World Vision®

FACILITATOR'S MANUAL FOR COMMUNITY HEALTH COMMITTEES (COMM)

SESSION 5: TRACKING COMMUNITY HEALTH STATUS

Field Test Version

Published by Global Health on behalf of World Vision International.

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Cover photo © Paul Bettings/World Vision
Cover photo: Nean Chou (far left) and Onn Kom (far right) are health workers who are part of the Village Health Support Group, organised by World Vision, in Cambodia. Nean and Onn visit pregnant mothers within their community, advising how to properly care for their babies.

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Toolkit

SESSION 5: TRACKING COMMUNITY HEALTH STATUS

Notes for the Facilitator

The COMM will be involved in the following types of community health tracking:

1. Ongoing tracking of behavioural practices
The COMM should track select indicators of health practices from the data that is collected by CHWs. This is true for all COMMs, whether or not they have carried out a root-cause analysis.

For those COMMs that have carried out the robust version of root-cause analysis, information was recorded in the column labelled 'Part 1: Local Statistics' in Tool 3b-3 found in Session 3b. In these cases, it is important that the COMM continue to use the same tool and track these behavioural practices over time – ideally every quarter. However, the COMM will not be asked to go out and collect this information again every quarter. Rather, this is information that it can obtain from CHWs, since the CHWs will be active in tracking behaviours when they make their household visits.

There are two ways that COMMs can collect data from CHWs:

- **Scenario 1:** If you are working in a project area where CHW data is routinely aggregated (by the MoH, yourself, or another NGO) and these aggregated results are available, then ensure that the COMM receives these results.
- **Scenario 2:** If CHW data is collected but not aggregated, or aggregated but not available, the COMM can collect some information from CHWs itself. However, this will be done in a semi-quantitative, as opposed to truly quantitative fashion. This will be explained in this session.

2. Periodic receipt of information from the local clinic (some COMMs)
Some COMMs may have interviewed local health staff in an earlier phase. If so, there is a question at the end of the interview asking what information the clinic will be able to provide to the COMM on a quarterly basis. Some clinics may not be able to provide anything, while others may have readily available statistics that they are willing to share. If the COMM has reached an agreement with the clinic to receive regular information, this will be a second source for tracking the health situation.

3. Tracking and reporting disease outbreaks
The COMM has a crucial role to play in the ongoing tracking and reporting of disease outbreaks. It should be able to apply its skills in coordination and record to organise and lead community-level efforts to control infectious disease spread during an outbreak.

4. Investigating and reporting adverse events
Finally, the COMM will be trained to investigate any adverse events that happen in its community (unusual deaths, breakdowns in treatment) in an attempt to uncover their causes.

The COMM will learn to do all of these things in this session. These activities will assist the COMM in **tracking** what is taking place in the community on a regular basis. In addition, every two years or so, the COMM may wish to repeat (or carry out for the first time) a robust root-cause analysis as a way of obtaining more complete and systematic information.

Note on Contextualisation

If you are working with a COMM that focuses on areas other than Maternal, Newborn and Child Health (MNCH), a COMM perhaps working with adolescents or adult men's health for example, then Tool 5-1 in this session will need to be adapted. You will need to include different indicators, relevant to the health issues the COMM is concerned with.

ACTIVITY 1: GATHERING INFORMATION FROM CHWS

Facilitator Preparation

If you are working with COMMs that did not carry out the robust root-cause analysis (Session 3b), you will need to use **Tool 5-1.** This includes all the same health practices as Tool 3b-3, but only has columns for recording information on a quarterly basis; not for a front-end root-cause analysis. You will need to review this form against the data that CHWs collect in your context and only include those rows, or indicators, that match that data. You should delete all rows for health practices that the CHWs do not collect data for.

Notes for the Facilitator

1. This activity is based on the assumption that CHWs exist in the community. If they do not, the COMM will not have access to ongoing behavioural and health practice information. In these cases, you should help the COMM find out if there are other sources of data that they may be able to locate and use; see point 2 below. If there are CHWs in your area, the COMM will work based on one of the two scenarios below. You should find out ahead of time which scenario is relevant for your situation, and focus only on that scenario in this activity.

