

# Global Future

Number 1, 2007

A WORLD VISION JOURNAL OF HUMAN DEVELOPMENT



**THIS EDITION**

## Children's health in crisis: community, national and international responses

### FEATURING

**Jens Stoltenberg**

Prime Minister of  
Norway

**Ann Veneman**

Executive Director,  
UNICEF

**Joy Phumaphi**

Vice President and  
Network Head of  
Human Development,  
The World Bank

**Francisco Songane**

Partnership for  
Maternal, Newborn  
and Child Health

# contents

Number 1, 2007

- 1 Impatient for revolution**  
ANNE PETERSON
- 2 Global solidarity for maternal and child health**  
JENS STOLTENBERG
- 4 Closing the gap: children and the Millennium Development Goals**  
ANN VENEMAN
- 6 The crisis in children's health**  
JOY PHUMAPHI
- 8 Malnutrition, an underlying cause of child mortality**  
CAROLYN MACDONALD
- 8 Setting children free to grow**  
NARANTSETSEG TSEVEGSUREN & JUSTIN DOUGLASS
- 10 The power of positive mothers**  
JACQUELINE LINO & GLADYS RUIZ
- 12 Communities fight TB, save children's lives**  
MARY GRACE GAYOSO
- 14 Linking up for infant and maternal health**  
REENA SAMUEL & BEULAH JAYAKUMAR
- 17 Building child health into HIV and AIDS programming**  
JEFF DYKSTRA & BRUCE WILKINSON
- 18 Long walk to treatment**  
MARTHA NEWSOME & ANNE PETERSON
- 19 Partnership for Maternal, Newborn & Child Health: the "continuum of care" approach**  
FRANCISCO SONGANE
- 21 The G8: an opportunity to achieve health care for all**  
ANNA MARRIOTT & MAX LAWSON
- 22 World Vision health: re-focused and re-energized**  
ANNE PETERSON
- 24 Wisdom, stature and grace**  
ANNA GRELLERT

# Letter

from a reader

Prakash Lal

POSTAGE

Greetings from Helsinki!

Thank you so much for Global Future magazine.

I am a great supporter of World Vision. From World Vision I've learnt many fundamentals for humanitarian and development work. I shall be eternally grateful to the agency.

God Bless World Vision and the work it does for the poor.

Prakash Lal  
Coordinator for Development Cooperation  
Fida International, Finland

## what next?

in number 2, 2007

### Can we close the education gap?

The right to an education is recognised as one of the most fundamental human rights, benefiting individuals and strengthening whole communities and civilisations. Access to education for all is enshrined in the Universal Declaration of Human Rights, the Convention on the Rights of the Child, and national laws. In Millennium Development Goal 2, governments have pledged to ensure that all girls and boys complete a full course of primary schooling; Goal 3 and the "Education For All" goals agreed in Dakar in 2000 emphasise extending this pledge to secondary education.

Yet at the half-way point towards 2015, the gaps are daunting: 80 million children (44 million of them girls) are out of school, with marginalised groups (26 million disabled and 30 million conflict-affected children) continuing to be excluded. And while universal access is critical, it must be coupled with improved learning outcomes – in particular, children achieving the basic literacy, numeracy and life skills essential for poverty reduction. An estimated \$12 billion is needed annually to meet the EFA goals – including early childhood care and learning, life skills for young people, and a 50% increase in adult literacy – but donor pledges need to be closely followed by actual disbursements.

This edition of Global Future examines the effectiveness of the international community's efforts to achieve education for all, and what needs to change for the next seven years if the MDGs for education are to succeed.

**front cover image:** Malnutrition caused five-year-old Mugiranza (left) to contract kwashiorkor – swelling his face and body, turning his hair and skin orange, and stunting his growth. His stunting is obvious when compared to healthy 18-month-old boy Samuel (right). Mugiranza is receiving life-saving treatment at Cyanika Health Centre in Rwanda.  
**photo:** Jon Warren/World Vision

**facing page background image:** Ten-year-old Ronald Mugwanyu (left), of Uganda, shares a book with his friends. Ronald, who lost his own mother to AIDS, wants to become a doctor to help sick people in his community.  
**photo:** Margaret Alerotek/World Vision

Global Future is published by World Vision International to encourage debate and discussion on development issues.

World Vision

**Publisher:** Dean R Hirsch, **Editor:** Heather Elliott, **Editorial Assistant:** Marina Mafani, **Editorial adviser:** Ted Vandelooy, **Contributing correspondents:** Denise Allen, Jan Butter, Kel Currah, Ruth Kahurananga, Paul Mikov, Joe Muwonge, Kirsty Nowlan, Jennifer Philpot-Nissen, David Westwood. **All opinions expressed in Global Future are those of the authors and do not represent the opinions of the World Vision organisation.** Articles may be freely reproduced, with acknowledgement, except where other copyright is indicated. Global Future is distributed to many NGOs and non-profit organisations in developing countries. Donations to support our production and mailing costs are very welcome (US\$20 suggested). **Correspondence and/or donations should be addressed to:** Global Future, World Vision International, 800 W Chestnut Ave, Monrovia, California 91016-3198 USA Telephone (1) 626-303-8811 Fax (1) 626-301-7786 e-mail: global\_future@wvi.org or World Vision, 6 chemin de la Tourelle, 1209 Geneva, Switzerland. Graphic design by Friend Creative (Australia). Printing by Pace Litho (USA).

www.globalfutureonline.org ISSN 0742-1524



# IMPATIENT FOR REVOLUTION

The success of the first child survival revolution, in the 1980s, is saving some six million lives each year. But communities are still rife with a milieu that allows disease and death. World-wide attention to AIDS, and more recently malaria, is jolting the world out of our complacency to recognise that more than 10 million children **still** die every year. This is equivalent to the deaths of half of the young children in the US, or the entire population of cities like Rio de Janeiro, Moscow, Shanghai, Lagos, Karachi, Paris, London. There is a growing interest, even impatience, in achieving the “child health” Millennium Development Goal – Goal 4: reducing child mortality by two-thirds by 2015.



UNICEF spearheaded the initial child survival revolution, and current Executive Director, Ann Veneman, reminds us of the past progress and of her agency’s renewed commitment to child survival. Norway’s Prime Minister Stoltenberg conveys the vital link between health and economics; indeed, the Prime Minister models political leadership as he increases funding from his own country and spearheads a global business plan for child survival. Dr Joy Phumaphi of the World Bank also emphasises how investing in health is crucial if countries are to break out of poverty. Dr Francisco Songane, building on his earlier success as Mozambique’s health minister, makes the case that the newly-consolidated global partnership PMNCH **can** facilitate national-level action to improve the health of mothers, newborns and children.

As the Millennium Development Goals reach their halfway point this year, there is global agreement that:

- we could achieve MDG 4 if we had sufficient political will
- we **cannot** achieve MDG 4 without addressing the needs of mothers (MDG 5)
- there are known cost-effective interventions that we aren’t implementing sufficiently
- we need a whole health system that is sufficiently resourced, in health workers and funds, and involves government and civil society working together.

While the world has been clarifying what works best in health, World Vision has been clarifying its own purpose and niche as a child-focused, community-based Christian organisation. This edition of *Global Future* shows glimpses of World Vision’s re-focused health strategy, which has strategically aligned our work with the wider global movement on health to help achieve our goals. The centre section shares examples of how World Vision’s strong community base re-invigorates our efforts to promote children’s well-being, with potential to significantly contribute to the MDGs. Malnutrition underlies more than 50% of child deaths, and World Vision’s community-based multi-sectoral response synergistically links nutrition and health with other sectors such as agriculture, safe water and household food security, for far greater impact – even without the more visible clinic or doctor. Similarly, harmonising work on AIDS and health in communities can bring new hope to those suffering from AIDS.

To turn MDG 4 into reality entails serving the poorest and most vulnerable: children caught in conflict areas, forgotten people, forgotten corners of urban slums, and inequities within and between countries. But the problem is **not** too big, if we each do our part – from supporting countries to implement quality health infrastructure, echoed in Oxfam’s call on the eve of the 2007 G8 meetings, to mobilising prevention and care at family and community level.

World Vision seeks to transform our “heart for children” into a focused, professional response that enables parents and mobilises communities to care for the health of their own children. Our hope and prayer is for the necessary groundswell of political will for a new child survival revolution. The cost of inaction is huge – lost economic and intellectual potential and millions of lives. The cost to respond is small. ■

**Dr E Anne Peterson is Director of Global Health for World Vision International.**



# GLOBAL SOLIDARITY FOR MATERNAL AND CHILD HEALTH

Prime Minister Jens Stoltenberg explains how and why Norway has made a special commitment to Millennium Development Goals 4 and 5, focusing on child mortality and maternal health.



"My family is healthy. My life has changed," says Mrs Kham, 27, of Laos. She and Anoy, 8 months old, benefit from World Vision's support and training to district health workers and clinics which have more accessible drop-in hours for women who are pregnant and with young children. Photo: Albert Yu/World Vision

What we do for mothers and children of the world will be our legacy as political leaders. Their health reflects the state of our society. As such, an investment in their health represents investment towards social development and the future of our countries.

As the Prime Minister of Norway, I see a need to mobilise world leaders, civil society, corporations and global institutions to take the necessary and courageous steps to protect the health of our mothers and children – steps to secure our common future. We need to foster global solidarity for maternal and child health.

## THE MORAL IMPERATIVE

We all – as individuals and as societies – have a moral imperative to respect, protect and fulfil the rights of women, their newborns and children. Most countries have ratified international human rights treaties and conventions which protect their rights to have a safe pregnancy, childbirth and healthy upbringing. And we know it can be done in a cost-effective manner.

Yet more than 500,000 women still die from pregnancy-related causes every year; three million stillbirths occur and more than 10 million children die before their fifth birthday – nearly 40% of these in the first month of life. This is only the tip of the iceberg, as for every neo-natal death, at least another 20 suffer birth injury, infection, complications of pre-term birth and other newborn conditions.<sup>1</sup>

Over 300 million women in the developing world currently suffer from short-term or long-term illness brought about by pregnancy and childbirth.<sup>2</sup> Unless efforts are stepped up radically to meet this large unfinished agenda, there is little hope of eliminating avoidable maternal and child mortality.

It is an unfair reality. Among all health statistics, those related to maternal, newborn and child health show the greatest disparity between developed and developing countries. More than 99% of maternal deaths and 98% of child deaths occur in poor countries.

## A GOOD INVESTMENT

Prosperity can bring better health. At the same time we now know that health is fundamental to

economic growth. The provision of health services is not an expense, it is an investment.

As an economist, I am convinced by the research in recent years that shows the economic benefits that accrue from investing in health in general, and in maternal and child health in particular. Professor Bloom and colleagues have shown that one third to half of the growth in East Asia from 1965 to 1990 could be attributed to reduced child mortality and its consequences.<sup>3</sup> More recently, Bloom *et al.* found that the economic returns from vaccination of children is a staggering 12–18% on an annual basis.<sup>4</sup> Scientists have also estimated that, between 1965 and 1990, child morbidity and mortality rates contributed to stifling economic growth in Africa and to about half of the unfavourable gap in economic growth rate between Africa and the rest of the world.<sup>5</sup> The health of our women and children affects the economic health of our nations.

