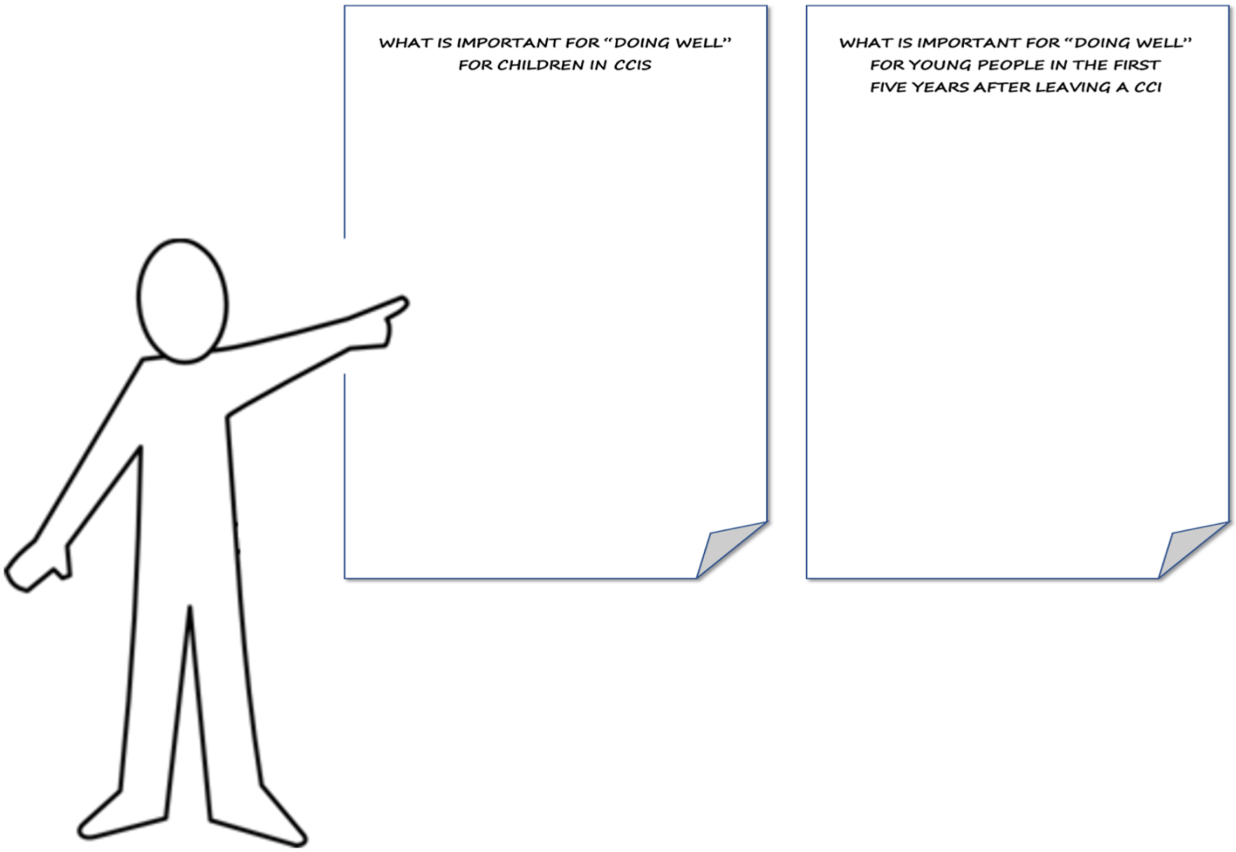
[Take a short break, or ask participants if they'd like to take a break, depending on what you believe is appropriate.]

4. FREE-LISTING: DOMAINS OF WELL-BEING

*[**Facilitator 2** passes out note cards or sticky notes]*

Facilitator 1: Now, remember that the purpose of today's group is to decide what parts of care-experienced children's lives are important to ask about and measure in a survey.

On these two large papers on the wall, I've written, "What is important for 'doing well' for children in CCIs," and here I've written "What is important for 'doing well' for young people in the first five years after leaving CCIs.



I would like us to make a complete list of all of the things that are important to look at in order to determine if a child is "doing well". In order to be able to say, "This child is doing well," what are all the different things that the child should have or be?

Please write one thing per card and stick it on the paper here. You can use as many cards and write as many things as you want.

SUGGESTED PROBES

[If participants are <u>confused about the activity</u>, you can say:]

- What is a sign of "doing well", or "having a good life," or "being happy"?
- What are the things that a researcher should be checking, or asking, to determine whether or not a child is "doing well"?
- We want to think about children ages 11 to 17.
- It's okay if some items only apply to certain groups of children and not others (e.g., girls, children with disabilities, very young children).

[If participants <u>aren't saying much</u> - or are stuck on just a few topics - you can say:]

- What does a child who is doing well *have?*
- How does a child who is doing well *feel?*
- How does a child who is doing well *act?*
- What does a child who is doing well *do?*
- What does their life look like? What does their family look like? What does their environment look like?
- What about in terms of…
    - Safety
    - Health
    - Food
    - Housing
    - Relationships (family, friends, community)
    - Emotions and feelings (mental health)
    - Education
    - Livelihoods (money, jobs)

[Please help any participants who do not have strong literacy skills or feel uncomfortable writing.]

[When everyone is finished, praise participants' work and comment on how the list they created will be very useful.]

5. WRAP-UP WITH PARTICIPANTS

Facilitator 1: Thank you all so much for participating in this activity. This activity was a really important part of our research, and you've made an important contribution to the work. We could not be successful without you.

Please remember what we agreed to at the beginning - that we will not share people's stories with others. We want to keep each other's experiences private.

We're going to use the results from these activities to make a new survey to help us see how well care leavers in Kenya are doing. Do you have any questions about the research?

Is there anything else you want to mention? that you didn't get a chance to talk about but you think we should know?

What did you think about the activity today? *[If they don't say much, you can ask:* Did you enjoy it? Did you learn anything new?]

The next step in our research is to gather the results from all our focus groups in the different counties and analyze them all together. After we do this, would it be okay if we contact you to ask you if our understanding of everyone's experiences sounds correct?

After that, we'll create a survey tool. We will need to test out the survey before we use it. Would it be okay if we contact you later to see if you want to help us test the survey?

[Dismiss the participants, thanking them again for their participation.]

FACILITATOR WRAP-UP INSTRUCTIONS

- *Take clear, readable photos of all drawings and written materials.*
- *Make sure the pseudonyms are readable on the drawings/written lists.*
- *Take photos of each written item (sticky note/card) individually, so it will be readable.*
- *Make sure it is clear whether the sticky notes/cards belong to the "children in CCIs" category or the "5 years after leaving a CCI" category.*
- *Write down any important observations, explanations, and take-aways in your notes so that you can remember them later.*
- *Gather all consent forms and store them in the folder for* **Consent Forms**.
- *Gather the FGD cover sheet, all drawings, written materials, and written notes and store them in the folder for* **FGD Data.**
- *Reminder:* ***It is very important that the <u>Consent Form</u> folder and the <u>FGD Data</u> folder are kept separate.*** *In order to preserve anonymity of the data, they should be kept separate while traveling, and also securely stored separately at the office in locked cabinets.*