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Reintegration of street-connected children in Kenya: Evaluation of Agape Children's Ministry's Family Strengthening Programme

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Abstract

In Kenya, the number of street-involved children continues to grow each decade, with most recent estimates as high as 250 000 to 300 000. Despite efforts by local government, nongovernmental organizations, and community-based organizations to address this problem, most children who receive services end up returning to the streets. Since 2021, Agape Children's Ministry has provided time-limited, crisis-oriented services to families recently reintegrated through its Family Strengthening Programme (FSP). We conducted an exploratory programme evaluation of Agape's FSP to ascertain whether it is achieving the intended outcomes. Thirty families ($n = 30$ children; $n = 38$ caregivers) were enrolled in the FSP during the study window and participated in the evaluation. Family functioning and child well-being increased to a statistically significant and large extent from before to after the intervention. All but two children remained reintegrated at the end of the study period. Results highlight the importance of using a holistic family-based programme that reunites children with their healthiest possible family environment with a plan specifically tailored to their individual needs and unique family situations. Results also bring to the fore the need for broad governmental attention to basic needs of families as an important part of improving family functioning.

KEYWORDS

family stability, family strengthening programme, family togetherness, Kenya, programme evaluation, street-connected children

1 | INTRODUCTION

Of the millions of children who are homeless worldwide (Goodman et al., 2016; Woan et al., 2013), two subgroups of street-connected children emerge: "on the street," comprising approximately 60%, and "of the street" approximately 40% (Alem & Laha, 2016; UNICEF, 2005). "On the street" refers to children who spend their days on the street but sleep at home with family; they may be sent to the

street by parents or go on their own to supplement income (Embleton et al., 2012). "Of the street" consists of children who see the street as their home, maintaining few or no ties with family (Goldblatt et al., 2015; Kaime-Atterhög & Ahlberg, 2008; Sorber et al., 2014).

In Kenya, the numbers of street-connected children continue to grow decade after decade (Kaime-Atterhög & Ahlberg, 2008; Suda, 1997), with estimates of 135 000 in 2001 (Ayaya & Esamai, 2001) to more recent numbers as high as 250 000 (Goodman

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et al., 2016, 2017) to 300 000 (Sorber et al., 2014). Despite various efforts by the Kenyan Government, nongovernmental organizations, and community-based organizations to remove children from the street and provide rehabilitation and vocational training, the majority of those who receive these types of services returns to the streets (Kaime-Atterhög & Ahlberg, 2008).

Services provided to street-connected children and youth are needed to reduce risk, prevent further marginalization from mainstream society, and promote their best chances in life (Coren et al., 2013; Fluke et al., 2012). Street-involved children are a highly vulnerable group, susceptible to numerous adverse circumstances including physical and sexual abuse, drug and alcohol use, early sexual activity, illiteracy, and lack of social supports (Wachira et al., 2015). It is globally recognized that children best develop in families, and there is a preference for family-based care over residential care or residing on the streets (Coren et al., 2013; United Nations General Assembly, 2019; van IJzendoorn et al., 2020).

One such organization in western Kenya that works to reunite children from the streets with their families is Agape Children's Ministry. Agape's approach entails conducting outreach to street-connected children who have run away from dangerous family situations in Kisumu, Kitale, and Nakuru and providing comprehensive services that equip them mentally, emotionally, and spiritually for long-term success at home with their families (Agape Children's Ministry, 2023). After reuniting street-connected children with family, Agape's Family Strengthening Programme (FSP) provides time-limited crisis-intervention services to reintegrated families to prevent the recurrence of family breakdown.

As the number of children living and working on Kenya's streets grows, the evaluation and promotion of successful interventions that sustain the long-term stability of former street children with families is paramount to making progress with this desperately vulnerable demographic in Kenya, throughout Africa, and worldwide. Interventions like Agape Children's Ministry's FSP hold great potential to positively impact child and family functioning, and evaluation of such programmes can inform replication of similar support models at local,

regional, national, and international levels. Here, we report findings from an initial programme evaluation of Agape's FSP to examine family togetherness and child well-being before and after participation. These findings highlight the essential elements of this service approach and offer insight on programme development for agencies working with recently reintegrated families worldwide.

1.1 | Family strengthening programme

The model used by Agape Children's Ministry (2023) is an innovative, love-based holistic programme that reunites a child with their healthiest possible family environment with a plan specifically tailored to their individual needs and their unique family situations. The model serves the best interest of each child through the following three steps, as shown in Figure 1:

Rescue: Outreach teams contact and develop relationships with vulnerable, at-risk children on the street and in government custody to refer children for further services as desired.

Rehabilitate: Agape provides children with a safe place to live and flourish while receiving individual and group counselling, spiritual care, remedial academic instruction, and preparation for reunification with family.

Reintegrate: Agape works to return children to a safe and loving family member and then helps equip each family to care for and love their children.

The foundation for all that Agape does and supporting each of the steps in the service delivery model is the noncoercive presentation of the redeeming message and love of Jesus Christ through discussion and reading with the goal of seeing lives transformed through God's truth. In the regions where Agape operates, 94.96% of Kenyans identify with the Christian religion (KNBS, 2019), and an individual's religious preference does not exclude a child or family from receiving Agape's services.