## COMMITTED TO MDGs 4 & 5

Seven years ago in 2000, I was one of nearly 200 leaders of UN member states that signed the Millennium Declaration. We laid out the common vision for global development, adopting the eight Millennium Development Goals (MDGs) – thus addressing the main challenges of our time.

## The problem doesn't need a technical solution, but political leadership, resources and action

My government is a strong supporter of all the Millennium Development Goals. But we have decided to make a special commitment to MDGs 4 and 5.

MDG 4 specifically addresses child mortality and we agreed to reduce child mortality by two thirds by 2015. MDG 5 focuses on improving maternal health by reducing the maternal mortality ratio by three quarters between 1990 and 2015. Both these goals are crucial in reducing perinatal and neo-natal deaths.

Reducing maternal, infant and child mortality requires putting knowledge into policy and

practice. It is not a problem in need of a technical solution – cost-effective interventions already exist;<sup>6</sup> it is a problem that requires political leadership, additional resources and action.

The time for concrete action is now. We are at a half-way point between 2000 and 2015. The momentum for a global campaign is building and I want us to exploit this potential. It is a source of hope for the world's children and mothers.

Even though progress has been slow and is increasingly uneven between the poor and the rich countries, with some well behind the 50% achievement of MDGs 4 and 5, there is light in the tunnel:

- We are already seeing an unprecedented political will globally to improve maternal and child health.
- Most countries have plans in place to attain MDGs 4 and 5. Regional frameworks are being finalised and adopted.
- The environment for aid and development has improved, with a higher public profile and new commitments from donors and governments. There is a need to ensure that promises are kept, and that resources aimed at countries and districts reach those areas and people in need.
- UN reform offers a new opportunity for a better utilisation of resources. UNICEF, the World Health Organization and the UN Population Fund (UNFPA) are in the process of working out ways of collaborating around MDGs 4 and 5.

My government will increase its contribution and efforts towards the attainment of MDGs 4 and 5. I also feel it is important to exploit the global impetus that has been created through the newly established Partnership for Maternal, Newborn and Child Health, which has its secretariat in Geneva.

### **NORWAY'S EFFORTS TO ACHIEVE MDGs 4 & 5**

I feel we can demonstrate good progress in many areas, which we need to now build on and take to scale.

Our MDG 4 and 5 efforts need to be multi-faceted, integrating

maternal, newborn and child health programmes. We must focus on the need to provide a continuum of care.

The interventions needed to reach the MDG targets range from building sustainable health systems, providing vaccines and clean water, expanding education for girls, the empowerment of women, to establishing international alliances and partnerships.

Norway is a major contributor to UNICEF, WHO and the Global Fund to fight AIDS, Tuberculosis and Malaria, all of which contribute to the fight against preventable maternal and child mortality.

### **Maternal, newborn and child care are often the entry point for family health services**

In the field of vaccination, Norway has heavily supported the GAVI Alliance (Global Alliance for Vaccination and Immunisation) since its launch in 2000. Over 150 million children have received hepatitis B, Hib, yellow fever and/or basic vaccines with GAVI support. According to UNICEF and WHO, this has saved 2.3 million lives.<sup>7</sup>

Our increased Norwegian MDG 4 and 5 efforts will also encompass strengthening bilateral co-operation with several large countries (India, Pakistan, Tanzania and possibly Nigeria) to accelerate implementation of national plans at sub-national levels. A pre-requisite for these partnerships is that MDGs 4 and 5 have political backing at the highest level, that the country's own health programmes are to be supported (not establish something new) and that they must reach out to the poorest communities.

Maternal, newborn and child care services are a cornerstone of public health services. Services for pregnant women are often the entry point for health services to the family and community to prevent and treat malaria, STI and HIV, as well as family planning and other services such as immunisations, nutritional advice and other health programmes and interventions.

### **PLAN TO ACCELERATE DELIVERY**

Together with our international partners we are developing a concrete Global Business Plan to accelerate the progress towards MDGs 4 and 5. The plan will provide necessary political impetus at the highest level to facilitate country-led action. This plan will:

- Explain, outline and focus on raising the additional resources that are needed to attain MDGs 4 and 5.
- Integrate the best management practices of the global initiatives into one national plan that is designed around needs at the local level. We hope to ensure that existing programmes, initiatives and mechanisms aimed at reducing maternal and child mortality are better organised.

This results-based strategy will allow maximal flexibility of resources at the local level. The Global Business Plan is a tool for mobilisation.

Success, or the bottom line, will be measured in terms of saved lives – in reductions in maternal, newborn and child mortality. We have to succeed. ■

**His Excellency Jens Stoltenberg is Prime Minister of Norway.**

<sup>1</sup> World Health Organization, *The world health report 2005: Make every mother and child count*, Geneva, 2005, p10

<sup>2</sup> *ibid.*

<sup>3</sup> D E Bloom and J G Williamson, "Demographic transitions and economic miracles in emerging Asia", *World Bank Economic Review*, 12(3), 1998, pp 419–55

<sup>4</sup> D E Bloom, D Cuning, M Weston, *World economics*, 6(3), 2005, pp 15–39

<sup>5</sup> D E Bloom and J D Sachs, "Geography, demography and economic growth in Africa", *Brookings Papers on Economic Activity*, Washington DC, Brookings Institute, 1998, pp 207–95

<sup>6</sup> L P Freedman, R J Waldman, H de Pinho, M E Wirth, A M Chowdhury, A Rosenfield, "Transforming health systems to improve the lives of women and children", *The Lancet*, (365), 2005, pp 997–1000

<sup>7</sup> See <http://www.gavialliance.org>



# CLOSING THE GAP: CHILDREN AND THE MILLENNIUM DEVELOPMENT GOALS

*Now is the key time for the world community to act to save the lives of six million children every year, urges UNICEF's Executive Director.*

Every year millions of children die of largely preventable conditions, some 40% within the first month of life. More than half a million women die as a result of maternal causes, most during delivery or in the first few days thereafter. For every woman who dies of maternal causes, approximately 20 more suffer injuries, infection and disabilities in pregnancy and childbirth. In addition, hundreds of millions of women and children are under-nourished, or have an illness or long-term disability.

However, there are reasons to be optimistic. In 1960, there were more than 20 million deaths among children under five every year. By 1990, the number had fallen to an estimated 12.9 million deaths and by 2005, the number was around 10 million deaths annually – a 50% reduction since

1960, and a 20% reduction since 1990.

## CURRENT TREND

If we are to reach MDG 4 (two-thirds reduction in the under-five mortality rate between 1990 and 2015), the number of under-five deaths will need to be reduced to 4.3 million per year. We will then be saving an additional six million children's lives every year. Evidence suggests that preventing the majority of these deaths is entirely feasible with a set of simple, low-cost interventions. As shown in the graph (right), between 1990 and 2005 there has been strong progress in Asia and the Pacific.

However, Africa must remain a focus for our efforts. While the population has also increased, the number of deaths among children under five in sub-Saharan Africa has increased from an estimated 4.1 million in 1990 to 4.9 million in 2005. At the current rate of progress on MDG 4, Africa will account for more than 57% of all global deaths among children in 2015, and we will be several decades behind on reaching MDG 4.

Two major challenges on the continent need to be urgently addressed.

The first is the **HIV pandemic**. While an estimated two million people are now receiving anti-retroviral therapy in low- and middle-income countries (or 28% of the estimated 7.1 million requiring treatment), the percentage of pregnant women receiving services to prevent mother-to-child transmission (pMTCT) is only around 11%, and only around 15% of children requiring treatment receive it. In addition, less than 4% of infants requiring cotrimoxazole prophylaxis receive it. In 2005 there were an estimated 15 million children who have lost one or both parents to AIDS, and around 80% live in sub-Saharan Africa.

The second major challenge is **conflict**. Of the 20 countries with the worst under-five mortality rates, 15 are or have recently been affected by conflict. Apart from Afghanistan, all of these countries are in sub-Saharan Africa.

## REPEATING SUCCESS

One of the best examples of progress in recent years has been in the area of measles.

The Measles Initiative, spearheaded by UNICEF, WHO, the American Red Cross, CDC<sup>1</sup> and the United Nations Foundation, set a goal of reducing measles-related deaths by 50% between 1999 and 2005. In fact, the goal has now been surpassed; measles-related deaths fell by 60% world-wide – a major public health success.

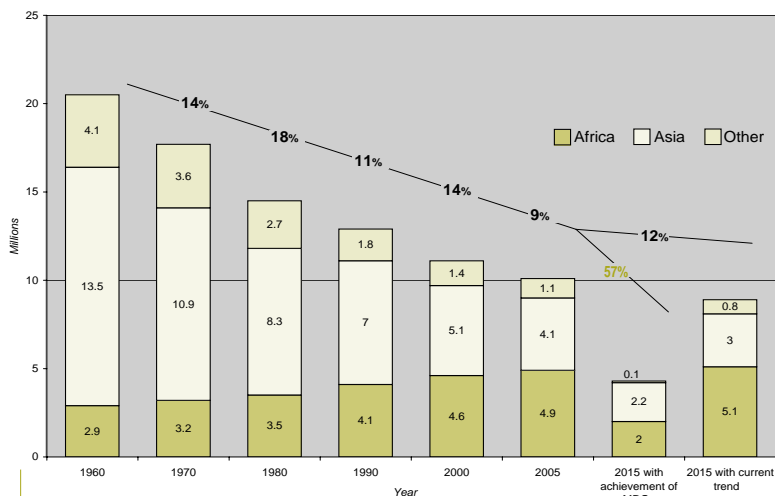
In Africa, the progress has been even greater: measles-related deaths fell by more than 75%. In 2006, more than 220 million children were vaccinated against measles with support from the Initiative, including over 30 million in Bangladesh alone. Much can be learnt from successful partnerships such as the Measles Initiative, and the lessons then applied to the MDGs.

**First**, clear and achievable goals need to be established. The MDGs provide the global framework for such goals, but they need to be translated into specific country targets for the number of lives saved per year, and into achievable and costed operational plans to improve the coverage of key evidence-based interventions.

**Second**, proven strategies and technologies should be used more widely. Integrated community-based programmes that deliver a package of high-impact interventions have demonstrated their effectiveness in reducing mortality. Such packages include immunisation, oral rehydration salts, vitamin A, insecticide-treated nets for malaria prevention, antibiotics for treatment of pneumonia and diarrhea, and encouraging mothers to breast-feed early and exclusively for six months.

In high HIV prevalence settings, pMTCT programmes linked to ante-natal care programmes and pediatric care and treatment programmes as a component of broader neo-natal and child health programmes are critical. Delivered at scale in parts of West Africa, preliminary results show that such packages have reduced under-five mortality by an estimated 20%.