2. It may also be possible to get data from projects working in the area when baselines, evaluations or other measures are carried out. You should find out when such data are collected and make sure that the COMM receives the summarised results to compare with the information it is receiving from CHWs.

For those COMMs that carried out the robust root-cause analysis (Session 3b), explain that they will track the progress of the behaviours they selected, over time. The COMM will not, however, need to go out and repeat the FGDs and KIIs every quarter. Rather, they will get the information from the work that the CHWs are doing. They will continue to use Tool 3b-3 that they worked with during the root-cause analysis (they will not use Tool 5-1).

For those COMMs that did not carry out the robust root-cause analysis, distribute Tool 5-1 (as prepared by you earlier, per the instructions in the box above). Review the tool with them, looking first at the health practices listed in each row, and then at the columns labelled Q1, Q2, Q3, Q4. Explain that they will collect information from CHWs every quarter in order to fill in the respective columns.

- **Scenario 1: Aggregated CHW data is available**
  Note: If this is your scenario, then you should obtain examples of aggregated data forms ahead of time in order to carry out this activity.

  If you are in a project area where CHW data is routinely aggregated and made available (or could be easily obtained upon request), then you will help the COMM to work with this data. Explain the way that the COMM will receive this data. This will vary by location. In some cases the COMM may need to go to the local health facility to request it, while in other cases you may provide it to them. Ideally, the COMM should be receiving this data on a quarterly basis.

  Now work with one example of a quarterly aggregated CHW data report. Have the members read through the information and find the indicators and behaviours that match up to the ones they collected during their root-cause analysis, if applicable. They can mark these with a dot or a check mark. Next, help the COMM transfer the data into the Q1 column of Tool 3b-3 or Tool 5-1, depending on the group you are working with. Tell the COMM to hold on to the tool for future presentations.

- **Scenario 2: Aggregated CHW data is not available**
  Inform the COMM members that they will need to communicate with CHWs regularly to find out what is happening in the community regarding the behaviours that the COMM wants to track on Tool 3b-3 or Tool 5-1. They can get this information from CHWs during the supportive meetings they will have with them (see Session 2).

  To do this, the COMM will give a pile of beans to each CHW, and use the beans to talk about the priority behaviours one by one. For each behaviour (for example, exclusive breastfeeding) among the families the CHW is visiting, the CHW should divide the beans to represent approximately how many families are practising this behaviour (hold in left hand) and how many are not (hold in right hand). The COMM will then collect all the beans that the CHWs have in their left hands (families practising) and place them one large pile, and then all the beans that the CHWs have in their right hands (families not practising) and place them in another large pile.

  By looking at the two piles, they can then determine an approximate percentage in the Q1 column (and Q2 next quarter, and so on). Then ask the CHWs to talk about the barriers they are seeing in the families.

  Demonstrate this method with the beans, and have the COMM members practise it in small groups. You may need to assist them in understanding the percentages. This may require some work on the flipchart or some other creative exercises. By the end, make sure that the COMM members understand how to fill in the information on Tool 3b-3 or Tool 5-1.

Responding to Issues
In addition to tracking the trends that the COMM is hearing from the CHWs on Tool 3b-3 or Tool 5-1, the COMM should also be alert to any new challenges or problems that are arising and to the ways that it can respond as a group. To give the COMM an example of what this might mean, share the story below about a health trend that was detected and successfully dealt with.

> In a Muslim community CHWs were noticing problems with malnourishment. They shared their observations with the COMM, and they worked together to identify the problem. They discovered that it was related to Ramadan, the month-long practice of fasting from sunrise to sunset. Mothers of infants and young children who were fasting were winding up with malnourished offspring. The COMM approached the Imam and described the problem. The Imam agreed that these mothers would be exempt from observing Ramadan.

