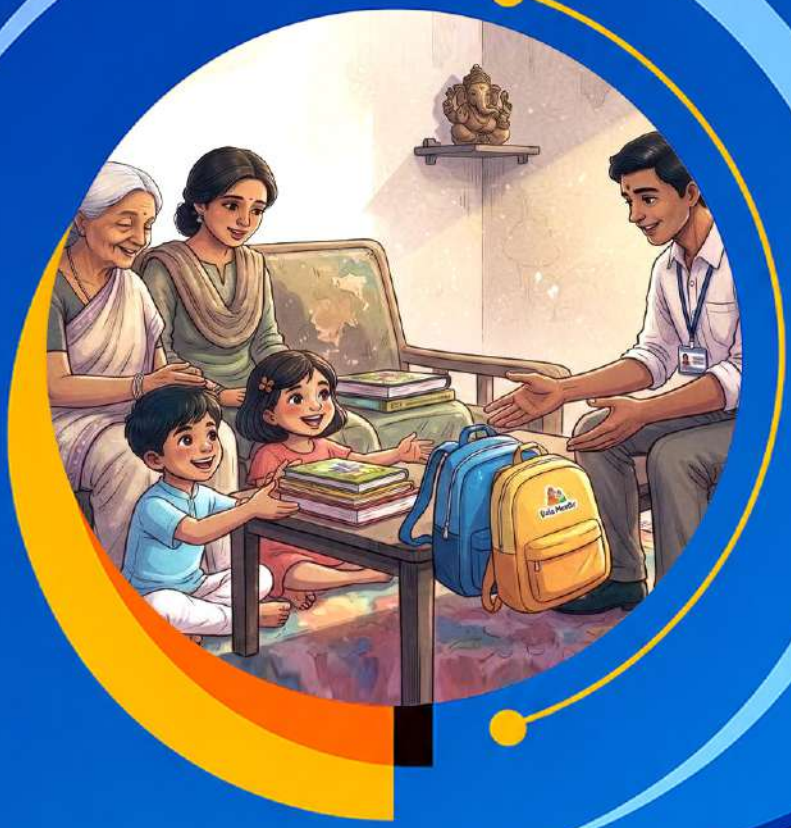


BALA MANDIR KINSHIP CARE PROGRAM

IMPACT REPORT 2026

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Introduction

Children who lose one or both parents face far-reaching challenges that extend beyond the immediate emotional impact of bereavement. The loss of a parent often disrupts family stability, reduces household income, alters caregiving arrangements, and exposes children to increased risks of poor educational attainment, compromised psychosocial wellbeing, and social exclusion. In India, unlike many countries with formal foster care systems, the overwhelming majority of such children continue to be cared for by surviving parents, grandparents, aunts, uncles or other members of the extended family. While these kinship care arrangements preserve family relationships and cultural identity, they frequently operate under considerable emotional, social and economic strain.

Globally, kinship care programmes have traditionally focused on ensuring that children remain within family-based care rather than entering institutional settings. These programmes commonly emphasise legal protection, financial assistance, case management and safeguarding services. While these remain essential, Bala Mandir Kamaraj Trust has adopted a broader and distinctly developmental approach to kinship care that extends beyond crisis response or social protection. Rather than viewing kinship care as a temporary welfare intervention, Bala Mandir conceptualises it as a long-term developmental commitment to every child and family enrolled in the programme.

At the heart of the programme is the concept of a "Virtual Home." Instead of relocating children into institutional care, the programme seeks to recreate within the child's own family, many of the opportunities, guidance and developmental supports that Bala Mandir has traditionally provided to children living in its home. Through a dedicated network of trained social workers supported by a custom-built digital case management platform, each child receives continuous individualised support while remaining within the care of his or her family. The programme combines educational assistance, mentoring, psychosocial support, counselling, parenting guidance, access to government entitlements, referrals to specialised services, and regular family engagement to ensure that children continue to experience holistic development within their natural family environment.

The programme is therefore founded on the belief that strengthening children requires strengthening families. Children's emotional security, psychosocial development and long-term resilience are closely linked to the wellbeing of their caregivers and the stability of the family environment. Consequently, BMKC's interventions extend beyond supporting the child alone to promoting caregiver wellbeing, enhancing caregiving capacity, strengthening family resilience and building supportive networks around each household. This family-centred philosophy distinguishes the programme from conventional child sponsorship or financial assistance models by recognizing that sustainable child wellbeing is achieved through nurturing the entire caregiving ecosystem.

To monitor whether these intended changes are occurring, BMKC has embedded an outcome monitoring framework within its routine program implementation. Standardized assessments of caregiver's mental health, subjective wellbeing, empowerment and child psychosocial functioning are integrated into the program's digital Management Information System (Dhruva), and administered as part of regular case management. This enables the program to move beyond measuring service delivery and instead assess whether families are experiencing meaningful improvements across key domains of wellbeing.

This report presents an analysis of these embedded program indicators. Unlike the previous year's evaluation, which adopted a conventional research design, the present report draws upon routinely collected monitoring data generated through day-to-day program implementation. The findings therefore provide an evidence-informed picture of the current status of children and caregivers enrolled in the programme while generating practical insights to strengthen service delivery, improve case management and guide future program development.