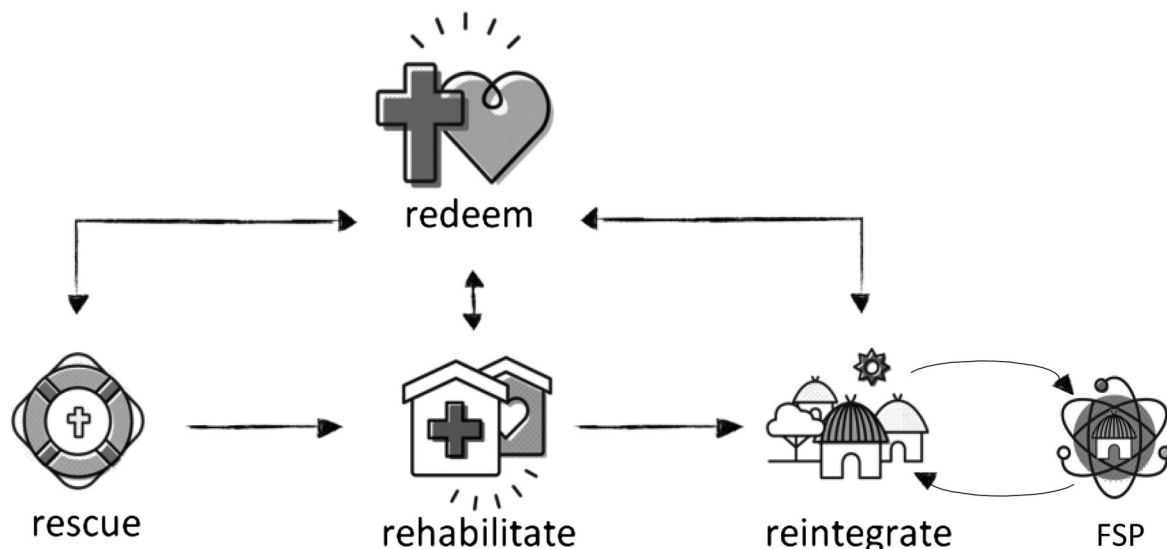


FIGURE 1 Agape Children's Ministry's service model. FSP, Family Strengthening Programme.

Since 2010, Agape has reunited 5494 children with their families with a long-term success rate of 78.12%. Overall, 4292 of 5494 of reintegrated children served by Agape are currently at home with family or remained at home with family until age 18. The first 2 years after reintegration are critical, as most cases of recidivism occur within the first 2 years post-reintegration. In an analysis of children rescued and later reintegrated by Agape from 2012 to 2019, only 3.16% of children ran away from home again after being reintegrated for 2 years (Agape Children's Ministry, 2023).

The FSP is a time-limited crisis-intervention programme designed to prevent family breakdown in the first 2 years after reunification. The programme was developed in 2021, and nine family strengthening officers (FSOs) were hired to assist Agape's 22 social workers in the field with a focus upon particularly challenging families that were voluntarily engaged with ongoing case management services with Agape. Families are referred to the FSP by the ongoing social worker; FSOs work as mediators within families to reconcile problems for up to 4 months before the case is returned to the social worker. Although formal education in human service fields is not as prevalent in developing nations, the FSOs typically possess certificates in religion or counselling beyond that of the social work team. The FSOs use a generalist relational-based approach to engage families in constructive problem-solving and planning for stability.

2 | LITERATURE ON STREET-CONNECTED CHILDREN

2.1 | Contexts surrounding migration of children to the streets

There are numerous risk factors that affect the families of street-connected children, like those served by Agape and other service providers, including poverty and inability to meet basic needs, child abuse and neglect, domestic violence and family conflict, single parenthood, the AIDS pandemic and/or orphanhood, rejection by caretakers, and delinquency (Embleton et al., 2013, 2016; Goldblatt et al., 2015; Goodman et al., 2017; Suda, 1997). In addition to household circumstances and relationships that may push children to the street, some children are pulled to the street by peer pressure or a desire for money, independence, work, or property (Seidel et al., 2018). An emerging body of research points to adverse mental, physical, and behavioural health outcomes for street-connected children, generating an international interest in developing policy and practice for working with these children (Corcoran & Wakia, 2016; Coren et al., 2013; Goodman et al., 2020).

2.2 | Responding to the crisis of street-connected children

The international and interagency Guidelines on Children's Reintegration provide a framework to support reintegration or maintenance of children with their families rather than institutionalized or separated

(Delap & Wedge, 2016); however, research on best practices is lacking (Corcoran & Wakia, 2016; Dybicz, 2005). To address this, Goodman et al. (2020) conducted a scoping review to explore family-level factors related to successful reintegration of children based on the typical timeline of risk factors/street migration, rescue/departure from the streets alongside service providers, rehabilitation, reintegration, and follow-up, the same cycle addressed by each intervention in Agape's overall service model. Researchers found that although four domains emerged as key to ensuring family stability (economic capital, social capital, cultural capital, and health capital), more evaluation of programme effectiveness is needed. Interventions like the FSP that attend to these domains, for example, by discussing family business and income, ensuring that family members and children are connected to faith communities and schools, supporting connections to tribal communities, and making health and well-being recommendations and referrals, can provide additional insight into successful programming in the critical areas identified by Goodman et al. (2020). Coren et al.'s (2013) systematic review included interventions aimed at any type of street-connected child, especially as reintegration may take years and children may live and work on the street while also engaging with services. Although case management and individual and family therapy have emerged as effective interventions for street children in higher income countries, further research is needed to determine applicability in lower income countries (Coren et al., 2013). Understanding Agape's use of case management for all reintegrated children and more intensive family therapy for the high-risk families referred to the FSP can provide important insight into successful practices that could be replicated.

2.3 | Family reunification/reintegration programmes for street-connected children

Interventions may be viewed as primary (addressing risk factors before street migration), secondary (intervention provided to children recently transitioning to street life who may still have family contacts), or tertiary (programming for children who live exclusively on the streets) (Dybicz, 2005). Most child-serving organizations in low-income countries like Kenya provide rescue, rehabilitation, and reintegration as a secondary or tertiary intervention (e.g., Undugu Society of Kenya, 2022).

Institutional homes like Agape's rehabilitation campuses are often used to house street children after rescue; while they typically have more resources than families in low- and middle-income countries, the capacity for housing children does not meet the need of children needing to be housed (Goodman et al., 2020). When family reintegration can be achieved safely, it is a highly valuable outcome, although it may not be appropriate in all cases (Coren et al., 2013). Although most children who accept services through Agape return to their parents or extended family/kin, long-term care or informal guardianship with community members are considered as options when reintegration is not possible.

Following reintegration of children with their families, long-term stability may depend on various factors, including locating and preparing family members and ensuring adequate financial and educational resources (Frimpong-Manso & Bugyei, 2019; Muguwe et al., 2011; Wilke et al., 2020). Frimpong-Manso et al. (2022) analysed 408 cases of children returned to families from institutional care in Ghana and found that cases with older children, ongoing case management, and referrals to community services had better rates of the children remaining at home. Successful reunification that results in long-term stability requires meeting both the physiological and psychological needs of children, described as four diverse categories of need: basic needs, security needs, relational needs, and educational needs (Wilke et al., 2023).