Explain to the COMM that they will use the information received from the CHWs not only to track health progress, but also to add actions to its Action Plan in response to these types of emerging issues.

Activity 2: Gathering Information from the Health Clinic (some COMMs)

If the COMM carried out a root-cause analysis, they may have interviewed the local health clinic. If so, they learned what information the clinic would provide to the COMM on a quarterly basis. Some clinics may not be able to provide any information, while others may have readily available statistics that they are willing to share. Based on the COMM's agreement with the clinic, it should retrieve available information every quarter. Any information that will be useful for Tool 3b-3 or Tool 5-1 can be used to fill in the column for the relevant quarter (Q1, Q2, Q3, Q4).

Activity 3: Tracking and Reporting Disease Outbreaks

Explain that you are now finished with the tool until the next quarter. Begin this new activity by asking the COMM to share stories of outbreaks of illness that may have occurred in the past, such as contagious infections or water or food-borne diseases, and to describe what happened. Did anybody do anything? Was the health facility alerted immediately or only after some time had passed? Did the community take any action? Were there any deaths from the outbreak?

Next, discuss with the group why it is important to be alert for outbreaks and to take quick action. How could the COMM (or CHWs) contribute to improving community response in the future? Write key actions on flipchart paper

for the COMM to add to its Action Plan in response to any future disease outbreaks. Emphasise the following points, if they are not mentioned during the COMM's discussion:

- The COMM should always ask CHWs if they are coming across more illness or unusual health situations than normal in their home visits. This is especially important if there is a suspected outbreak of a vaccine-preventable disease such as measles. In addition, if the area is at risk of cholera, the MoH should brief both the CHWs and the COMM on cholera awareness.
- Sharing the most current and appropriate information about the disease outbreak in a timely manner is crucial, both to and from community members and health facilities and officials. Mobilisation of the larger community can create unity around the outbreak response, and openness in sharing information prevents excessive fear and builds confidence in the community, thereby reducing stigma and negative outcomes.
- All suspected cases of infection should be identified and quickly reported to the health facility.
- Geography, climate, season and housing conditions all play major roles in understanding the spread of a disease, so should always be taken into consideration.

Explain to the COMM members that they will add actions they have discussed and agreed upon to the COMM's Action Plan in response to tracking and reporting disease outbreaks.

ACTIVITY 4: INVESTIGATING ADVERSE EVENTS

An 'adverse event', for our purposes, is one in which someone who was ill ended up suffering or dying unnecessarily due to problems with seeking (or not seeking) or receiving treatment. Explain to the COMM that they will need to investigate any adverse events in the community and attempt to uncover their causes. By doing so, the COMM will be able to address weaknesses in the system so that they are not repeated. Share Tool 5-2, Chain of Care Flowchart. Then share the scenarios below and ask COMM members where they think the breakdown in each scenario.

- **Scenario 1**: Maria's 6-month-old baby has died. The baby was suffering from diarrhoea for over a week beforehand. Maria was visited by a CHW a few days into the baby's illness. The CHW told Maria how to treat the baby for dehydration. Two days later, when the baby was still very sick, the CHW referred Maria to the clinic for care. Maria did not take the baby to the clinic. Shortly thereafter the baby died.

  In this scenario the COMM should be asking why Maria did not take the baby to the clinic. It could be that the clinic was too far away and there was no transportation or she didn't have money for transportation. Discuss one of these reasons, or some of your own creation, with the COMM. Then follow up by discussing solutions that would address the breakdown.

- **Scenario 2**: Patricia just gave birth to her third child. When she went into labour, her husband took her to the health facility. The staff were reportedly rude to her and told her to come back when she was closer to giving birth. She went home and decided to stay there for the birth, but she was in labour for three days before she finally gave birth. The baby is healthy, but Patricia has had trouble passing urine for several days and is in great pain. She refuses to go to the clinic to seek help for the problem because of the rude staff. Her husband and family are very worried about her health, which is getting worse by the day and preventing her from taking optimal care of her newborn baby.