Purpose of the Report

The primary purpose of this report is to examine the current status of children and caregivers enrolled in the BMKC Program using standardized outcome indicators integrated into routine program implementation.

Specifically, the report seeks to:

a) Describe the socio-demographic characteristics of families enrolled in the program.

b) Examine the mental health, subjective wellbeing, psychological wellbeing, and empowerment of caregivers using standardized assessment tools.

c) Assess the psychosocial wellbeing of children receiving care.

d) Explore relationships among key program indicators to identify factors associated with positive outcomes.

e) Generate evidence that can support program planning, decision-making, service improvement, and future monitoring.

Why Outcome Monitoring Matters

Outcome monitoring shifts the focus from services delivered to changes experienced by beneficiaries. It enables programs to assess whether caregivers are becoming emotionally healthier, whether children are experiencing improved psychosocial wellbeing, and whether families are developing greater resilience over time.

Within the BMKC Program, routine monitoring of outcome indicators serves several important purposes:

- It enables early identification of families experiencing psychological or social vulnerabilities.
- It supports individualized case planning based on assessed needs.
- It provides information regarding the effectiveness of program interventions.
- It can assist the social workers in prioritizing follow-up and referral services.
- It can contribute to continuous program learning and quality improvement.

Theory of Change Statement

"If widowed mothers and kinship care families receive sustained psychosocial support, family strengthening interventions, educational assistance, livelihood support and regular social work follow-up, then mothers will become more emotionally resilient, supported and empowered; family caregiving environments will improve; and children will experience better emotional, behavioral, educational and developmental outcomes despite the loss of a parent".

Outcome Measurement Framework

The outcome monitoring system is directly aligned with the Theory of Change. Each assessment tool included within the program's digital application has been selected to measure a specific outcome that the program seeks to influence.

Outcome Domain 1: Caregiver Wellbeing

The wellbeing of caregivers represents a critical pathway through which the program expects improvements in child wellbeing to occur. Routine monitoring therefore assesses multiple dimensions of caregiver functioning including emotional distress, subjective wellbeing, positive mental wellbeing and empowerment.

Outcome Domain 2: Child Wellbeing

Children's psychosocial wellbeing is a central outcome of the program. Routine monitoring examines children's emotional and behavioural adjustment, enabling the program to identify children who may require additional psychosocial support and to monitor broader patterns of child wellbeing across participating families.

Outcome Domain 3: Family Context

The program recognises that family circumstances shape both caregiver capacity and child outcomes. Information relating to household composition, socio-economic status, support received from relatives, government assistance and other contextual factors is therefore routinely collected to facilitate a comprehensive understanding of each family's circumstances.

Assessment Methodology

Assessment Design

This report is based on an analysis of routinely collected program monitoring data generated through the BMKC Program. The assessments were not undertaken as part of a standalone research study but formed an integral component of routine service delivery. As families engage with the program, the social workers conduct standardized assessments using the program's mobile application. The present report analyses these embedded indicators to provide an overview of the current status of participating families and to identify trends that can inform future program strengthening.

Data Source

All information analyzed in this report was extracted from the BMKC's digital management application-Dhruva. The application serves as the primary repository for beneficiary registration, family profiles, standardized assessments, case notes, referrals and follow-up information. Embedding assessment tools within the digital platform ensures standardized data collection, improves data quality, facilitates longitudinal tracking and enables timely review of beneficiary outcomes.

Sample Size

200 families (100 OLD, 100 NEW) - 200 mothers, 200+ children

Comparison Groups

OLD (2021-2022 admissions) families vs. NEW (2025-2026 admissions) families.

Outcome Indicators

Routine monitoring incorporates standardized assessment tools covering multiple dimensions of caregiver and child wellbeing.

Caregiver assessments

a) PatientHealth Questionnaire-4 (PHQ-4) - Higher scores reflect worse mental health

b) Subjective Wellbeing Inventory (SUBI)- Higher scores reflect better well being

c) Women's Empowerment Index - Short Form (WEI-SF)- Higher scores reflect more empowerment

d) WHO-5 Wellbeing Index - Higher scores reflect better well being

Child assessment

a) Pediatric Symptom Checklist (PSC-35)- Higher scores reflect more behavioral/emotional difficulties.

Family profile variables

The program additionally captures information relating to household composition, cause of parental death, caregiver characteristics, employment, educational status, income, support from relatives and in-laws, and other contextual factors that influence family wellbeing.