Positive family functioning improves psychosocial outcomes for families and individuals and can serve as a protective factor for vulnerable groups (Knerr et al., 2013). Strengthening relationships between children and their caregivers and service providers increases the chances of full rehabilitation and improved family functioning (Puffer et al., 2021a; Schimmel, 2008). Effective family reintegration programmes should regularly assess client progress, utilize comprehensive case management and monitoring systems, and analyse outcomes for revising, improving, and sharing methods (Corcoran & Wakia, 2016).

Towards this end and to ascertain an initial understanding of whether Agape is achieving the intended outcome of the FSP, which is to keep reintegrated families together, the following research questions and hypotheses were addressed:

Research Question 1. Is participating in the FSP associated with increased scores on the Family Togetherness Scale (FTS; Puffer et al., 2021b)?

Hypothesis 1. Participating in the FSP is associated with increased scores on the FTS.

Research Question 2. Is participating in the FSP associated with increased scores on the Child Status Index (CSI; O'Donnell et al., 2013)?

Hypothesis 2. Participating in the FSP is associated with increased scores on the CSI.

3 | METHOD

To test our hypotheses about the FSP, we employed a one group pretest/posttest design, which is considered a good choice when examining real-world settings, such as assessing an in-home, crisis, family-based programme, with each participant serving as their own baseline. The “pretest/posttest” included the FTS and CSI. The FTS and CSI were administered by the FSP clinicians during the first and last intervention visits with the families. The CSI is a measure that Agape already uses.

3.1 | Sampling approach

Participants comprised a nonprobability, purposive sample of 30 families enrolled in the FSP between 1 September and 31 October 2022. All families who were enrolled in the FSP during this time frame were offered the opportunity to participate in the evaluation study. All families had the ability to decline participation in the evaluation and still receive services from Agape. Families who did not complete the FSP prior to 28 February 2023 were excluded from the pre-/post-analysis sample.

3.2 | Measures

3.2.1 | Family strengthening programme

This is an in-home intervention that is delivered by FSOs following reintegration of a family and in response to a crisis. It consists of family and marriage counselling, as well as parent training. The overall goal is to keep families from breaking down following their reintegration.

3.2.2 | Child demographics

Table 1 summarizes the demographic characteristics of the child sample.

Sex

Biological sex is measured dichotomously as female or male.

Tribe

This measure represents study participants' self-identified tribal group membership and consists of three mutually exclusive categories: Kalenjin; Luhya; and Luo.

Location

Location conveys the geographic location of service to study participants (i.e., where participants received Agape services) at the time of their rescue from the street and concomitant start of participation in Agape services. This measure consists of three mutually exclusive categories: Kisumu, Kitale, and Nakuru, each corresponding to a municipal jurisdiction in Kenya.

Rescue source

Rescue source, a categorical measure with three mutually exclusive categories, signals the type of organization (i.e., government; partner; and street) from which Agape received a referral for services for a given child in the study sample. *Government* represents local or national governmental organizations in Kenya. *Partner* represents other (i.e., nongovernmental) organizational entities, such as faith-based advocacy and service organizations, community-based organizations, and nonprofits. *Street* signals that the child was referred for

TABLE 1 Descriptive statistics for child participants ($n = 30$).

Measure	<i>n</i>	%
Sex		
Female	10	33.3
Male	20	66.7
Tribe		
Luo	22	73.3
Luhya	7	23.3
Kalenjin	1	3.3
Location		
Kisumu	21	70.0
Kitale	6	20.0
Nakuru	3	10.0
Rescue source		
Streets	17	56.7
Government	8	26.7
Partner	5	16.7
Age at initial rescue ($M = 12.9$ years, $SD = 2.2$, $Mdn = 13$)		
8 years	1	3.3
9 years	1	3.3
10 years	2	6.7
11 years	4	13.3
12 years	4	13.3
13 years	7	23.3
14 years	4	13.3
15 years	4	13.3
16 years	1	3.3
17 years	2	6.7
Length of service receipt ($M = 55$ days, $SD = 37$, $Mdn = 57$)		
0 to 20 days	8	26.7
21 to 40 days	2	6.7
41 to 60 days	5	16.7
61 to 80 days	7	23.3
81 days or more	8	26.7
County of reintegration		
Bungoma	1	3.3
Home Bay	3	10.0
Kakamega	2	6.7
Kisumu	11	36.7
Nakuru	3	10.0
Nandi	1	3.3
Siaya	4	13.3
Trans-Nzoia	5	16.7
Family reunification status		
Child remains living with family	28	93.3
Child not living with family	2	6.7

Note: Table displays data for children only, excluding $n = 38$ family members who also participated in the study. *Length of service receipt*, a discrete numeric measure representing the number of days of Agape rehabilitation services received by the child, was recoded as an ordinal measure for table display. *Family reunification status* is a dichotomous measure signalling whether or not the child remained at home (i.e., was living at home with their family) following the intervention, as of the end of the study period. Percentages are rounded to the nearest tenth.

services following street-based outreach by Agape workers or was referred for services by others (e.g., friends, family, or workers at other nongovernmental organizations) who were at some point in contact with the child in a street-based setting.

Age at initial rescue

This discrete numeric measure marks the age (in years) when a child began receiving services from Agape. Values for this variable range from 8 to 17 years of age and are recorded for children only (i.e., measure excludes participating family members).

Length of service receipt

This discrete numeric measure conveys the duration (in days) of a child's participation in, and receipt of services associated with, Agape's residential rehabilitation programme, which all children participate in once rescued by Agape. Values range from 1 to 123 days and are recorded for children only.

County of reintegration

This categorical variable represents the geographic location of a child's family home, where the child resided following their rescue from the street and during their participation in the FSP intervention. Mutually exclusive categories include Bungoma, Homa Bay, Kisumu, Nakuru, Nandi, Siaya, and Trans-Nzoia, each corresponding to a county jurisdiction in Kenya. Values are recorded for the family, as this indicator represents the location of the home where the child was reintegrated.

Family reunification status

This dichotomous measure (yes/no) signals whether a child remained at home (i.e., was living at home with their family) following the FSP intervention, as of the end of the study period. Values are recorded for children only.