  Again, discuss where the breakdown is occurring in the chain of care, and the types of solutions that could address this breakdown.

Explain to the COMM that it will go through this process of identifying the cause of an adverse event any time one occurs in its community. COMM members will need to talk with the people involved in order to understand the sequence of events and determine where the problem arose. They will need to exercise sensitivity when speaking with bereaved individuals.

Now that the COMM has had a chance to look at two scenarios, have the members do the role play in Tool 5-3, Adverse Event Investigation Role Play. This will allow them to practise speaking with people to gather the information they need to try to determine the cause of the adverse event.

ACTIVITY 5: CREATE AN ACTION PLAN AND USE IT TO MONITOR PROGRESS

Distribute Tool 5-4, COMM Action Planning and Monitoring Tool: Tracking Community Health. Review the goals listed. The goals can also be thought of as minimum standards or key success factors for the COMM. The group members should indicate the activities they will undertake in order to receive quarterly information from CHWs and the health clinic, if applicable. They should also think through what they must do to make sure they learn of any disease outbreaks. They should develop a system for keeping track of adverse events – a notebook or a file where they maintain these records. All of these activities should be added to the form. The COMM secretary or a volunteer will be responsible for keeping this final version updated. Once again, you, as facilitator, should request a copy of this form every quarter so that you, too, can track the group's progress.

ACTIVITY 6: KNOWLEDGE ASSESSMENT FOR SESSION 5

As you close Session 5, ask the COMM to respond to each of the following statements as either 'true' or 'false' in order to assess the members' general understanding of the material. Allow the group time to discuss and agree on a collective response to each before it answers. If the group answers incorrectly, you will know that you need to revisit this information with the group before proceeding to the next session.

1. As the COMM tracks behavioural practices over time, conducting quarterly FGDs with community members is the recommended approach. *(Answer: FALSE)*

2. The COMM should communicate closely with CHWs to stay alert to new challenges or problems that are emerging and to determine ways that the COMM can respond. *(Answer: TRUE)*

3. If a disease outbreak or adverse event occurs, the COMM should take a leadership role in community-level tracking, investigating and reporting cases. *(Answer: TRUE)*

TOOL 5-1. COMMUNITY HEALTH TRACKING FORM

	Desired Behaviours	Percentages (from CHW data)				Comments
		Q1	Q2	Q3	Q4	
	**Pregnant Women: Adequate Diet**					
1	Pregnant women take one additional meal and an extra nutritious snack each day					
2	Families use iodised salt					
	**Pregnant Women: Iron Folate and De-worming**					
3	Pregnant women take iron-folate tablets every day for at least six months during pregnancy					
4	Pregnant women consume locally available, iron-rich foods such as fish, red meat, green leafy vegetables					
5	Pregnant women seek and take deworming tablets					
6	Pregnant women wear shoes					
	**Pregnant Women: Tetanus Toxoid**					
7	Pregnant women go for their tetanus toxoid injections					
	**Pregnant Women: Malaria**					
8	Pregnant women sleep under a specially treated bed net every night					

	(Tool 5-1 continued) **Desired Behaviours**	**Percentages (from CHW data)**				**Comments**
		Q1	**Q2**	**Q3**	**Q4**	
9	Pregnant women receive two or more doses of malaria prevention at the health clinic during their pregnancy					
10	Pregnant women with malaria are treated with correct drugs/medication					
	Pregnant Women: Birth Preparation					
11	Pregnant women work less, rest more					
12	Households prepare for birth with clean supplies at home for mother and infant; transportation is pre-arranged					
13	Families are prepared to go quickly to a facility if the woman experiences a danger sign or complication					
14	Husbands and families have access to financial resources for expenses related to the delivery					
15	Women avoid smoking, alcohol and illicit drugs during pregnancy					
	Pregnant Women: Healthy Timing and Spacing of Pregnancies					
16	Couples know about the health risks and benefits of using a family planning method					
17	Couples who desire another pregnancy after a live birth wait 24 months (preferably 36), but no more than 53 months					
	Pregnant Women: Health Services – Antenatal Care					
18	Pregnant women seek/demand antenatal care (ANC) services					
19	Husband/partner or other family member accompanies pregnant women to ANC visits					