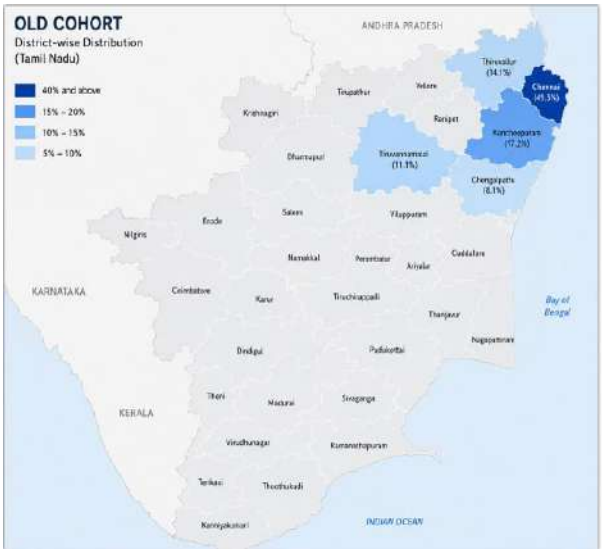
Data Analysis

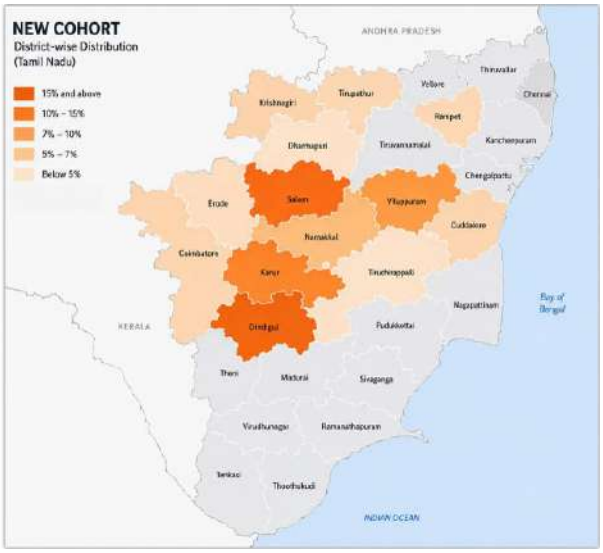
The report primarily presents descriptive analyses of caregiver wellbeing, child psychosocial functioning and family characteristics. Frequencies, percentages, measures of central tendency and graphical summaries are used to describe participant characteristics and outcome indicators.

In addition, relationships among selected variables are explored to identify patterns associated with caregiver wellbeing, child outcomes, family circumstances and program engagement. These analyses are intended to generate insights that support program learning and continuous improvement rather than establish causal relationships.

Results and Discussion

The geographic distribution of families differed substantially between the two cohorts, reflecting the expansion of the BMKC Program over time. The **old cohort** was primarily concentrated in the northern districts of Tamil Nadu, with nearly half of all families (49.5%) residing in **Chennai**, followed by **Kancheepuram (17.2%), Thiruvallur (14.1%), Tiruvannamalai (11.1%), and Chengalpattu (8.1%).** In contrast, the new cohort was geographically more diverse, with families drawn from a much wider range of districts across the





state. While only a small proportion of new families came from the districts represented in the old cohort, a considerable number were from **Salem (16.7%), Dindigul (15.6%), Karur (12.2%), Viluppuram (7.8%), Namakkal (6.7%)**, and several other districts including **Krishnagiri, Cuddalore, Tirupathur, Tiruchirappalli, Coimbatore, Erode, Dharmapuri, Ranipet, and Vellore.**

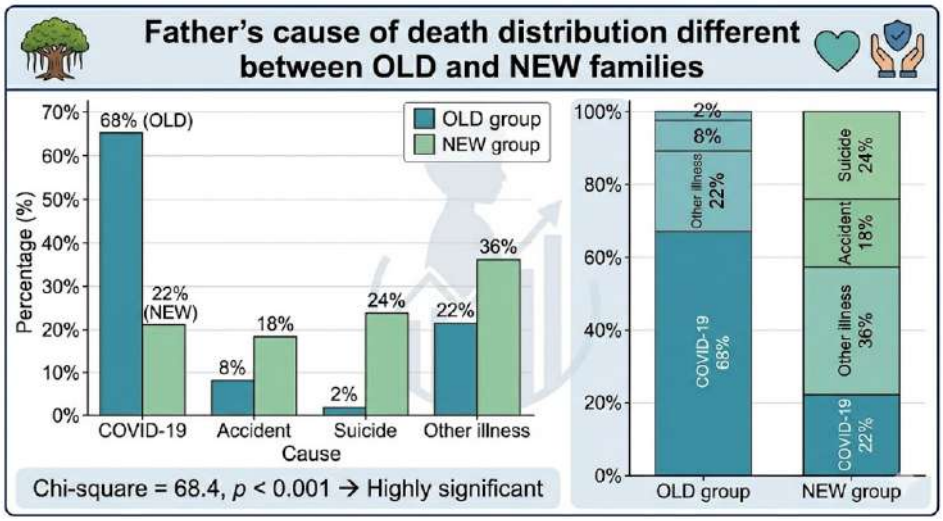
Demographic Profile of Mothers in the Old and New BMKC Cohorts

Characteristic	Old Families (n = 99)	New Families (n = 91)	Statistical Test	p-value
Employment Status			$\chi^2 = 0.77$	0.38
Employed	73 (73.7%)	72 (79.1%)		
Homemaker / Unemployed	26 (26.3%)	19 (20.9%)		
Mother's Monthly Income (INR)	Rs 6,570 ± 4,850	Rs 6,890 ± 4,200	t = -0.49	0.62
Husband's Income Before Death (INR)	Rs 4,230 ± 7,200	Rs 6,100 ± 9,100	t = -1.57	0.12
Cause of Husband's Death			$\chi^2 = 57.10$	<0.001
COVID-19	73 (73.7%)	17 (18.7%)		
Other Causes	26 (26.3%)	74 (81.3%)		
Guardian / Extended Family Support			$\chi^2 = 0.59$	0.44
Living with Extended Family	36 (36.4%)	38 (41.8%)		
No Extended Family Support	63 (63.6%)	53 (58.2%)		
Total Number of Children	1.85 ± 0.80	1.76 ± 0.60	t = 0.84	0.40
Family Size			$\chi^2 = 1.06$	0.30
One Child	28 (28.3%)	32 (35.2%)		
Two Children	58 (58.6%)	48 (52.7%)		
Three or More Children	13 (13.1%)	11 (12.1%)		