3.2.3 | Caregiver demographics

Table 2 summarizes the demographic characteristics of the subsample of caregivers who participated in the study.

Sex

Biological sex was measured dichotomously as female or male.

Location

This categorical variable represents the geographic location of the Agape office responsible for conducting the home visits for the child and family. Mutually exclusive categories include Kisumu, Kitale, and Nakuru.

Relationship to child

This measure conveys the caregiver's familial relationship (i.e., aunt; brother; father; grandfather; grandmother; or mother) with a child in the study sample.

TABLE 2 Descriptive statistics for family members ($n = 38$).

Measure	n	%
Sex		
Female	28	73.7
Male	10	26.3
Location		
Kisumu	27	71.1
Kitale	8	21.1
Nakuru	3	7.9
Family relation		
Mother	22	57.9
Father	8	21.1
Aunt	4	10.5
Grandmother	2	5.3
Grandfather	1	2.6
Brother	1	2.6

Note: Table displays data for family members only, excluding $n = 30$ children who also participated in the study. *Family relation* conveys the relational identity of project participants within their respective family groups. Percentages are rounded to the nearest tenth.

3.2.4 | Family functioning

Family functioning was measured using a modified version of the FTS, a 30-item tool validated in Kenya (Puffer et al., 2021b). Puffer et al.'s initial validation study with 30 families from peri-urban communities outside of Eldoret, Kenya, correctly identified distressed families in 89% of cases according to adult report and 76% of cases according to child report. The optimal cut-offs were associated with estimates of sensitivity/specificity of 0.88/0.90 and 0.75/0.77 for adult-report and child-report measures, respectively.

Prior to the start of the study period, Agape staff reviewed Puffer et al.'s FTS and determined that modifications were necessary because the original version of the scale contained some items that were deemed not culturally understandable by rural Kenyan families. We collaborated with Agape staff to adapt the FTS for use in the present study, using an iterative design process to modify scale items in close consultation with Agape staff and leadership. As with the original FTS, in our study, the adapted items are rated using 10- and 3-point Likert-type response scales (see Appendices A and B). We created a total score for each participant, with scores representing the mean of item ratings. Higher total FTS scores represent greater family functioning.

3.2.5 | Child Status Index

The CSI is a 48-item index that assesses a child's well-being and needs across six domains (food and nutrition; shelter and care; protection; health; psychosocial; and education and skills training) (O'Donnell et al., 2013). Each domain contains eight items, and each item is rated

by the administrator using a scale of 1 (*very bad*) to 4 (*good*). Item ratings are summed to create a total assessment score, ranging from 48 (*very bad*) to 192 (*good*). The CSI is designed to assist clinicians in creating individualized, goal-directed service plans for use in monitoring the well-being of children and families. Prior to the start of the present study, the CSI was already in use at Agape.

3.3 | Data collection

Data collection was accomplished by several different parties. The FSOs collected the FTS and CSI assessment data during their regular home visits pre- and post-intervention. These data were first recorded on paper (i.e., in handwritten hard copy). Copies of completed assessments were uploaded by Agape staff to secure, shared cloud space provided by Penn researchers. Then, Penn researchers entered data from each FTS and CSI assessment into Excel. Each assessment was double-entered and then checked for discrepancies between entries. Whenever a discrepancy was detected, the original hard copy assessment was reviewed, and the correct value was then recorded.

3.4 | Data analysis approach

Data were managed in Excel and analysed with R (version 4.2.2). Missing data ranged from 0% to 3% of cases for any single-scale item. Given the novel nature of the dataset, we used all values observed for each variable of interest to avoid loss of valuable data through listwise deletion. For descriptive statistics, we calculated frequencies and percentages for all categorical variables and means and standard deviations for all continuous variables. We also assessed the distributional properties of study variables, considering data normality and skewness.

We conducted paired-samples *t*-tests to determine whether there were significant changes within participants, in terms of their average FTS and CSI scores from before receiving Agape's FSP intervention to after receiving the intervention. We report Cohen's (1992) *d* (Lakens, 2013) to characterize standardized mean differences in pre- versus post-intervention scores. Effect size indicates the practical significance of a research outcome. A large effect size means that a finding has practical significance.

Beyond gauging change in scores from baseline to post-intervention, we also sought to explore the individual and/or contextual characteristics associated with differing amounts of change. Children and caregivers in the sample were grouped within different geographic locations in Kenya. Further, participants were assigned to one of nine Agape FSOs who delivered the FSP intervention and who administered pre- and post-intervention assessments. Conceptualizing geographic location and FSO groups as grouping variables, we acknowledge the nested structure of our data. Given this nested structure, fixed effects or multilevel modelling are ostensibly appropriate methods for investigating changes in family functioning and child well-being among recipients of Agape's FSP intervention.

However, we used analysis of covariance (ANCOVA) models to assess between-subjects variation because very few participants were assigned to each FSO. If the FSO assignment groups were included as dummy variables in regression models, we would have lacked sufficient statistical power to detect between-group differences, due to the small subgroup sizes (VanVoorhis & Morgan, 2007). Additionally, with small group-level sample sizes, multilevel models may underestimate the group-level variance components (Maas & Hox, 2005). Because our group-level sample sizes were small for FSO assignment ($n = 9$ groups) and location ($n = 3$ groups), we used ANCOVA rather than multilevel modelling (Bakdash & Marusich, 2017).

In separate ANCOVA models, we examined (i) the effect of FSO assignment and (ii) the effect of location, on changes in participants' assessment scores from pre- to post-intervention, adjusting for the baseline score. Controlling for baseline scores was necessary because any between-group variation in the mean change in post-intervention assessment score may also depend on the participant's basal score. In the process of generating each model, we used grouped scatterplots to verify linearity assumptions, and we verified the homogeneity of regression slopes by assessing the significance of the covariate * grouping variable interaction term. (This term was not significant in any of the models we generated.) We conducted Shapiro–Wilk tests to verify normality of residuals and Levene's test to verify homogeneity of residuals. We also examined standardized residuals to identify outliers (i.e., standardized residuals greater than |3|); none were found. For ANCOVA models, we report effect sizes as partial eta squared (η^2_p).

