CARE THAT COUNTS INITIATIVE
A Standards-Based Approach to Improving Quality of Programs for Vulnerable Children and Families

Background
Due to the long-term effects of HIV/AIDS and poverty, many countries are home to increasing numbers of vulnerable children requiring care and support beyond what can be provided by their families. Government, civil society, and the international donor community have attempted to fill those gaps in care and support through the provision of services to at-risk children. While standardization of those services is critical to the achievement of a measurable, systemic and sustained response, minimum standards of care for children do not exist in many developing countries.

Since 2008, the Care that Counts Initiative of the USAID Health Care Improvement (HCI) Project has provided technical assistance to ministries and partner organizations at the national, district and community levels in nine countries to develop minimum care standards for services to vulnerable children in seven domains: health, education, shelter, nutrition, psychosocial support, legal protection and household economic strengthening. (See Table 1 for sample standards for nutrition.)

Four countries—Ethiopia, Cote d’Ivoire, Tanzania, and Kenya—have successfully launched the standards of care for vulnerable children and are now scaling up implementation, while the other five countries—Haiti, Malawi, Mozambique, Nigeria and Zambia—are in process. See Figure 1 for the milestones in the standards development process reached by the nine countries.

Guided by core quality improvement (QI) principles, the Care that Counts Initiative promotes the following approaches:
- Ministry-led multidisciplinary QI teams at the national and local levels guide the improvement process.
The minimum standards document is aligned with the national strategy for care and support of vulnerable children and families.

Children are included as active participants in the standards process.

QI teams seek to understand and improve the multilayered systems and processes involved in providing services to children.

Members of the QI teams acquire capacity for improvement in the design and implementation of programs for vulnerable children and families.

QI teams develop “change packages” based on international best practices to guide improvement of work processes.

Process and outcome data are gathered and analyzed to provide evidence of improvement.

QI teams share lessons learned across different regions within countries and between countries through south-to-south exchanges.

**Applying a Standards-based Approach**

The Care that Counts Initiative has championed the idea that it is possible to develop and put into practice outcome-based standards for services provided to vulnerable children and families. Standards explicitly state “desired outcomes” or the common vision of what a service should achieve and the measurable difference that the service should make in children’s and families’ lives. The Initiative has built consensus among implementers for a consistent format for service standards that includes a statement of desired outcome, measurable goals, essential actions that define each major service, and guidelines that explain how the essential actions should be carried out. The standards guide government and implementing partners in reflecting on strategies (essential actions) that can be applied within their context to reach the desired outcomes.

Experience has shown us that merely writing a document on standards does not ensure that the standards will be implemented, nor that the standards even make a difference in the lives of children. Perhaps a standard is unattainable or not feasible in certain contexts. Or implementation of a standard could fail to produce a positive change in the lives of children, or even have...
unanticipated negative consequences. To address these concerns, the Initiative includes a piloting phase in the standards development process. For example, in Bagamoyo, Tanzania, a Most Vulnerable Children (MVC) improvement collaborative was initiated in 2010 as a demonstration site to improve learning before spreading the implementation of minimum standards to other areas and districts. The collaborative was designed to build on the existing systems and structures whereby village level committees served as QI teams. District coaches guided the village teams on identifying the existing quality gaps in services, changes that needed to be made to address the gaps, and the indicators to monitor improvement.

The piloting or learning phase includes three essential elements:

- Structured learning sessions for QI team members to come together to share experiences in implementation of the standards
- Development of implementation packages, or change packages, which describe the series of improvements, or changes, that teams will implement to effectively reach the minimum service standards. These changes are generally based on international best practices and are intended to guide teams as they test ways to improve work processes.
- To determine whether the proposed changes result in improvement or not, QI teams measure key indicators that are linked to the expected effects of the changes introduced.