The table presents the demographic characteristics of mothers and households in the old and new BMKC cohorts. Overall, the two groups were comparable across most socioeconomic and family characteristics. Approximately three-fourths of mothers in both cohorts were employed, with no significant difference in employment status ($p = 0.38$). Similarly, mothers' monthly income and husbands' income prior to death did not differ significantly between the groups ($p > 0.05$), suggesting comparable economic backgrounds.

Family support systems were also similar, with around 36-42% of mothers living with extended family members such as grandparents, aunts, or uncles, while the majority in both groups lived without such support (p = 0.44). Family composition was likewise comparable, with an average of fewer than two children per household and similar distributions of one-child, two-child, and larger families (p = 0.30).

Father's cause of death distribution difference between Old and New families

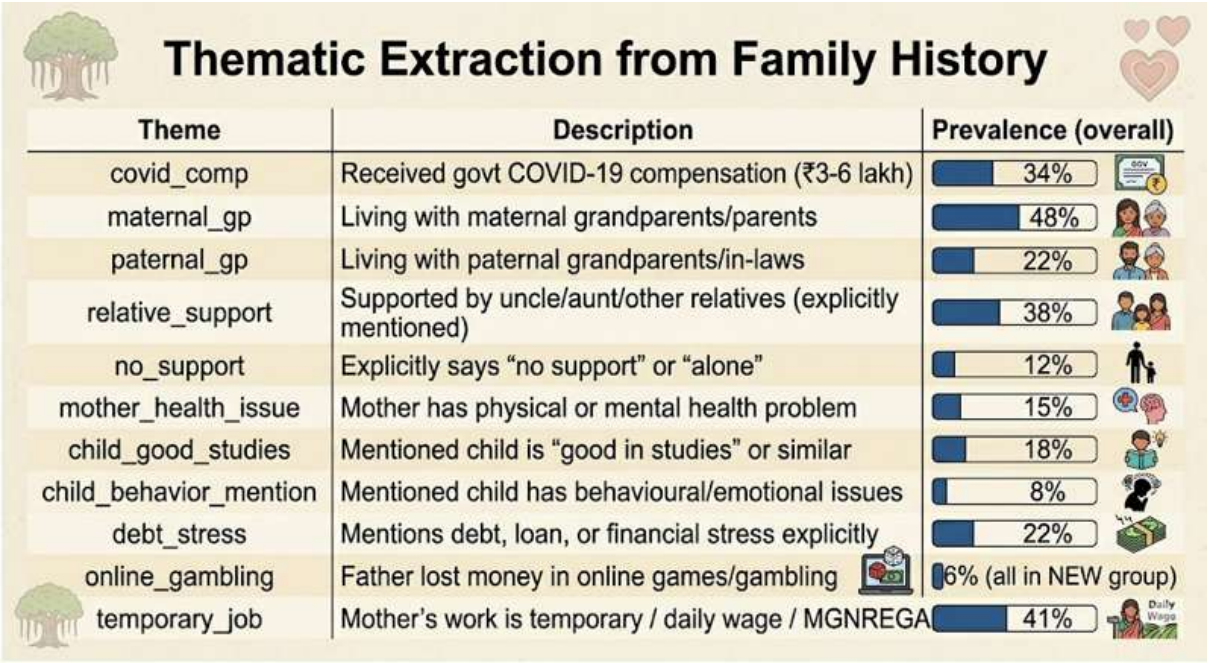


There was a clear difference in the causes of husbands' deaths between the two groups (χ^2 = 68.4, p < 0.001). In the old group, most families (68%) had lost the husband due to COVID-19, reflecting the program's initial focus during the pandemic. In the new group, COVID-related deaths were much lower (22%), with more families affected by other illnesses (36%), suicide (24%), and accidents (18%). This shows that the program has expanded beyond supporting COVID-affected families to include children who have lost a parent due to a wider range of causes.