Three critical components of such programmes are: the understanding that maternal health is intrinsically linked to newborn and child health; the focus on health systems strengthening at



Trend in under-five deaths, 1960–2015

Source: UNICEF, *The state of the world's children 2007*<sup>2</sup>

the district level; and the training of women to provide basic services at the community level. UNICEF will use the more than US\$1 billion that we already invest in health-related work every year to scale up such programmes with a particular focus on Africa and South Asia.

**Third**, communication and co-ordination among partners should be strengthened. Foundations such as Gates and new partnerships such as the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and UNITAID, the International Drug Purchase Facility, are providing important sources of financing and putting health at the top of the international development agenda. It is clear that no one organisation can achieve the MDGs alone. Comparative advantages must be clearly defined so that strategic partnerships can be formed on the basis of complementary strengths.

Government commitment and stewardship are critical conditions for sustainable success. Civil society, including non-government organisations such as World Vision, have a key role to play in implementation and in monitoring. In Ghana, local Red Cross women's groups have helped women learn and practise health promotion and basic health care. The business skills of the private sector represent an under-utilised resource that should be tapped more effectively.

**Fourth**, strong monitoring mechanisms are necessary to

ensure public accountability so that mid-course programme corrections can be made if required. For more than a decade, UNICEF has supported countries to collect statistically sound and internationally comparable data through the household survey programme, the Multiple Indicator Cluster Surveys (MICS).

Since 1995, more than 200 MICS have been implemented globally and MICS, along with the Demographic Health Surveys, provides the largest single source of information on the MDGs. UNICEF has now made a commitment to implement these surveys every three years so that almost all developing countries

have access to this important MDG and coverage data at regular intervals.

**Fifth**, successful national programmes should be documented and the results disseminated more widely. Several countries including Bangladesh, Brazil, China, Egypt, Indonesia, Mexico, Nepal, the Philippines and Vietnam are on track to achieve MDG 4 or have made strong progress in recent years. Cape Verde, Eritrea, Ethiopia, Malawi, Madagascar, Mauritius, Mozambique and Niger are all making strong progress in sub-Saharan Africa. The factors behind this success need to be explored and documented so that such experiences can be replicated.

**Finally** and most urgently, the world community needs to mobilise around this agenda. There is a rare but time-limited opportunity to demonstrate that, by working together, the lives of six million children can be saved every year. Let us grab it with both hands. ■

**Ms Ann M Veneman is Executive Director of UNICEF.**

<sup>1</sup> Centers for Disease Control and prevention, <http://www.cdc.gov/>

<sup>2</sup> Yearly under-five deaths are estimated using the number births at each one of the referenced years including projections through 2015 produced by the UN Population Division.



UNICEF Executive Director Ann Veneman visiting children and women at a UNICEF-supported project in India's Rajasthan state.

Photo: © UNICEF/HQ05-2284/Christie Johnston



# THE CRISIS IN CHILDREN'S HEALTH

*Good health creates a "virtuous cycle" of hope and opportunity, leading to economic growth which in turn enables further gains in health, argues Joy Phumaphi.*



*With good nutrition, health care and education, children can grow up to make positive contributions to their societies. This team of young people goes from street to street in the city of Mumbai, India, to present plays and talk to people about HIV and AIDS. "We have to do this", they say. "We see people dying, and people have so many questions".*

**Photo:** Jon Warren/World Vision

*"I hope you live without war,  
I hope you will always listen to your heart,  
I hope you will read lots of books,  
I hope you will be happy"*

– message from child to child<sup>1</sup>

Life is the most precious gift known to humanity. It is also the most demanding gift to care for and develop to its full potential, yet it can give the highest return on investment. As it turns into productive human capital, it creates and sustains wealth, and promotes economic growth and development for families, communities and countries. There is conclusive evidence that every additional year of education increases earning potential by as much as 11%.<sup>2</sup>

For the greatest level of healthy human development to occur, cognitive skills have to be maximised through good nutrition and stimulation in early childhood.

Yet the reality for children in developing countries is a harsh one that the world cannot ignore:

- Every minute, 20 children under the age of five years die. This means that nearly 30,000 children die every day, more than 10 million every year.<sup>3</sup>
- Every minute, a woman dies from complications in pregnancy and childbirth. This means that 1400 women die every day, more than half a million every year, leaving behind orphans and depleted livelihoods.<sup>4</sup>
- About 99% of maternal deaths and under-five child deaths occur in low- and middle-income countries, particularly in sub-Saharan Africa and South Asia.<sup>4</sup>
- Within each country, mothers and children from the poorest families are most likely to die.<sup>3</sup>

Whenever a child's health is threatened, life is lost; sometimes in death, as in the above cases, but most times in blunted opportunity, lost learning potential, retardation, and a crippled future.

For developing countries to break out of poverty into a more promising, sustainable future, people must have universal coverage and access to key services such as health and education that lead to improvements in health outcomes, and create a virtuous cycle of more hope and more opportunity.

Good health boosts economic growth, and in turn, economic growth enables further gains in health. The dramatic increases in development assistance for health and shifts in the major partners involved in the global health architecture recognise the important link between investment in health and economic development.

## CHILD-FOCUSED

Where the earmarking targets one aspect of development for the world's children, another holds them back. Whilst one in every four newborns may remain unimmunised, over 200 million do not reach their full potential because they are stunted in their early childhood development years.

## The world's children need comprehensive, holistic development

Where global targeting is disease-specific, the children are often forgotten (childhood TB is under-reported and untreated in many developing countries); the children come last (pediatric anti-retrovirals (ARVs) are still not as readily available as adult doses); and the children are denied access (coverage of newborns through pMTCT<sup>5</sup> services in Africa is at 10%, whereas access to ARVs for adults is at 28%).<sup>6</sup>

Today, in addition to the World Bank, new multilateral organisations, initiatives and foundations have assumed prominent roles in financing health and nutrition, with a special requirement to reach children – among them the Global Fund with its work on improving children's health and nutrition. GAVI<sup>7</sup> and GAIN<sup>8</sup> are also carrying out special initiatives focusing on the health and well-being of children.

## COLLABORATION

The world's children need holistic development. If we, as global partners, want to create a better future for our children, then we have to reach them better – in a comprehensive manner.

In order to be able to deliver this level of support to the health sector, countries and development partners must respond to a critical call not just



for coverage and access, but for strengthening country systems for the protection, nurturing and development of children.

The World Bank and WHO have acknowledged their need to work more closely together, recognising their respective strengths, in keeping with the expectations both of member states and of key partners at global, regional and country levels. Building on these different factors, a WHO–World Bank dialogue has been held on a common vision and direction for strengthening the performance for health in low- and middle-income countries.

Global demographic shifts have tremendous implications for future generations. The world's population more than doubled in the second half of the 20th century, mostly from population growth in developing countries.

High population growth poses significant challenges to country efforts to alleviate poverty and to facilitate access to basic services. In these countries, generations of stunted development potential create a vicious cycle of poverty and desperation.

Where population control has been widely adopted, ageing populations place a heavier burden on the young, making it imperative that their earning potential be fully realised.

As countries strive to meet the targets of MDGs 4 and 5 to reduce child mortality and improve maternal health, partnerships have become crucial, and it is clear that:

- tasks are too great for one entity alone;

- traditional programmes cannot scale up without harmonisation and alignment;
- combined effort and consensus are required to mobilise resources;
- there is an urgent need to share knowledge, skills and experience; and that
- stakeholders must pool resources to reach underserved populations.

I believe we owe at least this much to help safeguard the future of humanity! ■

**Dr Joy Phumaphi is Vice President and Network Head of Human Development for the World Bank.**

<sup>1</sup> World Health Organization, *Commission on Social Determinants of Health Newsletter*

<sup>2</sup> DFID/HM Treasury, *Keeping our promises: Delivering education for all*, UK Government, 2006, p 4 [http://www.unescobkk.org/fileadmin/user\\_upload/efaf/EFA\\_News/EFA\\_News2006/DFID\\_EFA.pdf](http://www.unescobkk.org/fileadmin/user_upload/efaf/EFA_News/EFA_News2006/DFID_EFA.pdf)

<sup>3</sup> World Health Organization, *The world health report 2005: Make every mother and child count*, 2005, [http://www.ops-oms.org/English/DD/PUB/whd\\_toolkit.pdf](http://www.ops-oms.org/English/DD/PUB/whd_toolkit.pdf)

<sup>3</sup> Joy Phumaphi, *Poverty and health: Children held hostage. Working towards equity in child survival*, World Health Organization, 2006

<sup>5</sup> pMTCT: prevention of mother-to-child transmission

<sup>6</sup> UNAIDS, *2006 Report on the global AIDS epidemic*, [http://www.unaids.org/en/HIV\\_data/2006GlobalReport/default.asp](http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp)

<sup>7</sup> See <http://www.gavialliance.org>

<sup>8</sup> Global Alliance for Improved Nutrition, <http://www.gainhealth.org/gain/ch/EN-EN/index.cfm>

## Further reference



### The Lancet series:

- ▶ **Child survival (2003)** Examines where and when children are dying, how many child deaths could be prevented, the role of public health and putting knowledge into action for child survival [http://www.who.int/child-adolescent-health/publications/CHILD\\_HEALTH/Lancet\\_CS.htm](http://www.who.int/child-adolescent-health/publications/CHILD_HEALTH/Lancet_CS.htm)
- ▶ **Neo-natal survival (2005)** Provides global estimates of the cause of four million annual neo-natal deaths; evidence-based, cost-effective interventions to reduce this and scale up neo-natal care; and calls on country leaders and donor agencies to uphold their promises [http://www.who.int/child-adolescent-health/publications/NEONATAL/Lancet\\_NSS.htm](http://www.who.int/child-adolescent-health/publications/NEONATAL/Lancet_NSS.htm)
- ▶ **Child development in developing countries (2007)**
  1. Development potential in the first five years [http://www.ecdgroup.com/docs/lib\\_003525057.pdf](http://www.ecdgroup.com/docs/lib_003525057.pdf)
  2. Risk factors for adverse outcomes [http://www.ecdgroup.com/docs/lib\\_003514724.pdf](http://www.ecdgroup.com/docs/lib_003514724.pdf)
  3. Strategies to avoid loss of development potential [http://www.ecdgroup.com/docs/lib\\_003503959.pdf](http://www.ecdgroup.com/docs/lib_003503959.pdf)
- ▶ **Can the world afford to save the lives of 6 million children a year? (The Lancet, 2005)** Assesses the cost of delivering interventions proven to reduce child mortality and whether achieving MDG 4 is within the financial capacities of donor and developing countries [http://www.coregroup.org/resources/lancet\\_price\\_tag\\_paper.pdf](http://www.coregroup.org/resources/lancet_price_tag_paper.pdf)
- ▶ **State of the world's mothers (Save the Children, 2007)** Examines the latest child survival data and trends, and compellingly argues why the world must act to prevent under-five deaths [http://www.savethechildren.net/alliance/what\\_we\\_do/newsdesk/2007-05-08.html](http://www.savethechildren.net/alliance/what_we_do/newsdesk/2007-05-08.html)
- ▶ **Directions in development: Repositioning nutrition as central to development (World Bank, 2006)** Outlines why nutrition must be central to development, highlighting economic and social improvements that depend on this <http://siteresources.worldbank.org/NUTRITION/Resources/281846-1131636806329/NutritionStrategyOverview.pdf>
- ▶ **More than words? Action for orphans and vulnerable children in Africa (World Vision UK, 2005)** Monitors progress towards the UN Declaration of Commitment on HIV/AIDS <https://www.worldvision.org.uk/server.php?show=nav,51>

This listing is provided for research purposes, and does not imply that World Vision endorses the entire content of external sources.