4 | RESULTS

This study evaluates changes in family functioning and child well-being among a sample of 68 clients (comprising 30 children and 38 caregivers of children) who received in-home crisis intervention services from Agape Children's Ministry following family reintegration. Participants were enrolled in Agape's FSP and this study between September and October 2022. They received services for varying lengths of time through February 2023.

4.1 | Sample characteristics

4.1.1 | Children

Table 1 displays descriptive statistics for the 30 children who participated. Two thirds of the sample children were male. Nearly three quarters of children identified as belonging to the Luo tribe ($n = 22$, 73.3%), and most children were receiving services at the Agape site in Kisumu ($n = 21$, 70%). Children were, on average, 12.9 ± 2.2 years of age (Mdn = 13 years) when initially rescued by Agape. The average child received residential rehabilitation services prior to reintegration for 55 ± 37 days (Mdn = 57 days). Collectively, slightly more than half of children in the study sample were reintegrated either in Kisumu

County ($n = 11$, 36.7%) or in Trans-Nzoia County ($n = 5$, 16.7%). Following the provision of crisis intervention services through Agape's FSP, nearly all children ($n = 28$, 93.3%) remained reintegrated with their families (i.e., were living at home with their families) as of the end of the study period.

4.1.2 | Push factors leading to street involvement

For the children and families in this study, the most prevalent push factor was theft for 37.84% ($n = 14$) of the children. Negative peer influence ($n = 8$, 21.62%) and behavioural issues ($n = 8$, 21.62%), such as disrespect and disobedience to parents, were also common factors for family separation. Poverty was identified as a push factor for family separation in 18.92% ($n = 7$) of the cases, and parental substance abuse and prostitution were evident in 13.51% ($n = 5$) of cases. Of the children involved in the study, only 22.22% ($n = 8$) came from homes where their biological mothers and fathers were still married and living together, while 30.56% ($n = 11$) had one deceased parent. Divorce and remarriage also figured prominently within the families involved in the study with 44.44% ($n = 16$) of children coming from homes with divorce, single parenthood, and remarriage. Only one of the children involved in the study was a total orphan, living with relatives.

4.1.3 | Caregivers

Thirty-eight participants were family members (hereafter sometimes termed *caregivers*) of children in the study sample. As shown in Table 2, nearly three quarters of caregivers were female ($n = 28$, 73.7%). In terms of their relationships with child participants, more than half of caregivers were mothers ($n = 22$, 57.9%). Most caregivers were served by Agape in Kisumu.

4.2 | FSP evaluation

4.2.1 | Family functioning

Family functioning was assessed using an adapted version of the FTS (Puffer et al., 2021b). Agape clinicians administered the FTS to each participant at two points in time—once before and once after the participant had received the intervention.

Prior to the intervention, a total of 73 FSP enrollees completed the FTS, including 32 child participants and 41 of their caregivers. Following the intervention, 68 of the Agape clients who completed the pre-intervention assessment then completed the same FTS assessment at post-intervention. Clients who completed the post-intervention FTS included 30 children and 38 of their family members. From Time 1 (pre-intervention) to Time 2 (post-intervention), five participants dropped out of the study, resulting in an overall attrition rate of 6.8%. For evaluation purposes, we report assessment scores for

TABLE 3 Family Togetherness Scale (FTS) assessment scores at baseline and follow-up.

Measure	Analytic sample		Client group			
			Children		Family members	
	M	SD	M	SD	M	SD
FTS score						
Pre-intervention	5.68	1.60	5.39	1.64	5.90	1.56
Post-intervention	8.16	0.83	8.24	0.63	8.10	0.97

Note: FTS was adapted from Puffer et al. (2021a, 2021b) and used in the present study to assess family functioning. The analytic sample is composed of 68 clients who completed the FTS assessment once before and once after receipt of crisis intervention services, as part of Agape's Family Strengthening Programme. FTS scores are rounded to the nearest hundredth.

those clients who completed the FTS at both time points, pre- and post-intervention. Hereafter, when we use the term analytic sample, we are referencing this group of 68 clients for whom pre- and post-intervention data are available.

Table 3 presents FTS scores for the analytic sample and details pre- and post-intervention scores by client group (i.e., child participants vs. their caregivers). Prior to the intervention, the average FTS score among participants in the analytic sample was 5.68 ± 1.60 (Mdn = 5.61). As compared with their caregivers, children had slightly lower pre-intervention FTS scores: The average pre-intervention FTS score among children was 5.39 ± 1.64 (Mdn = 5.06), while the average pre-intervention FTS score among caregivers was 5.90 ± 1.56 (Mdn = 5.91).¹ Mean FTS scores increased following the intervention. At Time 2 (post-intervention), the average FTS score for the analytic sample was 8.16 ± 0.83 (Mdn = 8.18). In contrast to the difference in child versus caregiver scores at Time 1, at Time 2, child participants had slightly higher average FTS scores ($M = 8.24 \pm 0.63$, Mdn = 8.17) than did their caregivers ($M = 8.10 \pm 0.97$, Mdn = 8.26).

We conducted paired-samples *t*-tests to determine whether there were significant changes within participants, in terms of their average FTS scores from before receiving the intervention to after. The mean of differences (i.e., pre-intervention assessment scores subtracted from post-intervention assessment scores) for 68 participants in the analytic sample was 2.49 ± 1.53 . The paired-samples *t*-test indicated that this mean of the differences is significantly greater than zero ($t(67) = 13.44$, $p < 0.001$, 95% CI [2.12, 2.86]) and is large in magnitude ($d = 1.63$).

To examine changes in FTS scores at a more granular level, we conducted two additional paired-samples *t*-tests—one with data from child participants only (excluding caregivers) and another separate test with data from caregivers only (excluding children). On average, children's FTS scores increased to a statistically significant extent from before to after receiving the intervention ($M = 2.85 \pm 1.62$, $t(29) = 9.67$, $p < 0.001$, 95% CI [2.25, 3.46], $d = 1.77$). We found similar results for the participating caregivers, whose average FTS scores increased significantly from pre- to post-intervention ($M = 2.20 \pm 1.41$, $t(37) = 9.65$, $p < 0.001$, 95% CI [1.74, 2.66], $d = 1.56$).