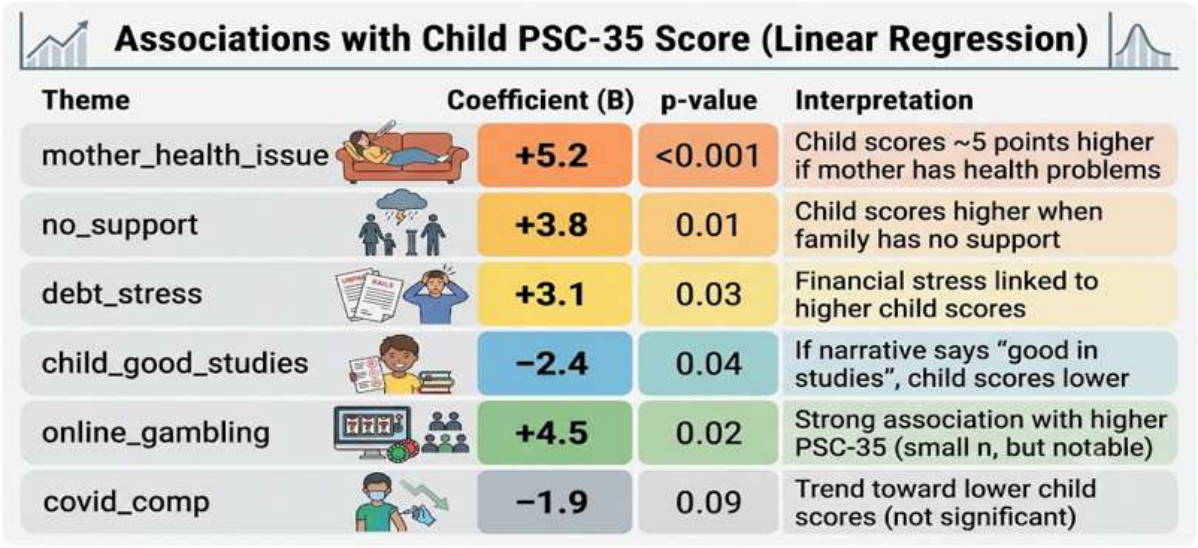
Research suggests that the circumstances surrounding parental death can significantly influence the experiences of surviving mothers and children. Sudden and unexpected deaths, such as accidents and suicides, are often associated with higher levels of trauma, grief, anxiety, depression, and post-traumatic stress symptoms among children compared to anticipated deaths following illness (Pham et al., 2018; Brent et al., 2018). Children bereaved by parental suicide are particularly vulnerable to long-term emotional and behavioural difficulties, including depression and suicidal thoughts that may persist for several years after the loss (Lee et al., 2017; Liu et al., 2023). The psychological wellbeing of the surviving caregiver also plays an important role in children's adjustment following bereavement, with poorer caregiver mental health being associated with worse outcomes for children (Cerniglia et al., as cited in the systematic review by Farina et al., 2026).

For mothers, sudden bereavement frequently brings an immediate transition to single parenting alongside increased financial responsibilities and caregiving demands. Families affected by suicide may additionally experience stigma, shame, guilt, and social isolation, which can reduce help-seeking and support from social networks (Pitman et al., 2016). Studies have shown that suicide bereavement is associated with higher rates of depression, anxiety, mental health service use, and financial vulnerability among surviving family members (Bolton et al., 2013).

Thematic Extraction from Family History



Associations with Child PSC-35 Score (Linear Regression)

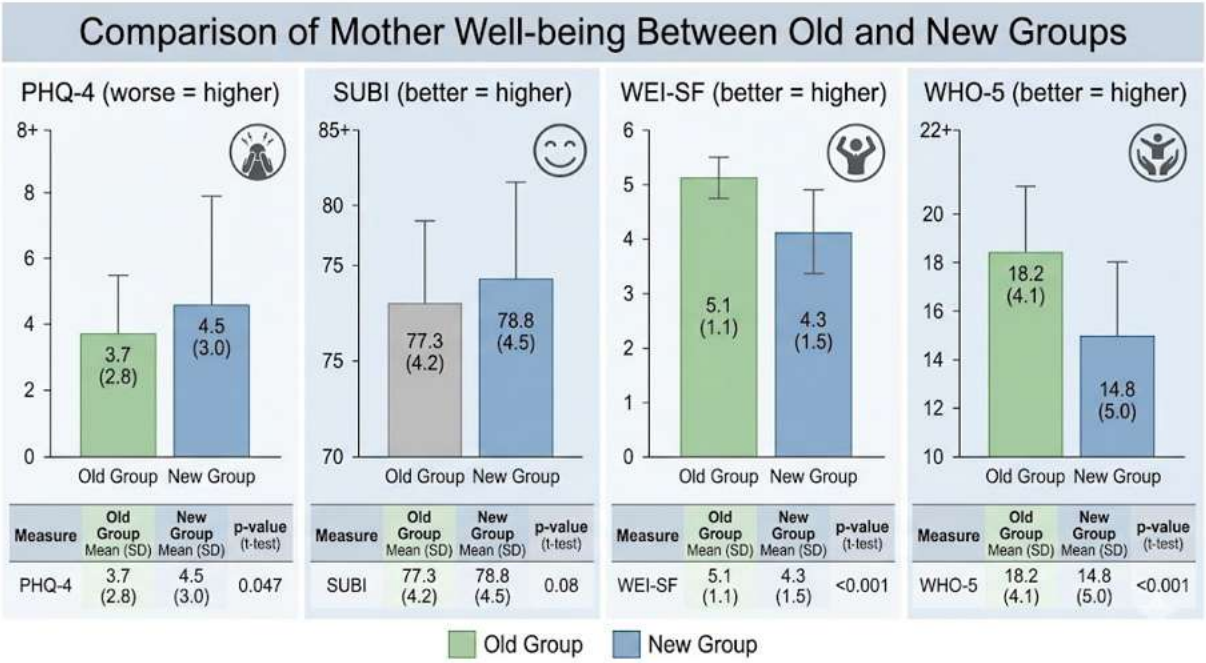


Based on the qualitative family histories documented by social workers in the Dhruva application, a thematic analysis was conducted and compared with children's PSC-35 scores. The findings suggest that children from families where *mothers were experiencing physical or mental health difficulties, where there was limited family or social support, or where households were facing significant debt or financial stress tended to have higher levels of emotional and behavioral difficulties.* In contrast, children whose family histories described them as being "good in studies" or performing well academically generally had lower PSC-35 scores, suggesting better overall adjustment and wellbeing.