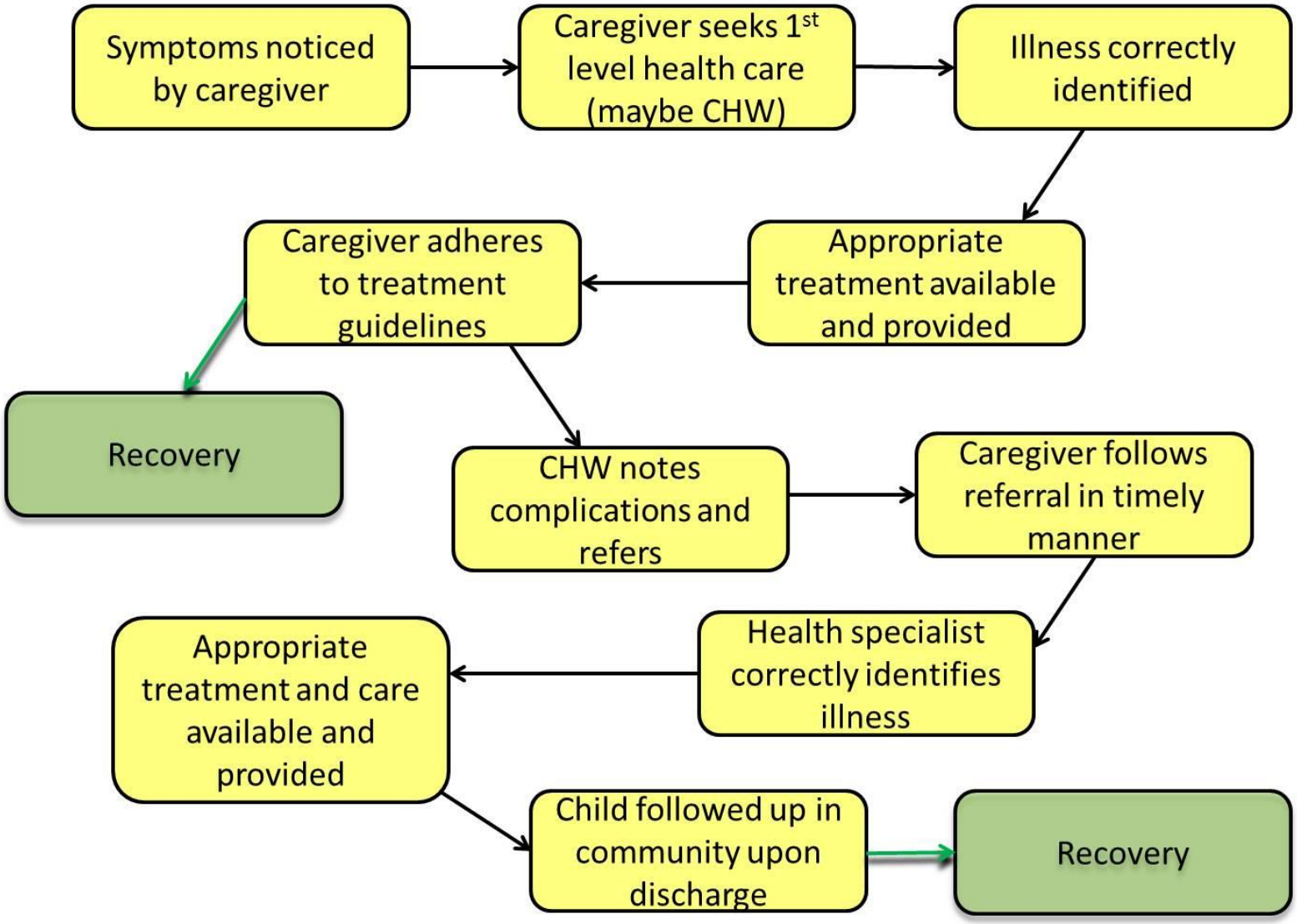
	(Tool 5-1 continued) Desired Behaviours	Percentages (from CHW data)				Comments
		Q1	Q2	Q3	Q4	
20	Pregnant women choose to get HIV testing and deliver at a facility					
21	TB+ pregnant women register with Directly Observed Treatment Short Course Strategy (DOTS) and follow treatment, completing the drug regime					
	**Pregnant Women: Health Services – Skilled Birth Attendant**					
22	Pregnant women and their family consider it a priority to give birth at a health facility					
	**Pregnant Women: Health Services – Postnatal Care**					
23	Women go to health facility for postnatal care for themselves and their newborn babies					
	**Children Under 2: Essential Newborn Care**					
24	Mothers practise cleaning of eye and cord care					
25	Mothers put baby to breast, wrap and cuddle skin to skin					
	**Children Under 2: Appropriate Breastfeeding**					
26	Mothers feed the baby exclusively breast milk until baby reaches 6 months of age					
27	Mothers continue to breastfeed their child for up to 24 months					
28	Mothers continue and increase breastfeeding during child's illnesses					
29	Mothers breastfeed on demand					
30	Mothers give the colostrum to their babies					
31	Mothers give no liquids or other foods before breast milk is offered					