## the World Vision Award for Innovation in Advocacy

### congratulations Maia Tsereteli, World Vision Georgia

Recognising the hard work and commitment of World Vision staff engaged in advocacy, this year we inaugurated the World Vision Award for Innovation in Advocacy.

Maia Tsereteli of World Vision Georgia received the award in May at the CIVICUS 7th World Assembly in Glasgow, Scotland. Maia's advocacy work on child welfare, carried out with personal commitment, motivation and integrity, has helped empower Georgia's Government and communities to address social problems through innovative approaches.

For more details on the excellent work of Maia and the other nominees visit <http://www.globalempowerment.org>



## MALNUTRITION, AN UNDERLYING CAUSE OF CHILD MORTALITY

The latter half of the 20th century saw significant reductions in child mortality in lower-income countries. Yet more than 10 million children under the age of five still die every year.<sup>1</sup> Over 98% of all child deaths occur in developing countries – 90% in only 42 countries.<sup>2</sup> Neo-natal disorders account for 37% of global child deaths, and in children who survive the newborn period the major causes of mortality are acute respiratory infections (19% of all child deaths), diarrheal diseases (17%), and malaria (8%).<sup>3</sup> Underlying these direct causes of death is childhood malnutrition, which is associated with more than half of all child deaths.<sup>4</sup>

Malnutrition reduces a child's resistance to disease. Even mild malnutrition weakens the immune system, rendering a child both more vulnerable to infection and less able to fight it. In turn, infections contribute to malnutrition, by depressing the appetite just when the body's effort to combat the illness is depleting stored energy and nutrients. This vicious circle of malnutrition and infection leads to ever-increasing weakness, and too often, to premature death.

"Malnutrition" encompasses a broad range of nutritional deficits, and relates both to quantity and quality of food. Often it's assumed that insufficient quantity of food, leading to inadequate intake of energy (kilojoules/calories) and protein, is the major nutritional problem in developing countries. Indeed, **protein-energy malnutrition** is a serious issue, and research has shown that even mildly underweight<sup>5</sup> children are twice as likely to die from infectious disease, while moderately or severely underweight children have a five- to eight-fold increase in mortality risk.<sup>6</sup> Yet in recent years it has become clear that **micro-nutrient malnutrition** (vitamin and mineral deficiencies) contributes substantially to the global burden of illness and mortality.

For example, vitamin A deficiency (responsible for 1.15 million child deaths annually<sup>7</sup>) increases a child's risk of death from diarrhea, measles and malaria by 20–24%,<sup>8</sup> while zinc deficiency raises the risk of death from diarrhea, pneumonia and malaria by 13–21%.<sup>9</sup>

Micro-nutrient deficiencies are also linked with functional problems such as morbidity from infectious diseases, compromised child development, reduced intellectual capacity and decreased work productivity.<sup>10</sup> Thus, widespread micro-nutrient malnutrition has major implications not only for the survival and health of affected individuals, but also for the development potential and economic situation of their communities and countries.

We cannot reach the Millennium Development Goal of reducing child mortality by two-thirds of 1990 levels by 2015 without substantively reducing child malnutrition. Malnutrition significantly hinders progress towards some other MDGs as well.<sup>11</sup> How needless this is, when micro-nutrient deficiencies and other forms of malnutrition are largely preventable through existing cost-effective interventions. In fact, providing micro-nutrients to populations with widespread deficiencies has been recognised as one of the best investments of development aid.<sup>12</sup>

Key nutrition interventions known to save children's lives include breast-feeding and complementary feeding, and vitamin A and zinc supplementation. Universal coverage of these interventions as an integrated nutrition package in the 42 countries with 90% of child deaths could save about 2.4 million children each year (25% of total deaths).<sup>13</sup> Combining nutrition interventions with management of common childhood diseases would reduce child deaths even more dramatically, and is an urgent global health priority. ■

**Dr Carolyn MacDonald is Senior Sector Specialist, Nutrition and Health, for World Vision Canada.**

<sup>1</sup> O B Ahmad, A D Lopez & M Inoue, "The decline in child mortality: A reappraisal", *Bulletin of the World Health Organisation*, 2000, 78:1175–91 <sup>2</sup> R E Black, S S Morris & J Bryce, "Where and why are 10 million children dying every year?", *The Lancet*, 2003, 361:2226–34 <sup>3</sup> WHO, *World Health Report 2005: Make every mother and child count*, 2005 <sup>4</sup> L E Caulfield, M de Onis, M Blossner & R E Black, "Undernutrition as an underlying cause of child deaths associated with diarrhea, pneumonia, malaria, and measles", *American Journal of Clinical Nutrition*, 2004, 80:193–8 <sup>5</sup> "Mildly underweight" is defined as at least one Standard Deviation below the international reference weight-for-age. <sup>6</sup> Black, Morris & Bryce, *op. cit.* <sup>7</sup> The Micronutrient Initiative, *Vitamin and mineral deficiency: A global damage assessment report*, 2003 <sup>8</sup> A I Rice, K P West & R E Black, "Vitamin A deficiency" in M Ezzati, A D Lopez, A Rodgers & C J L Murray (eds), *Comparative quantification of health risks: Global and regional burden of disease attributable to selected major risk factors*, WHO, 2004 <sup>9</sup> L E Caulfield & R E Black, "Zinc deficiency" in M Ezzati, *et al.*, *ibid.* <sup>10</sup> J M Hunt, "Reversing productivity losses from iron deficiency: The economic case" in "Forging effective strategies to combat iron deficiency", *Journal of Nutrition*, 2002, 132:794S–801S <sup>11</sup> World Bank, *Repositioning nutrition as central to development: A strategy for large-scale action*, 2006 <sup>12</sup> B Lomborg (ed.), *Global crises, global solutions*, Environmental Assessment Institute, Cambridge, 2004 <sup>13</sup> G Jones, R W Steketee, R E Black, Z A Bhutta & S S Morris, "How many child deaths can we prevent this year?", *The Lancet*, 2003, 362:65–71

## Setting children free to grow

### MONGOLIA

**"According to FAO estimates, 45% of Mongolia's population is considered under-nourished – in the Asia-Pacific region, second only to North Korea's 57%. Vitamin D deficiency and anemia are alarmingly common in Mongolia. One in two Mongolian children are anemic – usually caused by lack of iron. A third of pregnant women are anemic, a factor in Mongolia's high maternal mortality rate (about 157 per 100,000 live births). And one in three Mongolian children suffers from rickets – a painful bone-deforming disease caused by lack of vitamin D. Both conditions profoundly affect children's learning, play and growth, and if untreated, can cause permanent damage.**

**Traditional complementary foods for babies are nutrient-poor, consisting of flour- or rice-based porridge made with water or occasionally milk, sugar and butter. Other factors are inadequate feeding and weaning**



Above – Six-year-old Ganchimeg holds a sachet of 'Sprinkles', a low-cost vitamin/mineral powder added to children's food. Her legs have been deformed by rickets, but she is now much healthier and suffers less pain.

photo: Philip Maher/World Vision

Opposite page – Tsedevsuren and her twin sons  
photos: Justin Douglass/World Vision Mongolia

# Global

VOICES OF LIFE FROM AROUND THE WORLD

practices, and diarrheal and respiratory illness. But the food insecurity experienced by many Mongolians can be traced to the country's hasty shift from a centrally planned to a market-driven economy in the early 1990s. Jobs were lost when state-run industries shut down; domestic food production fell 70% when large state farms collapsed. A delay in emergency resources meant a shortage of most consumer goods, while inflation and the ailing tugrik currency decreased people's purchasing power. Consecutive dzud cycles (dry summer followed by extremely cold winter with heavy snow) aggravated falling grain production.

While some segments of the economy are reviving, macro-economic data can hide the fact that many families cannot access the basic necessities. Until economic growth occurs and its benefits reach most Mongolians, food insecurity and malnutrition look set to continue. National statistics indicate that about 20% of Mongolians are living below the poverty line. The most food-insecure are the unemployed, the elderly, female-headed households, children, pensioners and herders.

A World Vision survey in 1997 revealed that the average Mongolian household was spending over 70% of its income on food, leaving little for other daily needs. Some 22% of children under age five were chronically under-nourished. An assessment in June–July 2004 indicated that the food security situation had not improved much. Some families were borrowing to buy food. The price of imported rice keeps rising, and while in summer people can substitute cheaper foods, in winter/spring when other groceries cost more, many families' diets become unbalanced.

The World Vision nutrition programme in Mongolia has reduced the prevalence of micro-nutrient deficiency in children under age five, and in pregnant and breast-feeding women, through vitamin D and iron supplements. Our cross-sectional evaluation found that anemia prevalence in children aged 6–35 months fell from 55% (2000/1 baseline) to 33% (2003).

Key to this success are home-based fortification and improved breast-feeding practices. Community nutrition workers distribute "Sprinkles", a multi-micro-nutrient supplement for children aged 6–35 months; older children receive iron syrup. World Vision distributes rice to families during the critical winter/spring period. Using the "Hearth" approach, we've train mothers of well-nourished children to train and support other mothers – reaching some 10,000 urban and rural children. When people better understand nutrition, their attitudes and practices change. We also seek to strengthen Mongolia's nutrition policy – for example, fortification of staple foods. Meanwhile, research into the causes of childhood anemia in Mongolia continues." ■

Reported by Dr Narantsetseg Tsevegsuren, Health Director, and Mr Justin Douglass, Communications Coordinator, World Vision Mongolia

Factory workers **Tsedevsuren** and her husband live with their five children in Ulaanbaatar, the capital of Mongolia. Their youngest are three-year-old twin boys.



"My children often used to get sick," said Tsedevsuren sadly. One twin, Erdene-Sukh, had ear infections and used to vomit after meals; he also had acute respiratory infections and acute anemia. Both he and Erdene-Baatar, the other twin, were weak and underweight, with small appetites. They had abnormal-sized heads with stunted bodies. When sick, they did not sleep well and cried a lot. Those days were tough. "Life was difficult," said Tsedevsuren, looking down at the floor: "I had to take my children to hospital many times; I could not afford the bus fare and the medical expenses."

Things started to change when their sister, Bayarmaa, now aged 11, was sponsored by World Vision. The family received 150 kilograms of rice, plus clothing, school stationery and medical check-ups. At a summer Health Strengthening Camp, the twins received therapeutic massage and nutritious food including dairy products, while their family members and carers learned about making nutritious meals, correct massage, and the causes, symptoms and prevention of rickets, anemia and other common illnesses.