These findings are consistent with existing research showing that maternal mental health difficulties and parental stress are strongly associated with increased emotional and behavioural problems among children. A recent systematic review and meta-analysis found significant associations between parental stress and both children's emotional problems and behavioural difficulties (Ribas et al., 2024). Similarly, studies have

shown that maternal mental health problems can negatively influence children's behavioural, emotional, and social development over time (Lowthian et al., 2023; Patel & Prince, 2012). Lack of social support and financial stress can further compound these risks by increasing caregiver burden and reducing the emotional resources available for responsive caregiving and supervision. Conversely, positive school performance is often considered an indicator of resilience, social competence, and better psychosocial adjustment among children facing adversity.

Comparison of Maternal Well-being Between Old and New Groups



Measure	Old Group Mean (SD)	New Group Mean (SD)	p-value (t-test)
PHQ-4	3.7 (2.8)	4.5 (3.0)	0.047
SUBI	77.3 (4.2)	78.8 (4.5)	0.08
WEI-SF	5.1 (1.1)	4.3 (1.5)	<0.001
WHO-5	18.2 (4.1)	14.8 (5.0)	<0.001

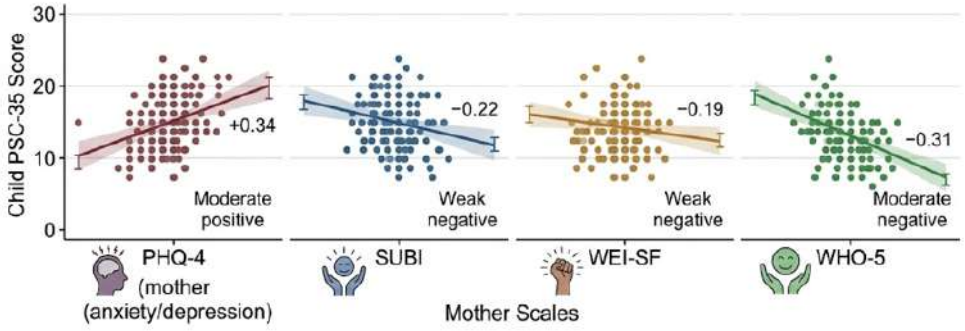
Mothers in the new group report slightly more anxiety/depression (PHQ-4), much lower work empowerment (WEI-SF), and significantly lower overall psychological well-being (WHO-5) compared to mothers in the old group. Mothers who joined the programme more recently (new group) are struggling more emotionally and feel less in control of their work life than those who joined earlier (old group).

Correlation Between Mother Measures and Child PSC-35 Scores

We calculated the correlation coefficient (Pearson's r) between each mother scale and the child's PSC-35 score (all children, both groups combined, N = 189 with valid scores).

Correlation Between Mother Measures and Child PSC-35 Scores

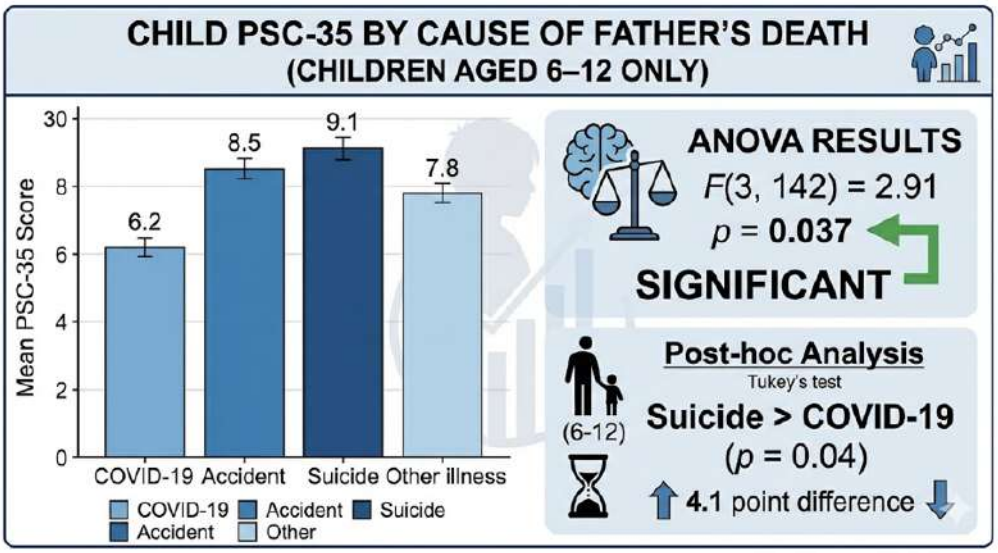
	Mother Scale	Correlation with Child PSC-35	*p*-value	Interpretation
1.	PHQ-4 (mother anxiety/depression)	+0.34	<0.001	Moderate positive
2.	SUBI (mother life satisfaction)	−0.22	0.003	Weak negative
3.	WEI-SF (mother empowerment)	−0.19	0.009	Weak negative
4.	WHO-5 (mother well-being)	−0.31	<0.001	Moderate negative