We also used ANCOVA to examine the effects of group-level variables on mean change in FTS scores from baseline to post-intervention. For these analyses, we stratified the dataset by participant identity and ran separate models, examining between-group

differences in the stratified samples of children only ($n = 30$) and of caregivers only ($n = 38$). In terms of children's mean change in FTS score (from baseline to post-intervention), after adjusting for baseline scores, we found a significant difference between the FSO assignment groups, $F(8, 20) = 3.433$, $p = 0.012$, $\eta^2p = 0.579$; we did not, however, find any significant difference between the location groups, $F(2, 26) = 0.541$, $p = 0.588$, $\eta^2p = 0.040$. In terms of caregivers' mean change in FTS scores, after adjusting for baseline scores, we found a significant difference between FSO groups, $F(8, 28) = 7.96$, $p < 0.001$, $\eta^2p = 0.695$, and a significant difference between location groups, $F(2, 33) = 6.99$, $p = 0.003$, $\eta^2p = 0.297$.

4.2.2 | Child well-being

To assess child well-being, Agape clinicians completed the CSI (O'Donnell et al., 2013) for each family, once before and once after the intervention. At baseline (Time 1 or pre-intervention), the mean CSI score for children in the analytic sample was 2.59 ± 0.15 (Mdn = 2.57). Following the intervention, the mean CSI score increased to 3.08 ± 0.27 (Mdn = 3.00).

We conducted a paired-samples *t*-test to assess the within-subjects change in CSI scores from baseline (Time 1 or pre-intervention) to post-intervention (Time 2). The mean of differences (i.e., pre-intervention CSI scores subtracted from post-intervention scores) for 29 children in the analytic sample was 0.47 ± 0.27 .² This mean of the differences is significantly greater than zero ($t(28) = 9.50$, $p < 0.001$, 95% CI [0.37, 0.57]) and is large in magnitude ($d = 1.76$).

We used ANCOVA to examine the effects of group-level variables on mean change in children's CSI assessment scores from baseline to post-intervention. In terms of children's mean change in CSI score, after adjusting for the baseline CSI score, we found a significant difference between the FSO groups, $F(8, 19) = 5.47$, $p = 0.001$, $\eta^2p = 0.697$, and between the location groups, $F(2, 24) = 8.77$, $p = 0.001$, $\eta^2p = 0.422$.

5 | DISCUSSION

For all study participants, including 30 children and 38 of their caregivers, family functioning was assessed using an adapted version of

the FTS (Puffer et al., 2021a). For each participating child, well-being was assessed using the CSI. Study participants completed the same assessments at two points in time (once before implementation of crisis intervention services and once after the intervention had concluded). Employing a one group pretest/posttest design, we examined family functioning and child well-being, using paired-samples *t*-tests to investigate within-subject changes in scores from baseline to post-intervention. FTS scores increased to a statistically significant and large extent from before to after client receipt of Agape's family strengthening intervention. This important finding indicates that families displayed improved functioning following participation in the FSP.

Previous studies have found case management and family therapy to be effective in higher income countries with distressed families (Coren et al., 2013), with less known about the nature of family-based interventions in lower income countries. FSP participants here reported significant increases in numerous domains of family functioning, such as communication, financial planning, distribution of household roles and responsibilities, and connectedness. Therefore, this study fills an important gap in the literature on such programmes in lower income countries (Dybicz, 2005).

Using Cohen's *d*, our findings indicate that the magnitude of change in FTS scores was slightly greater for children in the study sample, as compared with their participating caregivers. Prior to the intervention, children had lower average scores than their caregivers, and following the intervention, the children had higher average scores. While we cannot directly infer causality, this might suggest that the FSP has a particularly strong impact on how children perceive the functioning of their families. These findings differ from previous studies indicating that recently reintegrated children often struggle to cope with living at home, possibly due to inadequate family preparation prior to reintegration (Frimpong-Manso, 2012; Frimpong-Manso & Bugyei, 2019).

CSI scores likewise increased to a statistically significant and large extent across six key domains (food, shelter, protection, health, psychosocial, and education) from before to after child receipt of the intervention, supporting earlier findings that long-term family stability requires attention to children's material and psychosocial needs (Wilke et al., 2023). Of the four domains critical to ensuring family stability (economic capital, social capital, cultural capital, and health capital) identified by Goodman et al. (2020), the increased CSI scores point to the importance of family economics, social/relationships, and health; the only item not directly measured in the CSI is cultural capital.

The paired-samples *t*-tests to assess within-subjects change in FTS and CSI scores from baseline (Time 1 or pre-intervention) to post-intervention (Time 2) showed a statistically significant increase on both scales and large effects. While we are unable to infer causality, findings do indicate that family functioning and child well-being increased from before to after the FSP intervention.

ANCOVA models revealed that, after adjusting for participants' baseline FTS scores, mean change in FTS score varied significantly between the FSO groups. This variation in mean score change was

found for children as well as for caregivers, reinforcing earlier research underscoring the importance of caring and supportive relationships between street children and service providers (Schimmel, 2008). Additionally, after adjusting for baseline scores, ANCOVA models revealed a significant difference in the mean FTS score change of caregivers grouped in different geographic locations; no such between-location variation was observed for children. In terms of the mean change in CSI scores from baseline to post-intervention, ANCOVA models found significant between-group differences by FSO group and by location. When between-group differences were significant, relatively large effect sizes were observed, indicating that FSO characteristics and geographic location may have considerable impact on participants' change in scores from pre- to post-intervention. In future studies, researchers should assess the influence of these group-level variables using more advanced statistical methods (e.g., multilevel modelling) with larger samples.

5.1 | Limitations

The primary limitation in this study is the same as in any one group pretest/posttest study, namely, the inability to infer causality between receipt of the FSP and the outcomes observed. Time, financial constraints, and familiarity with the research process precluded the recruitment or inclusion of a control or comparison group. This limitation poses multiple threats to internal validity, including history, maturation, and testing effects—all of which could influence the differences we observed in participants' baseline versus post-intervention scores. Also, the personalities and/or individual characteristics of Agape FSOs may have played some role in the changes observed in scores at baseline versus post-intervention. Indeed, results from ANCOVA models show that after adjusting for baseline scores, average change in assessment scores differed depending on participants' FSO groups. It is possible that children and caregivers were influenced by “interviewer” bias, because Agape FSOs administered the pre- and post-intervention assessments to participants. Participants could have been wanting to please the “interviewer” in relation to how they answered FTS questions. Another limitation is that nine different FSOs collected the data, and we are unable to determine the extent to which FSOs adhered to standard assessment procedures. Unobserved variation between FSOs—such as individual differences in training, work experience, and procedures for assessment and/or data collection—may have impacted findings.