Tsedevsuren became a "volunteer mother" after seeing how much her children improved as a result of the nutrition programme. She received training in children's health; how to care for a child, such as proper bathing and dressing; complementary food cooking; identifying common childhood diseases; and where to get help. Now she teaches other mothers what she has learnt. Tsedevsuren is responsible for 12 other households.

"I like the World Vision nutrition training; it helps me to take care of my children. Now they don't get sick anymore," said a beaming Tsedevsuren. She adds: "I was once depressed and lonely... now I have self-confidence. Thank you for letting me understand what child care is all about." The older brother and sister who take turns babysitting have their hands full, as the twins are now healthy and more active, and their appetites have grown. They even like vegetables now!



"now I have self-confidence"

## The power of positive mothers

### PERU

*“In a community in the mountains of Peru, a strategy to influence behaviour has changed the lives of children who had been destined for chronic malnutrition. In the process, it has empowered their mothers.*

Ancaschaca, home to 82 families, 30% of whom have children under age five, is part of a World Vision Area Development Programme. Since 2002, a “Hearth” initiative has been underway here. Hearth’s premise is that solutions to community problems already exist within the community. It applies a strategy called “positive deviance” to help bring about behaviour change, and, through prevention, to reduce the prevalence of chronic malnutrition in girls and boys younger than five.<sup>1</sup>

An initial baseline study revealed that 64% of Ancaschaca’s children under five had chronic malnutrition. These children’s fate seemed decided: not to grow, learn or develop as they should. Thousands of Peruvian children are in this situation. We decided that we would try to change this reality. We began by raising the awareness of community and village authorities about these figures and their impacts. At first, they didn’t see the issue as important for all families. It seemed that families’ survival priorities revolved around their plots of land, their animals, and only then, their children.

Why was this? Something interesting about these early meetings was that the attendees who took the available seats in the community hall were mostly men. The few women who did attend sat on the floor, their eyes downcast. Only the men spoke, and they paid most attention to their fellow men. The authorities took an interest only in the works to be carried out that year: the school’s perimeter fence, or the clean-up of the road so that animals could more easily carry produce to the market. To the men, “development” focused on infrastructure, not people.

It was difficult to know what the women thought, since they didn’t have a voice nor vote in the communities. The few men who communicated often with the mothers were health promoters; they were the women’s main link with the programme. So, we invested time in empowering health promoters to have stronger voices in the community assemblies. Since fathers didn’t come to health meetings, messages about child health were directed to the community meetings.

#### Photos

Left – children in traditional dress  
Opposite – a community meeting

photos: World Vision Peru

Meanwhile, we held assemblies for the women, to brief them on the initial study’s results. At first, mothers’ participation was quite irregular; their husbands didn’t allow them to take part. But gradually, the men realised that the meals their wives served them were changing: no longer only potatoes or wheat or corn; now there were vegetables, eggs and fruit. Now they were washing the children’s hands more thoroughly, and dressing them in warmer clothes so that they didn’t catch colds... a range of behaviours that hadn’t been considered before but were significant for their children’s health. The women of Ancaschaca began to be recognised as more than “the ones who care for the children and small animals” – they became the main defenders of their children’s right to develop in the best conditions possible.

#### THE POSITIVE DEVIANCE APPROACH

After an initial “knowledge, attitudes and practices” survey, the next step was a “positive deviance” inquiry to identify the positive practices of the mothers who had healthy children despite similar circumstances.

We found that mothers could have well-nourished children if they initiated breast-feeding soon after birth, exclusively breast-fed until six months old and then introduced nutrient-dense foods. It was clear that certain household practices, such as giving a child his/her own plate, not withholding food to punish a child, hand washing (before meals, before food preparation, after changing nappies or after the toilet), and using toilets rather than open fields, all helped mothers to raise well-nourished children. Conversely, many of the mothers not following these practices had malnourished children.

The project helped the mothers to organise themselves, asking them to identify a “model” mother – one whose positive attitudes and behaviours influenced the good health and nutrition of her own children, even though she had no economic advantage; one who could be a clear leader, motivating the others to practice new behaviours, and accompanying them in the change process.

There weren’t too many mothers with all these capacities, but the women nominated as their “Mother Guides” women who worked energetically and were open to new learning and communication. They elected the most enthusiastic, dedicated, participatory ones, who knew a little about childcare and feeding, and didn’t have marital problems. (The work would involve visiting homes and leading practical sessions, on top of their family workload, so it was very important that their husbands accepted these activities.) These pioneers set an example so that little by little, other mothers felt they could take on the Mother Guide lifestyle.

It wasn’t easy at first. Mothers they visited threw them out or didn’t invite them in or accept their advice; some didn’t



Global  
VOICES OF LIFE FROM AROUND THE WORLD

# “I am happy to be a Mother Guide to my neighbours”

want to go to a venue outside their own home; others didn't want someone entering their home to watch them “in action”. But gradually, the Mother Guides' perseverance gained the other mothers' confidence.

The broader project continued building capacity of local authorities and women leaders to support children's well-being, through workshops, conferences and internships applying adult education methodologies. Mother Guides were trained in:

- introduction to the “Hearth” nutrition approach
- balanced eating and food preparation
- feeding for children under 12 months
- hygiene and control of acute diarrheal illnesses
- early stimulation for children under 12 months
- weight/height standardisation, and
- the importance of vaccination.

Trained Mother Guides replicated the sessions with groups of five other mothers. Some 80% of mothers of children under five participated. One important learning was the relative calorific values and costs of common local meals, such as quinoa (a grain) pie, or tarwi (lupin) with rice. Practical sessions have been shared with other relevant groups – such as those who supply fresh produce to the community. The community now respects these sessions as a space to learn, share one's experiences, grow as a human being, and have one's ideas heard. Most importantly, many children are healthier. In Ancaschaca and other communities covered by the ADP, there has been a **2% decrease in chronic malnutrition (stunting)** since 2002.

Sonia Rimachi Cruz, a 27-year-old woman with two boys aged 5 and 7, is a living example of “positive deviance”. Her children are healthy ones and despite her limitations, she has always struggled for them to have the best. From the start, Sonia proved her interest with consistent participation. She has always expressed her opinions, at first only among the women, now as an active participant in community assemblies.

Sonia is a Mother Guide, and thanks to her strong leadership skills she is now president of the local Rotary Fund Chickens Committee. Her community respects her. She says: “I am happy to be a Mother Guide – to be able to help my neighbours attain better practices for caring and feeding their children.”



Sonia harvesting potatoes with her family

The Mother Guides are now regarded as a local authority... and enjoy the respect and trust of the community men. Women now participate actively in the community assemblies: requesting the opportunity to speak, expressing their views – no longer seated on the floor but on the seats, once occupied only by men.

What began in the area of health turned out to be a holistic intervention in early childhood development, embracing economic development and education – going far beyond the chronic malnutrition which sparked off the intervention.” ■

Reported by Ms Jacqueline Lino, Food Security Special Project Manager, and Ms Gladys Ruiz, National Health and Nutrition Adviser, World Vision Peru

<sup>1</sup> Dr Gretchen Berggren, with her husband Warren, created the original Hearth model in Haiti in the 1960s and introduced the concept to World Vision in the 1990s. World Vision has since implemented it in numerous countries. The programme uses the “positive deviance” approach to identify positive behaviours practised by the care providers of well-nourished children and to transfer such practices to those with malnourished children. For background, see: <http://www.positivedeviance.org/pdf/fieldguide.pdf>



life  
UND THE GLOBE

## Communities fight TB, save children's lives

### PHILIPPINES

*“It takes no more than a single cough or sneeze from an untreated tuberculosis (TB) patient to infect 10 to 20 persons. This deadly disease does not discriminate by age, race or economic class. Every year, some 1.6 million people die of TB and the disease continues to kill.”<sup>1</sup>*

*In the Philippines, 75 people die every day of TB. On the World Health Organization (WHO) watchlist of countries having a high TB burden, the Philippines ranks ninth in the world and third in the western Pacific region.<sup>2</sup> The disease remains the country's sixth-highest cause of mortality and morbidity, and is still the major cause of death among children.<sup>3</sup>*

*In this country where a closely-knit family culture thrives, extended families commonly live under one roof, making transmission of airborne diseases highly probable. Researchers at the University of the Philippines discovered that immediate and extended family members were the most frequently mentioned infectious contact among children with TB. They found that the disease was transmitted to the child because of inadequate or non-treatment of the infectious adult, and that an adult with multi-drug resistant TB transmits those deadly strains to a child. The conclusion of this study stated: “Early case finding and adequate treatment is necessary to prevent excess mortality and morbidity among children and to prevent future disabilities brought about by inadequate or non-treatment. A contact investigation of the household should be initiated immediately when a child is suspected of having TB, to establish the diagnosis and guide therapy.”<sup>4</sup>*

*Occurrence of TB in children indicates continuous transmission of the disease in the community, with infection at an early age leading to future generations of adults with TB. Thus, curing the source of infection in children – usually the adults – is the key to prevent further spread of TB.*

World Vision training a TB task force



### MOBILISING COMMUNITIES

*The Social Mobilisation on Tuberculosis (SMT) Project of World Vision Philippines, a five-year project funded by the Global Fund to Fight AIDS, TB and Malaria (GFATM), has been finding and curing TB cases in the communities since 2003. Its unique approach to TB prevention and control is mobilising communities to fight TB.*

*In 1998, in response to an alarming rate of TB cases in the country, the Philippines had launched its first TB prevention and control programme. Called Kusog Baga (“Healthy Lungs” in Visayan), funded by the Canadian International Development Agency and implemented by World Vision, that initiative focused on establishing Directly Observed Treatment Shortcourse (DOTS)<sup>5</sup> infrastructure in selected provinces.*

*The SMT Project has been organising and training community TB task forces nation-wide to assist the National TB Program in discovering and curing more TB cases, and to increase the demand for DOTS therapy in the public and private DOTS centres in under-served poor populations.*

*The trained TB task force members identify people with TB symptoms for referral to public health facilities, act as treatment partners, conduct health education in villages, and conduct TB and DOTS awareness activities. Awareness activities include puppet shows, community drama, pageants, mall exhibits, village-based classes, election-style parades, sticker campaigns, and even community radio programmes. Some have organised “little TB task forces” to encourage children's participation in TB prevention and control.*

*TB task force members volunteer their time and efforts, with no monetary incentive. They are not doctors, nurses, or professional health workers. They are ordinary villagers – fishermen, farmers, teachers, housewives and others – who do something more than ordinary with their lives.*

*At the time of writing, 270 TB task forces benefiting over a million Filipinos have been organised by the project. These task forces have been of great assistance to health workers seeking out TB cases – especially with the number of Filipino health workers in the country declining due to the demand for their services abroad.*

*In World Vision's experience, any project implemented at the grassroots level will not succeed without participation and ownership of the communities involved. Local ownership and partnership paves the way for culturally*

Global  
VOICES OF LIFE FROM AROUND THE WORLD

and context-specific projects which are better understood and implemented, and which empower communities to sustain the project after funding ceases.

The success of this SMT Project, and the earlier Kusog Baga one, have led to the “grassroots task force” approach being adopted by the Philippines Ministry of Health as part of the national strategy in the fight against TB. Other countries in the region look to the Philippines as a pioneer in this approach, and World Vision also has adapted this approach in TB projects in Indonesia and India.