The analysis showed a clear relationship between maternal wellbeing and children's emotional and behavioral outcomes. Children whose mothers reported higher levels of anxiety and depression on the PHQ-4 tended to have higher PSC-35 scores, indicating greater emotional and behavioral difficulties. In contrast, children whose mothers reported better wellbeing and life satisfaction on the WHO-5 and SUBI, and greater confidence and empowerment in their work roles on the WEI-SF, generally had lower PSC-35 scores, suggesting better psychosocial adjustment. Among all maternal factors examined, **maternal anxiety and depression showed the strongest association with child outcomes,** accounting for approximately 12% of the variation in children's PSC-35 scores. This represents a clinically meaningful relationship and supports the view that **improving maternal mental health and wellbeing may have positive benefits for children as well.**

This finding is strongly supported by existing literature. Numerous studies have shown that maternal anxiety and depression are associated with higher rates of emotional and behavioural problems in children, including anxiety, depression, attention difficulties, and conduct problems (Meadows, McLanahan, & Brooks-Gunn, 2007; Rogers et al., 2020). Meta-analytic evidence further indicates that maternal depression and anxiety can influence children's social-emotional development well beyond infancy and into adolescence (Rogers et al., 2020). Similarly, studies have consistently found that children of mothers experiencing depression exhibit higher levels of both internalising and externalising behavioural problems (Turney, 2012; Huntley et al., 2017). These findings reinforce the importance of adopting a family-centred approach in which **supporting maternal mental health is viewed as an important pathway for improving child wellbeing outcomes.**

Child PSC-35 by Cause of Father's Death (Children aged 6-12 only)



Children whose father died by suicide have slightly higher behavioral/emotional scores than children whose father died of COVID-19. However, all averages are well below clinical concern (usually 28+). The difference is small but statistically detectable.

Correlations: Social Worker Visits vs. Mother Scores (both groups combined together)

Visit measure	Mother PHQ-4 (worse higher)	Mother WHO-5 (well-being)	Mother SUBI	Mother WEI-SF
Total Visits	r = −0.21 (p = 0.003)	r = +0.18 (p = 0.01)	r = +0.09 (p = 0.20)	r = +0.11 (p = 0.12)
Visits last 30 days	r = −0.15 (p = 0.03)	r = +0.12 (p = 0.09)	r = +0.06 (p = 0.38)	r = +0.08 (p = 0.26)
Avg visits/month	r = −0.19 (p = 0.006)	r = +0.16 (p = 0.02)	r = +0.07 (p = 0.31)	r = +0.10 (p = 0.15)

Correlation analyses demonstrated that greater engagement with social workers was associated with better maternal mental health outcomes. Mothers who received more visits overall, as well as a higher average number of visits per month, reported significantly lower levels of anxiety and depression and higher levels of wellbeing. Recent visits during the previous 30 days were also associated with lower anxiety and depression scores, although their relationship with wellbeing was weaker. While social worker visits showed positive associations with mothers' subjective wellbeing and economic empowerment, these relationships were not statistically significant. Overall, the findings suggest that sustained and regular social work engagement may contribute to improved maternal mental health and wellbeing among kinship care families.

These findings are consistent with evidence suggesting that sustained social support and case management can improve caregiver wellbeing and resilience among vulnerable families. **Case management approaches that combine regular contact, emotional support, practical assistance, and linkage to services have been shown to reduce caregiver distress and improve mental health outcomes** (Broll et al., 2025). Similarly, community-based interventions that strengthen caregiver support systems and caregiver-child relationships have been associated with improvements in family functioning and psychosocial wellbeing among vulnerable children and their caregivers (Penner et al., 2020).

Social Worker Visits vs. Child PSC-35 Score (for both groups combined)

Visit measure	Correlation with child PSC-35	p-value
Total Visits	r = −0.24	<0.001
Visits last 30 days	r = −0.11	0.12 (ns)
Avg visits/month	r = −0.20	0.006

ns* - not significant

Correlation analyses also indicated that greater social worker engagement was associated with better child psychosocial outcomes. Children (especially between 6-12 years) from families receiving a higher total number of visits and more frequent visits per month had significantly lower PSC-35 scores, indicating fewer emotional and behavioural difficulties. However, visits received during the previous 30 days were not significantly associated with PSC-35 scores. These findings suggest that the cumulative and sustained nature of social work support may be more important for child wellbeing than short-term or episodic contact.