**Gathering Evidence of Improvement**

Organizations at national and community levels need to understand if their programs are actually making a positive difference in the wellbeing of vulnerable children and their families. **Are our programs actually meeting the desired outcomes as stated in the standards?** Documenting that an actual change has occurred as a result of implementing an intervention is critical to the improvement process. Data to answer this question are gathered by QI team members, implementing agency partners and government officials, who must all make decisions about what specific data they will collect, who will collect it, how it will be analyzed, and how it will be used to make decisions about making further changes.

To gather evidence in evaluating whether standards are making a difference in the lives of children, HCI has used both outcome and process indicators. In the Bagamoyo demonstration project, data on ten process indicators was gathered at baseline and monthly for nine months, to establish the level of compliance with the service standards and the wellbeing of children and their households. Figure 2 shows the improvement in service coverage in the areas of food security, provision of adequate shelter, and use of insecticide treated mosquito nets. In the course of implementation of the Bagamoyo collaborative, there have been notable achievements in terms of processes and access to services for vulnerable children through the involvement, sensitization and resource mobilization at the community level. Community-level QI teams meet regularly to review performance in providing services, continually learn from one another, and implement actual changes in the way they do their work.

![Children's Workshop in Haiti: Children providing input as to what they consider quality services for children and families. Photo by URC.](image)

**Figure 2. Improvements in service coverage – Bagamoyo, Tanzania**

- **May**
  - QIT formed and trained
- **June**
  - Mobilization for:
    - Home and house renovation
    - Food and nutrition education
  - MVC who get two or more meals a day
- **July**
  - Mobilization for ITN and consistent use
  - MVC sleeping under insecticide-treated mosquito nets (ITNs)
  - MVC living in secure, dry, and adequate shelter
  - MVC LIVING IN SECURE, DRY, AND ADEQUATE SHELTER
  - MVC SLEEPING UNDER INSECTICIDE TREATED MOSQUITO NETS (ITNs)
  - MVC WHO GET TWO OR MORE MEALS A DAY
  - More meals a day
  - Mobilization for ITN and consistent use

![Graph showing improvements in service coverage in Bagamoyo, Tanzania](graph)
Kenya employed the Child Status Index (CSI) as the primary source of outcome data (see Box 1). The CSI was administered in June 2010, before standards were provided to community workers, and again in June 2011, after standards were implemented in the community. CSI scores in nutrition and food security improved from baseline to one year after implementation of the standards at the community level (Figure 3).

In addition to measuring changes in child outcome and process measures, country teams have also developed local data collection tools for documenting the standards implementation process. Journals or scrapbooks are used in the communities to document the gaps in services and the changes made as the gaps were addressed. Other tools have been used to evaluate the feasibility and usefulness of the essential actions provided in the standards – what works in one context may not be effective or even possible in another.

**Conclusion**

Many learning opportunities emerged during the first four years of the Care that Counts Initiative. Through working in several different countries, HCI has fine-tuned a ministry-led process of developing, piloting, finalizing and spreading minimum care standards for delivery of services for vulnerable children and families. Strengthening capacity of community members and organizations has potential as a locally owned and sustained mechanism for improving the wellbeing of vulnerable children and families.

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**Box 1**

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**The Child Status Index**

The Child Status Index (CSI) is a tool that can be helpful in assessing and tracking priority services a vulnerable child needs. Equally useful for initial assessment and follow-up monitoring, the tool focuses on essential actions and is flexible enough that users can adapt criteria to the local context. Data from the Child Status Index and community mapping of services can be used together to inform coordination of care.

Developed by MEASURE Evaluation and Duke University with PEPFAR and USAID support, the CSI is based on six domains with 12 measurable goals related to the six core services that, taken together, approximate a standard for overall child health and wellbeing. The CSI measures attainment of goals in six domains of care: food and nutrition; shelter and care; protection; health; psychosocial; and education and skills. The index includes a four-point scale for each goal so that the child’s wellbeing can be assessed as good, fair, bad, or very bad. The goals themselves, as well as the rating guidance, are phrased in ways that allow for some local variation, yet the measures are still meaningful and specific. The accompanying Child Status Record, which records status over time, indicates services received and identifies critical events that have occurred in the life of the child.