“even if  
I am poor,  
I still want  
to help”

The Global Fund has recognised the importance of national TB programmes harnessing community contributions to TB care, and of investing in advocacy and social mobilisation for TB control.<sup>6</sup> With the success of the first GFATM-funded TB project in the Philippines, the country was once again granted financial assistance to scale up and enhance the national TB programme. World Vision Philippines’ SMT Project continues to be the arm of the GFATM project, addressing this call for community participation in another TB project that will scale up the social mobilisation strategy until 2011... a renewed challenge to achieve the vision of a TB-free community for children.” ■

Report and photography by Ms Mary Grace Gayoso, Communication Specialist, Social Mobilisation on Tuberculosis (SMT) Project, World Vision Philippines

<sup>1</sup> World Health Organization, Tuberculosis fact sheet, 2007, <http://www.who.int/mediacentre/factsheets/fs104/en/>

<sup>2</sup> Department of Health, Manila, Technical briefer on the National TB Program, 2007

<sup>3</sup> *ibid.*

<sup>4</sup> C Pama & S Gatchalian, Clinical profile of culture-proven tuberculosis cases among Filipino children aged 3 months to 18 years, Department of Pediatrics, University of the Philippines, Manila, 2001

<sup>5</sup> DOTS is recognised by WHO as the most cost-effective strategy for curing TB, and it ensures treatment compliance of patients. The active TB patient has a “treatment partner” who ensures that s/he is taking his/her medicines daily for six months, observes the patient’s progress, and reminds the patient of his/her scheduled check-ups. A DOTS patient is neither admitted nor confined in a hospital, but is treated at home.

<sup>6</sup> Lawson et al., HIV/AIDS, tuberculosis and malaria: The status and impact of the three diseases, The Global Fund to fight AIDS, TB and Malaria, 2005

\* Names of TB-affected people have been changed to protect their privacy.



“Rosa” and “Josie”

The “Perez” family from the island of Palawan was saved from the deadly disease with the help of a TB task force member.

“Rosa” Perez and her 17-year-old daughter “Josie” contracted TB from Rosa’s husband. The task force quickly helped Rosa, her husband and daughter gain access to TB treatment.

Fortunately, her other four children were spared from the disease, and now the family is facing life’s challenges together with better health.

“Dilsy Oracion”, a 40-year-old housewife and TB task force member, lives in a small *nipa* hut in a village of Loboc, Bohol province. Her own economic difficulty does not stop her from helping those sick with TB. “Even if I am poor, I still want to help, because helping brings fulfillment and great joy in my heart,” she said.

Dilsy tirelessly walks two kilometres to visit people with TB symptoms in their village, and convinces them to submit their sputum to the health centre for examination. She became a treatment partner for 19-year-old “Edgar”, who is now cured. Edgar is a construction worker in the city and financially helps to send his younger siblings to school.

“Dilsy” encouraged “Edgar” to take his medicine



“now we have women telling other women about these practices”

**Manju Mathew**, World Vision India's Programme Manager of the Child Survival Project, speaks highly of the *Aganwadi* workers: "As each of them reaches out to 1000 people, they are the rubber that hits the road. Community mobilisation is easier, as women listen to these workers who are part of the community. But if the capacity of these workers is low then the community's health is also sub-standard."

A critical achievement, says Ms Mathew, is "the interface that was created by World Vision between the *Aganwadi* worker (under the ICDS) and the ANM (under the Ministry of Health), who meet regularly to follow up cases. This did not exist earlier." Another: "The targeted and timed counselling approach that World Vision developed has been adopted by the ICDS for the entire state of Uttar Pradesh."

She adds: "One of the challenges was partnering with the government officials at the various levels, but as we slowly started to dialogue and meet, it became a lot easier to implement and train the workers."

## Linking up for infant and maternal health

### INDIA

*"I know the community and its traditions, beliefs and practices, as I live here; I am related to many of the people in the village as a daughter, sister, aunt or mother-in-law, and this helped me reach out to many more women in my community."*

– Chattiya Devi, a 35-year-old *Aganwadi* worker with the Integrated Child Development Scheme (ICDS), the biggest child-focused programme run by the Government of India

### STRENGTHENING LOCAL NETWORKS

*"If Millennium Development Goals 4 (reduce child mortality) and 5 (improve maternal health) are to be achieved by 2015, success in improving child health indicators in India will be critical."*

Uttar Pradesh (UP) is India's most populous state with 166 million people, a density of 689 persons per square kilometre (vs 324 for India as a whole), and an above-average population growth rate (2.4% a year vs a national average of 1.9%). But UP also has a serious maternal and child mortality burden: the state's health indicators have lagged far behind the rest of the country; infant mortality is 82 per 1000 live births; there is an average of 517 cases of pregnancy-related female mortality per 100,000 live births (vs the national average of 301).<sup>1</sup>

Recognising that an attack on these health challenges would have far greater impact in densely-populated areas, World Vision set sights on UP's Ballia district, with its rural population of 2.5 million – and launched the **Ballia Rural Integrated Child Survival (BRICS) Project**, in partnership with USAID, in 1998. Interventions focused on areas critical to child survival in this region: increased immunisation<sup>2</sup> coverage, safe motherhood initiatives, increased coverage of family planning methods, essential care of the newborn, improved care during pneumonia and diarrhoea, and prevention of malnutrition and vitamin A deficiency.

This innovative child survival and reproductive health project sought to partner with and strengthen existing public, private and community health services, and to sustain and replicate best practices in reducing fertility and infant, child and maternal mortality. It focused on building capacity of key health actors, whether Ministry of Health or private sector employees: *Aganwadi* workers (AWWs), also known as community development workers (Gramin Swasthya Sevika or GSS); auxiliary nurses and midwives (ANWs); dais or traditional birth attendants; registered medical practitioners; and staff of the local Primary Health Centre, the Panchayat (village council) and other NGOs.

The project developed "integrated behaviour change" communications in the local language, such as flip charts with pictures and related text. It also developed registers for tracking pregnancy, infant feeding practices, inputs such as immunisation received by villagers, and maternal and infant health outcomes (including deaths). *Aganwadi* workers, each of whom reaches a population of 1000, were the main implementers. With the project's support, they enabled villagers to link up with health public services. Meanwhile, the project advocated and facilitated better supply and quality of essential health services.

### SCALE-UP AND PARTNERSHIP

Recognising that strengthening the ICDS and allied rural health structures in UP state required a systematic and sustained focus, the **Pragati Child Survival Project** began in 2003 to scale up methods and tools developed in the BRICS Project. The project focuses



on immunisation, family planning, maternal and infant nutrition, and vitamin A supplementation. It covers 3.25 million people including 312,404 children under the age of three and 714,000 married women of reproductive age, living in over 5000 villages in Ballia, Lalitpur and Moradabad districts of UP.

Partners are the Ministry of Health (which operates basic health centres at block and village level servicing most of the population); the ICDS, whose Aganwadi workers (AWWs) educate and link people to the government health system; and with local NGOs in Ballia and Lalitpur (which help co-ordinate and support AWWs and strengthen community-level linkages).

The project designed and helped implement registers for identifying and tracking beneficiaries, and has trained and supported workers in delivering agreed behaviour change messages to mothers and families. In a "targeted and timed" approach, counselling is aimed at those who would practise the behaviours and those who would influence them, and is timed so that people receive the messages neither too early nor too late, making behaviour change more likely. This constitutes a "continuum of care" that begins in early pregnancy and lasts until the end of infancy, covering all the interventions of the project.

- **At village level:** The project supports routine identification and registering of pregnant women and newborns, provides timed counselling, and brings villagers to ANW or AWW outposts for immunisation and family planning services. A standard supervisory checklist enables findings from one month to inform the next month's activities. In line with Ministry of Health plans, the project facilitates bi-annual vitamin A supplementation rounds. Men's meetings help to sensitise fathers and husbands to support the women in their families in practising the key health behaviours – a need that we identified through a "doer/non-doer analysis".
- **At block level:** Project staff organise monthly meetings for health and ICDS officials, and for all ANWs and AWWs in each block, to review the previous month and plan the next month's activities and special events such as outreach camps. Project staff also report regularly to ICDS on technical and programme issues.
- **At district level:** By regularly updating the Chief Medical Office, the project has helped to identify supply delay points, sometimes physically transporting supplies to the ANM outposts. Volunteer AWW support persons meet regularly with project staff in each district to exchange feedback and deal with administrative matters. ■

Reported by Dr Beulah Jayakumar, National Child Health Coordinator, and Ms Reena Samuel, Communications Coordinator, World Vision India; photos by staff of Ballia Child Survival Project

<sup>1</sup> Figures from 2001 Census

<sup>2</sup> Under the Expanded Program for Immunisation (EPI) supported by the Government of India, WHO, et al., a child is vaccinated five times before his/her first birthday, with free vaccines through the public health services. But coverage is low, both for "demand" reasons (low awareness of the importance and timings of these vaccines) and "supply" reasons (frequent stock outs at the health outposts). Mechanisms are in place to tackle the supply issues, but there is no mechanism to identify and track beneficiary cohorts, to ensure that they utilise services in a timely manner. The project addresses this gap.

Chattiya Devi is among the many women who have benefited from the training organised by World Vision India. "I wrote a script on my life and performed a *nukkad* (street theatre). I learned the importance of breast-feeding; I did not follow the practice for my older son, but after the training I ensured that my other two children were well breast-fed. And when I enacted the script with other GSS, the women in the community understood the importance."

Chattiya Devi says proudly: "I impart knowledge on health issues in the local language. Now we have women telling other women about these practices, and going to the health centre for vaccination on their own. They don't need us."

She adds: "As an Aganwadi worker I've also managed to start 15 Self-Help Groups. I helped them open their accounts in the local bank. I try to get all the women in the community into a SHG. I also to teach them read and write. Now women can do their own bank work. They can read health information posters and story books."

Chattiya Devi (left) talks to the women from the village in their homes



Chattiya Devi (left) discusses project activities with a World Vision programme supervisor (centre) and World Vision volunteer (right)



life

UND THE GLOBE

## LOVE, HOPE AND HEALTH

Each week in Kapululwe ADP, about one hour from Zambia's capital Lusaka, Judith Mwalaputa goes to visit Harriet Shibila and her father, Patson. Judith is a RAPIDS-trained volunteer care-giver and 15-year-old Harriet, who is HIV-positive, is her friend and client.

In early 2007 when Judith first learned of Harriet's plight, she immediately began her regular visits to the home, despite having a newborn baby of her own. She found Harriet, who lives alone with her father since her mother's death years ago, very ill. "Harriet was covered in sores, had persistent diarrhea, and was struggling with malaria," explains Judith.

Judith began to care for Harriet as she would her own child – bathing her; tending to her sores and making her as comfortable as possible in her small hut. Most importantly, in line with her RAPIDS training she began discussing with Harriet's father the importance of having Harriet tested for HIV. When Patson agreed, Judith linked the family to the nearest counselling and testing services. Once Harriet's HIV-positive status was revealed, Judith facilitated a CD4 count<sup>1</sup> then helped to get Harriet on to appropriate anti-retroviral treatment.