The findings also suggest that visits may not improve child behaviour directly. Rather, **social worker visits appear to operate primarily through improvements in maternal wellbeing and mental health.** Earlier analyses in this study showed that more frequent visits were associated with lower maternal anxiety and depression and higher levels of wellbeing, while better maternal mental health was in turn associated with lower PSC-35 scores among children. **This supports a pathway in which social worker engagement strengthens the mother's emotional wellbeing and coping capacity, which subsequently creates a more supportive and stable environment for the child, leading to better child outcomes.**

Social Worker Total Visits vs. Outcomes (0-2, 3-5, 6+ visits)

Outcome	Significant pair	p-value
Mother PHQ-4 (anxiety)	6+ visits lower than 0-2 visits	0.01
Mother WHO-5 (well-being)	6+ visits higher than 0-2 visits	0.02
Child PSC-35	6+ visits lower than 0-2 visits	0.007

Families receiving six or more social worker visits showed significantly better outcomes than those receiving only 0-2 visits. Mothers in the higher-contact group reported lower anxiety and depression and higher levels of wellbeing, while their children had fewer emotional and behavioral difficulties. These findings suggest that sustained engagement with families may contribute to improved maternal wellbeing and, indirectly, to better child outcomes. The results support a family-centred approach in which strengthening caregiver wellbeing serves as an important pathway for improving children's psychosocial adjustment.

The findings are consistent with the **Family Stress Model** (Conger et al., 1992), which proposes that stressful life events such as bereavement, financial hardship, and social isolation influence children's outcomes primarily through their effects on caregiver wellbeing and family functioning. Similarly, research has shown that improvements in caregiver mental health often lead to improvements in children's emotional and behavioural functioning (Goodman et al., 2011; Lowthian et al., 2023).In the present analysis, social worker visits were associated with better maternal mental health, which in turn was associated with fewer emotional and behavioural problems among children, suggesting that improvements in child wellbeing may occur through improvements in maternal wellbeing.



Comparison of 2025 with 2026 impact assessment

1. Mother Well-being

The findings related to maternal well-being are remarkably consistent across both evaluations, although the current study provides stronger evidence regarding psychological health.

In the **previous evaluation**, mothers who had been in the program for two to three years reported significantly lower depression, greater empowerment, improved self-efficacy, stronger decision-making abilities, and higher levels of social connectedness compared to newly enrolled mothers.

The **current evaluation** reached a similar conclusion using different measures. **Mothers in the long-term program group demonstrated lower anxiety and depression (PHQ-4) and higher psychological well-being (WHO-5) compared to newly enrolled families.**

Taken together, both studies suggest that sustained participation in the BMKC Program contributes positively to maternal psychosocial well-being and resilience.

2. Child Outcomes

The findings on child outcomes must be interpreted carefully because the two evaluations measured very different aspects of child development.

The **previous evaluation** included a broad assessment of child outcomes, examining academic performance, reading fluency, reading comprehension, school attendance, and behavioural and emotional functioning using the Strengths and Difficulties Questionnaire (SDQ). The results showed that children with longer program exposure performed better academically, demonstrated stronger reading and comprehension skills, and were reported by caregivers to have significantly fewer emotional and behavioural difficulties.

In contrast, the **current evaluation** *did not assess educational outcomes, academic achievement, school performance, reading ability, or attendance.* Child outcomes were measured solely through the Paediatric Symptom Checklist (PSC-35), which focuses on behavioural and emotional functioning.

The findings suggest that the program does not appear to improve children's well-being directly if entire age group is taken. However, if the age group is controlled and only children between 6-12 years are compared, **children in long-term Kinship Care families exhibit substantially fewer behavioural and emotional difficulties than children in newly enrolled families.**

3. Understanding the Program's Pathway of Change

One of the most notable similarities between the two evaluations is the emerging evidence regarding how the program creates impact.

In the **previous evaluation**, path analysis demonstrated that social worker support contributed to increased maternal empowerment, which in turn reduced maternal depression. Empowerment was therefore identified as a key mechanism through which program support translated into improved well-being.

The **current evaluation** extends this understanding further by showing that maternal mental health appears to be the primary pathway through which child outcomes are influenced. Further analysis showed that the differences seen in children's outcomes were closely linked to the emotional well-being of their caregivers. When mothers reported lower levels of distress and better psychological well-being, their children also tended to have better outcomes.

Together, **the two studies suggest a coherent pathway of change**: sustained social work support strengthens mothers psychologically, and these improvements in caregiver well-being subsequently benefit children.

4. Role of Social Worker and Home Visits

The importance of sustained engagement with families is evident in both evaluations.

The **previous study** found that stronger social worker involvement was associated with greater maternal empowerment, lower depression, improved parenting, and better child outcomes.

The current evaluation provides even stronger support for this relationship through the identification of a dose-response effect. **Families receiving six or more home visits demonstrated significantly better maternal mental health and more favourable child behavioural outcomes than families receiving fewer visits.**

The findings therefore reinforce the importance of sustained and consistent contact with families over time.

A **key lesson emerging** from this evaluation is that supporting children may increasingly require supporting caregivers first. As the needs of families become more complex, *the role of the social worker may evolve from primarily facilitating access to services and benefits toward strengthening family resilience, caregiver well-being, and the emotional environment within the household.* This approach is likely to have the greatest long-term benefit for both caregivers and children.

5. Implications for Program Direction

The findings suggest that the profile of families entering the BMKC Program is changing, with newer families experiencing more complex emotional and psychosocial challenges than earlier cohorts. While educational assistance and economic support remain important, the increasing prevalence of suicide-related bereavement and lower access to external support systems indicate a growing need for psychosocial interventions. Future program efforts may therefore need to place greater emphasis on caregiver mental health, emotional recovery, grief support, and family resilience.

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