	(Tool 5-1 continued) Desired Behaviours	Percentages (from CHW data)				Comments
		Q1	Q2	Q3	Q4	
32	Caregivers do not give the child any bottles					
	**Children Under 2: Handwashing with Soap**					
33	Families understand the importance of toileting facilities and use them					
34	Families understand the importance of keeping a clean hand-washing station with an effective product (soap, lime/lemon or ash) in or near the house and use it					
35	Caregivers wash hands with soap before cooking, eating and feeding baby and after toilet and disposal of faeces					
	**Children Under 2: Appropriate Complementary Feeding**					
36	Caregivers provide variety of food that includes animal-source foods using responsive feeding techniques					
37	Caregivers understand the function of the growth card and take child to growth monitoring every month until immunisations are completed, then every two to three months					
	**Children Under 2: Adequate Iron, Anaemia**					
38	Caregivers recognise local, iron-rich foods (animal-source including insects and fish, and dark green leafy vegetables) and feed to the child, or give iron-fortified complementary food					
	**Children under 2: Vitamin A Supplements**					
39	Caregivers give vitamin A-rich foods to their children, including fruits or vegetables (yellow or orange in colour) and animal-source foods					

	(Tool 5-1 continued) Desired Behaviours	Percentages (from CHW data)				Comments
		Q1	Q2	Q3	Q4	
40	Caregivers seek vitamin A capsules for children 6–59 months old					
	**Children under 2: Oral Rehydration Therapy (ORT) and Zinc**					
41	Caregivers understand that children with diarrhoea need more fluid and for children under 6 months, this is breast milk only					
42	Caregivers practise threefold oral rehydration therapy (ORT) approach: oral rehydration solution (ORS); zinc; continued breastfeeding and complementary foods, if appropriate					
43	Caregivers recognise the signs of severe dehydration and take the child to a healthcare facility for skilled care					
44	Caregivers know definition of diarrhoea and signs of dehydration (three or more liquid stools per day)					
	**Children Under 2: Malaria**					
45	Caregivers recognise the danger signs of malaria and take child to the health facility					
46	When child is given antimalarials, caregivers ensure that child takes medication promptly					
47	Caregivers keep children under bed nets (LLINs) every night					