Because participants were not randomly assigned to any condition or treatment, it is likely that contrasted groups (e.g., groups by location or by FSO) differed from each other by many characteristics, in addition to the grouping criteria. Any observed relationships could reflect the confounded effects of these other interrelated factors rather than the effect of the FSP. To reduce potential confounding factors, we used ANCOVA to statistically adjust for the influence of pre-intervention scores, which helps to account for pre-existing differences among participants. With all of this in mind, our study should be regarded as an initial exploratory investigation of the FSP, with results

suggesting areas for further study with more rigorous, controlled, or comparison designs and larger sample sizes.

5.2 | Recommendations for programming

Based on the promising results of this evaluation and the lessons learned, we propose the following recommendations to inform similar programmes worldwide working with recently reintegrated families.

Organizations working with reintegrated families should continue the intensive work that promotes family organization, emotional closeness, and communication or problem-solving. Improvements in these skills enhance family functioning, confirming Knerr et al.'s (2013) findings of protectiveness. Validating Puffer et al. (2021a), findings indicate that it is critical to assess and clinically attend to relationships between children and their caregivers.

Likewise, organizations working with reintegrated families should ensure attention to the diverse needs of families following reintegration so that well-being continues to increase across domains. Service providers working with recently reintegrated families must attend to the diverse domains affecting families; our results support Wilke et al.'s (2023) finding that basic needs, security needs, relational needs, and educational needs are all important components of family stability.

5.3 | Recommendations for ongoing evaluation and future research

We recommend that organizations, like Agape, that work with reintegrated families engage in ongoing evaluation through the development of a structured evaluation process and/or provision of a dedicated "internal evaluator" staffing role. By enhancing the monitoring, evaluating, and sharing of results of family reintegration programmes, methods both internally and externally can be revised and improved (Corcoran & Wakia, 2016; Goodman et al., 2020). The tools introduced in this evaluation study could be used for replication and ongoing assessment of child and family functioning within family reintegration programmes.

To assess effectiveness of programmes like FSP, ultimately, a randomized controlled trial (RCT) or quasi-experimental study must be undertaken. RCTs are prospective studies that measure the effectiveness of a new intervention. Although no study is likely on its own to prove causality, randomization reduces bias and provides a rigorous tool to examine cause-effect relationships between an intervention and outcome. The act of randomization balances participant characteristics (both observed and unobserved) between the groups, allowing attribution of any differences in outcome to the intervention. This is not possible with any other study design. Another, slightly less rigorous but often more feasible possibility is employing a quasi-experimental design that uses a comparison group and propensity score matching. Propensity score matching is a statistical matching technique that attempts to estimate the effect of an intervention by accounting for the covariates that predict receiving the treatment.

Such an approach reduces bias due to confounding variables (Abadie & Imbens, 2005).

While it is essential to employ rigorous research designs when evaluating programmes like Agape's FSP, there are inherent limitations to carrying out this work. The nature and scope of available services, as well as the circumstances of children and families receiving services in a low- to middle-income country (LMIC) such as Kenya, may create practical and logistical barriers to research. Researchers' needs must be carefully balanced with the needs and day-to-day realities of service providers and the children and families they serve.

Ethical concerns may arise when researchers propose RCTs for programme evaluation, because this design requires the use of a control group—and thus ostensibly denies a subset of participants the opportunity to receive potentially critical services, such as those provided via Agape's FSP. Such concerns may prohibit the organization from ever undertaking an RCT. Moreover, the lack of regulatory frameworks in some LMICs may increase risk to human subjects, including members of vulnerable populations (Alemayehu et al., 2018).

Resource constraints in LMICs are another potential impediment to the use of RCTs and other more rigorous research designs. Agape currently lacks the requisite infrastructure and resources (e.g., adequate funding and staff training) to employ sophisticated designs such as RCTs. While this hurdle is not unique to Agape, it does highlight an important challenge related to conducting this kind of research in an LMIC. Similarly, there are certain logistical challenges for nonprofit agencies undertaking research in an LMIC. These include challenges with travel and communication, which can make the coordination of research activities arduous and impede the timely and efficient conduct of research. Additional funding would likely reduce or eliminate some of these barriers, enabling Agape and other nonprofit organizations operating in LMICs to carry out more rigorous evaluation research.

Lastly, as related to carrying out ongoing rigorous evaluation research, we adapted the original version of FTS based on expert feedback from local Kenyan staff at Agape. Therefore, any long-term use of the adapted FTS to measure family togetherness/functioning should only continue following instrument validation. *Validity* is the extent to which an instrument measures what it is supposed to measure and performs as it is designed to perform. It is rare, if nearly impossible, that an instrument be 100% valid, so validity is generally measured in degrees. As a process, validation involves collecting and analysing data to assess the accuracy of an instrument. This is an area where Agape and other service providers should continue to collaborate with university partners, as instrument validation may require advanced research expertise and staffing capacities difficult for many nonprofit agencies to independently bring to bear.

6 | CONCLUSION

Agape Children's Ministry in Kenya rescues vulnerable children from harmful, dangerous situations, psychosocially and spiritually equipping them for increased likelihood of long-term success at home with their

families. Agape reunites at-risk children with their families while preparing and empowering their caregivers to care for and love them. Over the past 12 years, Agape has responsibly reunited over 5000 vulnerable street and at-risk children with their families. As part of the Christian Alliance for Orphans' research challenge grant programme, we partnered with Agape to provide an initial evaluation of their relatively new FSP, which provides crisis, in-home counselling support to recently reintegrated families who need more help and guidance than provided by the case manager. We assessed family togetherness/functioning and child well-being before and after the FSP. Results showed positive associations between participation in the FSP and improved family togetherness/functioning and child well-being from the perspectives of both the children and their caregivers. We recommend that organizations serving reintegrated families take into consideration the lessons learned here from this research-practice collaboration. We note that broad governmental attention to the basic needs of families would provide a better foundation for improved family functioning. We also suggest additional research on the FSP that uses a more sophisticated research design to further explore the impact of the FSP on family togetherness/functioning and child well-being.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to disclose.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author.