Three months later, Harriet has regained her health and is now an active student and a contributor to her family and village. "We are very thankful for Judith and World Vision. If God had not brought Judith to us, Harriet would be dead today," said Patson. "Judith showed us how to live."



# "Judith showed us how to live"

Additional interventions by World Vision, including a recently installed borehole near Harriet's home, the distribution of malaria-preventing bed nets, and home care kits, are all working together to improve the overall health of this household and community.

Meanwhile, Judith keeps showing up to monitor Harriet's health, help around the house and, most importantly, offer Harriet the unconditional love and human touch that she deserves. "When Judith comes, I am happy. She helps me in so many ways," said Harriet.

Perhaps the most encouraging thing about this story is that it is not unique. Each week across Zambia 12,000 RAPIDS-trained care-givers like Judith are visiting homes like Harriet's to bring the same combination of love, hope and health and to provide the critical linkages to government health services and treatments. In doing so, these care-givers are showing the world that the fight is not in vain and that sometimes, sad situations can have happy outcomes.

**Above** – Judith, a RAPIDS-trained volunteer caregiver, cares for a very sick Harriet

**Left** – Harriet has regained her health

**Opposite** – Judith and Patson set up World Vision-supplied malaria-preventing bed nets

**Photos:** World Vision Zambia



# Global

VOICES OF LIFE FROM AROUND THE WORLD

## Building child health into HIV and AIDS programming

### ZAMBIA

“Strengthening community and clinical linkages to address HIV and AIDS creates remarkable potential for significant child health benefits within the same target populations. The **Reaching HIV/AIDS-Affected People with Integrated Development and Support (RAPIDS)** programme in Zambia demonstrates that effective coverage of malaria, micro-nutrient supplementation, de-worming and vaccination can be achieved with minimal costs under existing HIV/AIDS programmes.

RAPIDS is a consortium of six NGOs: World Vision (lead agency), Africare, CARE, Catholic Relief Services, Expanded Church Response, and the Salvation Army. This six-year programme is funded through a \$57 million investment by the United States Government under the President’s Emergency Plan for AIDS Relief, and represents one of World Vision’s most comprehensive, country-wide approaches to improving the lives of those affected by HIV and AIDS.

This programme, reaching all nine Zambian provinces, and 50 of Zambia’s 72 districts, leverages the various strengths and expertise of our partners to help each organisation improve and expand its ability to care for orphans and vulnerable children (OVCs) and people living with HIV or AIDS (PLWHA), and to support young people to develop their vocations, livelihoods/businesses, and life skills, including behaviours to prevent the spread of HIV. At the time of writing, RAPIDS is providing ongoing support to some 200,000 OVCs, 42,000 PLWHA, and 24,000 youth.

Our community-led approach recognises that in high HIV/AIDS-prevalent countries like Zambia, care must be delivered to the **household** level. In most cases, the problems identifiable in one target group (OVCs, PLWHA, youth) are linked to and/or exacerbated by those in the other groups. HIV may infect individuals, but it affects households. This understanding enables us to provide services to the households in a much more holistic way that addresses not only the effects of HIV and AIDS, but the causes as well.

Working via households successfully leverages local people’s efforts, lowers programme costs, and ultimately helps far more people. RAPIDS provides home-based care to both children and parents (through the same trained care-giver), material support in the form of in-kind contributions like clothing, bicycles,

insecticide-treated nets and educational materials, small grants to faith- and community-based organisations, training in life skills and development of livelihood opportunities for youth, and agricultural support and livestock to improve household resilience.

RAPIDS also fosters critical linkages to clinical and community health services, and is utilising and enhancing Government of Zambia initiatives such as Child Health Week, where in 2007 we will provide both Vitamin A and mebendazole (de-worming medicine) for more than a million children.

The heart and soul (and arms and legs) of our work are our 12,000 trained volunteer care-givers. These men and women, many of whom are battling the scourge of HIV or AIDS in their own homes, are heroes. Each week they are out visiting households and meeting the practical needs of more than 250,000 people across Zambia. They are literally saving and improving the lives of their neighbours, and represent the essence of a community-led response in the battle against HIV and AIDS.

The excellent work of these care-givers has attracted the attention of many private partners who recognise a great national distribution platform when they see one. For example, in late 2006 a representative from the Global Business Coalition against HIV/AIDS, Malaria and Tuberculosis (GBC) visited our programmes and saw not only the great need for insecticide-treated bed nets, but just as importantly, our ability to distribute and monitor usage through our care-givers. GBC quickly assembled a \$2.55 million public-private partnership which used funding from more than a dozen corporate partners and the US Government to purchase 500,000 nets that will reach extremely vulnerable households in 64 of Zambia’s 72 districts and protect more than 10% of Zambia’s total population.

Other private partnerships include both cash and in-kind contributions from Hasbro, 23,000 bicycles for care-givers and OVCs from SRAM Corporation and World Bicycle Relief, and tens of thousands of care kits assembled by churches and community organisations in the US. Together, these private cash and in-kind contributions are currently enabling us to achieve a 1:1 match on our US Government grant. It’s particularly gratifying to see corporate and other private partners who have not traditionally engaged in the fight against HIV and AIDS finding a useful on-ramp to help through RAPIDS.

World Vision is ensuring that through these efforts, RAPIDS is effectively making significant, large-scale impacts, leveraging an existing HIV/AIDS programming platform to deliver on child health more broadly. There is still much to do, but we are seeing the positive outcomes we had hoped for in the lives of so many Zambians affected by HIV and AIDS. ” ■

Reported by Mr Bruce Wilkinson, Chief of Party, and Mr Jeff Dykstra, Director of Communications and Private Partnerships, RAPIDS Programme, World Vision Zambia

<sup>1</sup> Counting the number of CD4 T-cells in the blood indicates the immune system’s strength, how far the HIV has advanced, and the likelihood of related illnesses occurring.

\* Harriet and her father gave written permission for their names, photos and story to be published.





West Africa. I call it LET: Life-Extending Treatment. It isn't really new because it fits with a "positive living" approach, but seldom is a full package of the proven interventions promoted to help newly-diagnosed PLWH.

"It's so simple – very similar to the basic community-based health package we promote for young children: a good diet; safe drinking water all the way into the household and into people's mouths; micro-nutrients (vitamin A, zinc, etc.); drugs to treat/prevent other infections (e.g. cotrimoxazole); malaria prevention (e.g. bed nets) and early treatment; preventing tuberculosis; emotional and psychological support – social networks; family planning to prevent unintended pregnancy.

"How much difference could this make? We know that providing a bed net plus a simple antibiotic cotrimoxazole can reduce malaria in PLWH an astonishing 97%,<sup>2</sup> and that the same drug with safe drinking water can reduce by 67% the diarrhea that kills many PLWH.<sup>3</sup> What would it mean to the millions every year who progress from HIV to AIDS, or to the 4.8 million children and adults<sup>4</sup> who might have to wait years before the ARVs they need are available? What if healthy life could be extended just a few more years? What would it mean to the 12 million African children orphaned by AIDS<sup>5</sup> if their parents had stayed healthy and able to care for them for even a few years longer? LET interventions can be scaled up quickly and cheaply. LET could delay disease, death and orphaning long enough for the world to scale up ARV."

**Martha:** "In our work in 25 African countries, I have been inspired by the local heroes – the neighbours and church members – digging deep into their pockets and hearts to provide and care for children. This community responsiveness is the backbone to World Vision's response to the HIV crisis. We work to mobilise and strengthen community care coalitions (CCCs): community groups who take responsibility to identify, monitor, assist and protect orphans and vulnerable children (OVCs) and PLWH. The response has been phenomenal. During 2006, 41,500 home visitors cared for over 616,000 OVCs and

42,000 PLWH through almost 3400 CCCs across Africa."<sup>6</sup>

**What is World Vision's role?**  
We are there in the community when a new mother comes home diagnosed with HIV, when a child misses school to care for an ailing parent, when final life care is needed. As these highly-motivated home visitors work with HIV-affected households, they are confronting children's and parents' critical health and nutrition needs. With training and supervision, the home visitors can provide care from diagnosis, through Life-Extending Treatment, to home-based care and treatment support programmes.

This linking of LET interventions to AIDS and OVC care through CCCs can extend life and hope for millions. We are dreaming about the countless years of fullness of life that can be restored for those living with HIV – years to enjoy and spend with their loved ones.

Like the unfinished agenda in child survival, the advocacy voice and political will to encourage so simple a solution is lacking. No-one should walk that "long walk to treatment" alone and without hope. ■

**Ms Martha Newsome is Director and Ministry Leader for World Vision International's Global HIV and AIDS Hope Initiative and Dr E Anne Peterson is World Vision International's Director for Global Health**

<sup>1</sup> CDC: Centers for Disease Control and prevention. <http://www.cdc.gov/>

<sup>2</sup> L Altman, "Project curbs malaria in Ugandan group", *New York Times*, 1 March 2007

<sup>3</sup> USAID, *Integrating hygiene improvement into HIV/AIDS programming to reduce diarrhea morbidity*, 2006, p 2 <http://www.hip.watsan.net/content/download/1528/7298/file/HIP%20HIV%20and%20HIV-AIDS%20integration8-06.pdf>

<sup>4</sup> UNICEF, *Africa's orphaned and vulnerable generations: children affected by AIDS*, 2006; WHO, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, 2007

<sup>5</sup> WHO, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, 2007

<sup>6</sup> This data is from World Vision's HIV monitoring system being used in Africa called the Core HIV & AIDS Response Monitoring System (CHARMS).

# LONG WALK TO TREATMENT

*Martha Newsome and Anne Peterson reflect on the simplicity and synergy of linking child health interventions to benefit people living with HIV, through community volunteers.*

One AIDS activist called it the "long walk to treatment". For too long we've left people to walk alone through the years from HIV diagnosis to eventual sickness. We've worked hard to scale up anti-retroviral (ARV) treatment so that there will be hope when the body begins to give way from HIV into AIDS. But can we do more, so that they're not walking alone those many years? YES!

**Anne:** "I remember the day that this issue struck home for me. I'd been working in AIDS for years and it seemed that people living with HIV (PLWH) didn't live as long in Africa as in the US, but the data was unclear. Then one day I went from a home-based care project in Soweto, South Africa, to a small orphanage across town caring for abandoned babies. The contrast was horrifying. In Soweto, the HIV+ babies were usually dead by ages 1–2, but in this quiet middle-class neighbourhood, HIV+ children were healthy at ages four, five or even six. What was the difference, and could we replicate it in the community?