	(Tool 5-1 continued) Desired Behaviours	Percentages (from CHW data)				Comments
		Q1	Q2	Q3	Q4	
	**Children Under 2: Full Immunisation for Age and De-worming**					
48	Caregivers seek immunisations at health facility					
49	Caregivers ensure that the child's health card is updated after each visit to the clinic and keep the card safe					
50	Caregivers ensure child receives de-worming medication starting at 12 months of age					
51	Caregivers ensure that when child begins to walk, he or she wears shoes					
	**Children Under 2: Acute Respiratory Infection**					
52	Caregivers recognise the danger signs of pneumonia and take child to health facility					
53	Caregivers seek treatment for pneumonia in children and complete the full course of medication					
	Children Under 2: Paediatric HIV and TB					
54	Infants born to HIV+ mothers are tested four to six weeks after delivery and receive appropriate care (PMTCT)					
55	Caregivers recognise the importance of infants born to HIV-positive mothers getting specialised PMTCT services					
56	Family members understand the correct ways to prevent mother-to-child transmission of HIV					
	Children Under 2: Birth Registration					
57	Caregivers register the infant's birth during the first month of life					

TOOL 5-2. CHAIN OF CARE FLOWCHART



TOOL 5-3. ADVERSE EVENT INVESTIGATION ROLE PLAY

Print this page and cut the list of characters below into individual slips. Ask for volunteers to play those characters, giving them the slips of paper with information about their roles. The rest will play COMM members who will talk to each of these characters to try to find out why Ruth's' baby (see scenario below) was born underweight and then died. They can approach the characters in any order they like.

Tell the characters that they are free to elaborate on the information given. It is just provided for guidance so the COMM can piece together the story.

Read the following scenario to the whole group. Then have the 'COMM' visit each character and ask questions to try to discover the cause or causes of the adverse event.

> Ruth gave birth to her first child six weeks ago. She was pregnant for the full term and the birth was normal, but the baby was underweight. The baby died after four weeks.

Clinic staff: We saw her once during her pregnancy. That was when we confirmed she was pregnant. She did not come for any antenatal care visits.
Ruth: There is a CHW in my village. Her name is Roxanna. She is very nice. She came to my house once and shared some information with me. It took a lot of time though. When she came a second time, I had to turn her away because I didn't have time to chat.
CHW: I visited Ruth in the first term of her pregnancy and informed her about the importance of diet and rest. I also encouraged her to go for regular antenatal care visits. She listened attentively, but I wasn't convinced that she would follow the recommendations. I looked forward to visiting her again to check up on how everything was going and to reinforce the information from my first visit. But when I visited her the second time, she turned me away, saying she was very busy.
Ruth's partner: We did not talk much about the pregnancy or if there was anything she needed to do differently because she was pregnant. So here in the house, everything was normal.
Ruth's best friend: I told her she needed to rest more, but from what I could tell, she was working as much as she usually does in her fields, even in her last month of pregnancy.
Ruth's mother: I noticed that her diet seemed the same as usual, and as she came close to full term her belly was not as big as I would expect. So I was concerned, but I don't interfere with her personal affairs.
Ruth's neighbour: I see Ruth and her partner together often. She works very hard. Her partner has an even temperament as long as she doesn't raise a fuss about anything. Then he reminds her he's the boss.

TOOL 5-4. COMM ACTION PLANNING AND MONITORING TOOL: TRACKING COMMUNITY HEALTH STATUS

TRACKING COMMUNITY HEALTH STATUS

Name of COMM: _____ **Year:** _____ **Quarter: Q1** _____ **Q2** _____ **Q3**____ **_Q4** _____

Instructions: Fill out the table below with the activities the COMM will undertake to track the community health status. Tick the boxes under 'Goals' only when the activities are complete and the goals have been achieved.

Goals

☐ We received data from CHWs this quarter and used it to update our community health tracking forms.

Were there any adverse events this quarter? Yes _____ No _____

☐ If there were any adverse events this quarter, we investigated their cause and took any necessary action.

Were there any outbreaks of disease this quarter? Yes _____ No _____

☐ If there were any disease outbreaks this quarter, we reported them to the health authorities.

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

(Tool 5-4 continued)

COMM Activities	Who	Resources	Planned Date to Complete	Date Actually Completed	Comments

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