ETHICS STATEMENT

The study was approved by the University of Pennsylvania's Institutional Review Board.

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ENDNOTES

¹ We conducted independent samples *t*-tests to further assess differences in the mean FTS scores of children versus their family members at specific points in time. At baseline (pre-intervention), we found no significant difference in the mean FTS scores of children versus family

members, $t(66) = -1.48, p = 0.143$. We likewise found no significant difference in the mean FTS scores of children versus family members at follow-up (post-intervention), $t(66) = 0.71, p = 0.481$.

² One child from the analytic sample was excluded from this analysis due to the absence of key data on the post-intervention CSI assessment measure.

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APPENDIX A: FAMILY TOGETHERNESS SCALE (ADAPTED)—CHILD VERSION

The present study uses an adapted version of the FTS, originally developed by Puffer et al. (2021a) to assess family functioning among children and adults in Kenya. This appendix provides a comprehensive list of items in the adapted FTS scale, administered to child participants in the present study to assess family functioning. Items were rated by the participant on a 10-point Likert-type scale, ranging from 1 to 10. For items in the first question set, *None* (1) and *A lot* (10) served as the scale anchors. For items in the second question set, the anchors were *Not at all* (1) and *Completely* (10). For items in the third question set, *Never* (1) and *Very often* (10) were the scale anchors. Item response sets also included a “Not applicable” category, selected when a respondent reported that a given scale item did not apply to their family situation or personal life circumstances.

- 1.1 How much your parents make plans together for business?
- 1.2 How much do your parents make plans together for planting?
- 1.3 How much do adults act kindly towards children in your household?
- 1.4 How much do children act respectfully towards adults in your household?
- 1.5 How much do your parents work together to make a household budget?
- 2.1 Your parents make efforts to provide for your basic needs.
- 2.2 Your parents agree on what is best for your family.
- 2.3 Your parents speak in a kind way to one another.
- 2.4 Your parents are honest with each other.
- 2.5 Your family members understand what chores they are responsible for in your household.
- 2.6 The boy child(ren) and girl child(ren) are treated equally in your household.
- 2.7 Chores are assigned fairly among the members of your household.
- 2.8 Children in your household complete all of their assigned chores.
- 2.9 Some children in your household are punished more harshly than others.
- 3.1 How often are your family members dishonest with each other?
- 3.2 How often do your family members work together on things outside of the home compound?
- 3.3 How often does your family make stories together?
- 3.4 How often do any of your family members sleep outside of the home compound in unknown places?
- 3.5 How often do your parents laugh together?
- 3.6 How often do children in your household do what their parents ask them to do?
- 3.7 How often do family members in your household quarrel with each other?
- 3.8 How often do family members in your household act violently towards one another?

- 3.9 How often do your parents say encouraging things to you?
- 3.10 How often do family members in your household accept responsibility for their mistakes?
- 3.11 How often do family members in your household misunderstand each other?
- 3.12 How often does your mother/stepmother prepare a meal for your father/stepfather?
- 3.13 How often does your mother/stepmother prepare a meal for the whole family?
- 3.14 How often does your father/stepfather provide money for your family's basic needs?

APPENDIX B: FAMILY TOGETHERNESS SCALE (ADAPTED)—ADULT VERSION

This appendix provides a comprehensive list of items in the adapted FTS scale, administered to adult participants in the present study to assess family functioning. Items were rated by the participant on a 10-point Likert-type scale, featuring the same scale anchors as those used in the child version (see Appendix A). Item response sets also included a “Not applicable” category, selected when a respondent reported that a given scale item did not apply to their family situation or personal life circumstances.

- 1.1 How much do you and your spouse make plans together for business?
- 1.2 How much do you and your spouse make plans together for planting?
- 1.3 How much do adults act kindly towards children in your household?
- 1.4 How much do children act respectfully towards adults in your household?
- 1.5 How much do you and your spouse work together to make a household budget?
- 2.1 Your spouse makes efforts to provide for your basic needs.
- 2.2 You and your spouse agree on what is best for your family.
- 2.3 You and your spouse speak in a kind way to one another.
- 2.4 You and your spouse are honest with each other.
- 2.5 Your family members understand what chores they are responsible for in your household.
- 2.6 The boy child(ren) and girl child(ren) are treated equally in your household.
- 2.7 Chores are assigned fairly among the members of your household.
- 2.8 Children in your household complete all of their assigned chores.
- 2.9 Some children in your household are punished more harshly than others.
- 3.1 How often are your family members dishonest with each other?
- 3.2 How often do your family members work together on things outside of the home compound?
- 3.3 How often does your family make stories together?

- 3.4 How often do any of your family members sleep outside of the home compound in unknown places?
- 3.5 How often do you and your spouse laugh together?
- 3.6 How often do children in your household do what their parents ask them to do?
- 3.7 How often do family members in your household quarrel with each other?
- 3.8 How often do family members in your household act violently towards one another?
- 3.9 How often does your spouse say encouraging things to you?
- 3.10 How often do family members in your household accept responsibility for their mistakes?
- 3.11 How often do family members in your household misunderstand each other?
- 3.12 How often does the mother/stepmother prepare a meal for the father/stepfather in your household?
- 3.13 How often does the mother/stepmother in your household prepare a meal for the whole family?
- 3.14 How often does the father/stepfather in your household provide money for the family's basic needs?
- APPENDIX C: CHILD STATUS INDEX**
- This appendix provides a list of Child Status Index domains and scale items (O'Donnell et al., 2013), used in the present study to assess child well-being. For a comprehensive overview of Child Status Index items and associated rating scales, see O'Donnell et al. (2008).
1. Food and nutrition
 - 1a. Food security
 - 1b. Nutrition and growth
 2. Shelter and care
 - 2a. Shelter
 - 2b. Care
 3. Protection
 - 3a. Abuse and exploitation
 - 3b. Legal protection
 4. Health
 - 4a. Wellness
 - 4b. Health care services
 5. Psychosocial
 - 5a. Emotional health
 - 5b. Social behaviour
 6. Education and skills training
 - 6a. Performance
 - 6b. Education and work