"I began to look for the explanation, and there was the evidence, scattered across CDC<sup>1</sup> studies from Kenya, Uganda and



# PARTNERSHIP FOR MATERNAL, NEWBORN & CHILD HEALTH: THE “CONTINUUM OF CARE” APPROACH

*Francisco Songane explains how and why maternal, newborn and child health belong in one overall health plan, within the context of a health care system that delivers high-quality services.*



*In Ghana, on Child Health Day in May 2004, a young girl eats fresh mangoes while her mother and sister look on.  
photo: Kendra Siekmans/World Vision*

An important moment in history was created in 2000 when 189 heads of state signed the Millennium Declaration, and later that year the United Nations Secretary General spelled out the Millennium Development Goals (MDGs) as the indicators against which to measure progress.

The health of women and children is central to the improvement of health of the total population and MDGs 4 and 5 have become the reference point to generate action.

The extreme levels of poverty in most parts of the world and the lack of improvement in the health status of populations provide compelling evidence of the gravity of the situation and a sombre picture of unconscionable inequalities at the dawn of the 21st century.

## REGIONAL INEQUALITY

Recent reviews have shown that mortality rates vary among world regions. Just 42 countries account for 90% of child deaths in the world each year. India, Nigeria, Pakistan, Ethiopia and Democratic Republic of the Congo alone account for about 4.2 million child deaths per year (out of a world total of 10.8 million).

Sub-Saharan Africa accounts for nearly one half (47%) of maternal mortality. The lifetime risk of dying in childbirth is 1 in 16 in Africa, compared to 1 in 2,800 in Western Europe or North America. In Asia we find this figure is 1 in 94. In the Americas, the lifetime risk of dying in childbirth is 1 in 160. If we compare country by country the figures are even more staggering, ranging from 1 in 6 in Sierra Leone to 1 in 30,000 in Sweden. What is happening in sub-Saharan Africa now is similar to what Sweden endured in the 17th century. Similar shocking figures can be found in Asia – in Afghanistan where the risk is 1 in 6 – and in the Americas – where Haiti tops the continent with 1 in 29.

The accompanying maps (next page) show the distribution of maternal and neo-natal deaths. This map coincides with the distribution of child deaths, providing a graphic picture pinpointing where the problem lies. All these countries have one thing in common – they are poor, with weak and often non-functional health systems.

## WHAT HAS CHANGED?

Considerable work has been done to change the situation, but progress is slow and in some instances indicators have stagnated or even deteriorated. Globally the under-five mortality rate has come down from 95 to 76 per 1000 live births between 1990 and 2005. However, in Africa child mortality rates average 150 per 1000 live births. Seven countries in Africa have seen no improvement in child mortality in the past 50 years.

On the maternal side, there has been progress in South-East and East Asia, North Africa and Latin America, however the last decade has seen no progress in sub-Saharan Africa. Several initiatives were launched to co-ordinate action in the efforts to improve the health of women and children, but the approach has not been comprehensive and the issues have been addressed separately as “child” or “mother” and, more recently, “the newborn”.

## A PARTNERSHIP

It is within this context of a paradigm shift that the Partnership for Maternal, Newborn and Child Health was created in September 2005. The aim is to enhance co-ordination and harmonisation among the different players and ensure that the three areas are addressed in an integrated manner through the “continuum of care” approach. The life cycle continuum encompasses the pre-pregnancy period, through pregnancy and childbirth, to the newborn and the child. This continuum has also a spatial dimension in terms of where the care is provided, from the household to the community and linking with the health network up to the highest referral level. In real life things happen at the same time and the mother is the centre-piece. Whether we are seeing the newborn or vaccinating a child or conducting an ante-natal clinic, the mother is always present and often accompanied by children, even if they are not the reason for seeking care.

The re-focusing of maternal, newborn and child health (MNCH) does not mean another vertical approach. Implementation should be within one overall health plan, and within the context of a health care system that delivers services of high quality where they are needed. If a country, like many of

those listed amongst the 75 high-burden countries, can provide a caesarean section when and where it is needed, that country has a health care system that works.

One of the principles guiding the Partnership is strong country leadership. The added value of the Partnership is to have the different partners interested in MNCH sit around the table and discuss with the authorities how to best address MNCH issues and agree on how to put it in practice. This approach emphasises better use of existing resources, minimises duplication and overlap, and avoids fragmentation.

Another important added value of the Partnership is advocacy, i.e. making the case for the maternal, newborn and child health communities to speak with one voice and to promote the continuum of care. The child and mother are inseparable in life, and should be addressed together in MNCH policy. All partners are expected to send this same message. Communication is key in the process of consensus building in order to ensure that what is agreed globally with the leadership of the different institutions is fully transmitted to the regional levels and the countries' offices. This consolidation of messages is a fundamental step towards mobilisation of resources. ■

**Dr Francisco Songane is Director of the Partnership For Maternal, Newborn and Child Health.**

<sup>1</sup> <http://www.unmillenniumproject.com>

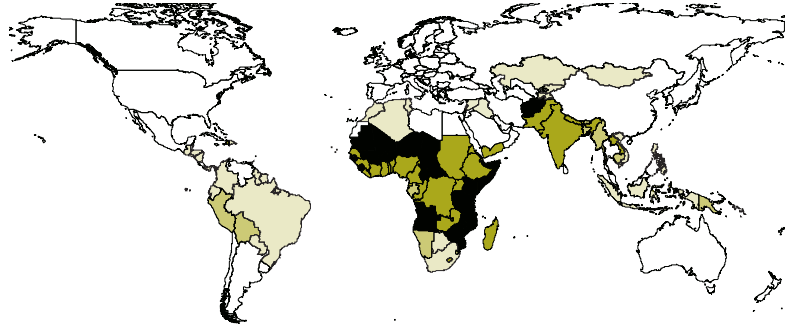
<sup>2</sup> L P Freedman (lead author), UN Millennium Project, Task Force on Child Health and Maternal Health, *Who's got the power? Transforming health systems for women and children*, Earthscan, London, 2005

<sup>3</sup> UNICEF, UNFPA, WHO Department of Reproductive Health and Research, *Maternal mortality in 2000*, Geneva, 2004

<sup>4</sup> R E Black, S S Morris & J Bryce, "Where and why are 10 million children dying every year?" *The Lancet* (361), 2003, pp 2226–34

<sup>5</sup> C Ronsmans & W Graham, on behalf of The Lancet Maternal Survival Series steering group, "Maternal mortality: Who, when where, and why", *The Lancet* (365), 2006, pp 13–24

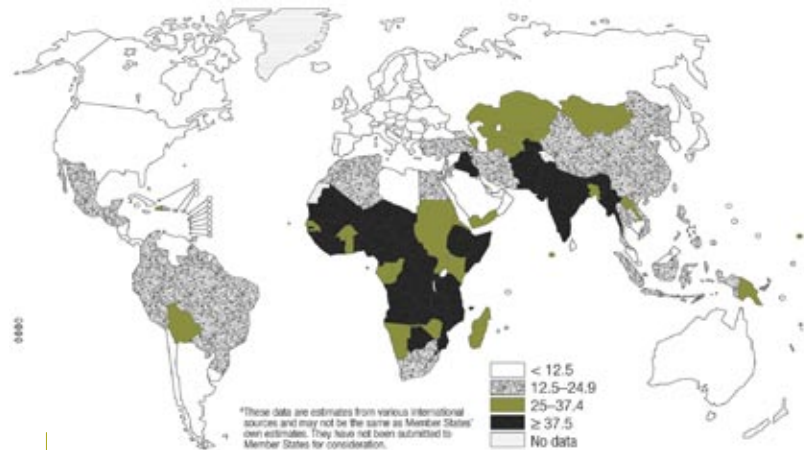
<sup>6</sup> Partnership for Maternal, Newborn and Child Health, *Ten-year strategy*, p 6 <http://www.who.int/pmnch/events/2007/10yearsstrategy.pdf>



□ <100    □ 100-299    □ 300-499    □ 500-999    ■ 1000+

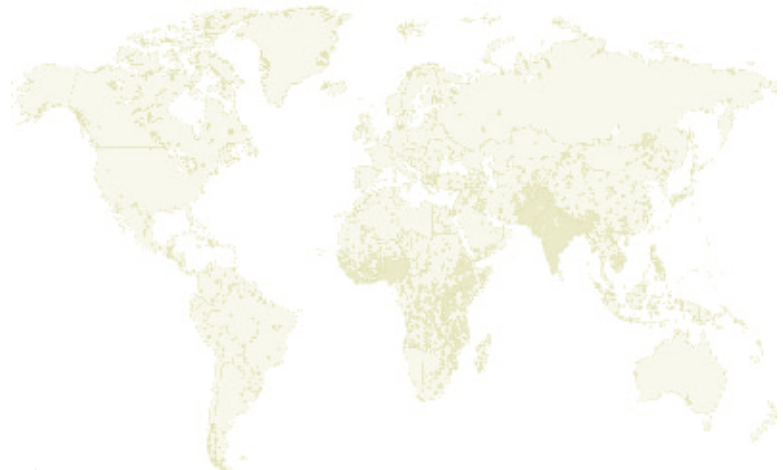
Where do the deaths occur? Maternal deaths per 100,000 live births, 2000

Source: WHO, The world health report 2005: Make every mother and child count, p 9



Neo-natal mortality rate per 1000 live births in 2000

Source: WHO, The world health report 2005: Make every mother and child count, p 9



World-wide distribution of child deaths; each dot represents 5,000 deaths

Source: Black et al. 'When and why are 10 million children dying every year?', *The Lancet*, Vol 361, June 28 2003



# THE G8: AN OPPORTUNITY TO ACHIEVE HEALTH CARE FOR ALL

*The international community recognises critical obstacles to the health MDGs. The G8 can provide real solutions and change the lives of millions, argue Anna Marriott and Max Lawson.*

The world is waking up to the logic that the Millennium Development Goals on health will never be achieved unless massive investments are made into public health care delivery systems. Oxfam and its allies are calling on the G8 to lead and direct this rising energy for action into desperately-needed health outcomes, and make a difference to millions in Africa.

The last decade has seen unprecedented attention to health by the international community. Aid for health has risen but, despite this, the right to health care remains a distant reality to most. Why are we not seeing this increased aid translating to greater results on the ground?

## THE NUTS AND BOLTS

Much-needed long-term investments are not being made to scale up and strengthen the nuts

and bolts of public health care delivery systems:

- clinics and hospitals, and wider infrastructure to access them;
- critical medicines and medical equipment;
- information systems so necessary to detect where the problems are and where to target resources; and, most importantly of all,
- the skilled and motivated workers needed to deliver health care for all, even for those living in the most remote areas. (The World Health Organization calculates that over one million more trained health workers are needed in Africa alone.)

We know that when money is invested in public health systems it can deliver results – even in the poorest countries. More than one-third of Sri Lanka's population lives below the poverty line, but its maternal mortality rate is one of the lowest in the world.<sup>1</sup> The reason for this? When a Sri Lankan woman gives birth there is a 97% chance that she will be attended by a qualified midwife.<sup>2</sup> Ongoing investments in building strong public health systems have been responsible for major improvements in key indicators such as maternal and infant mortality rates in other poor countries too, including Uganda, Cuba and the Indian State of Kerala.<sup>3</sup>

## REMOVING BARRIERS

Why are these lessons not being applied in other countries? A large part of the problem is the fragmented and chaotic delivery of health aid. The last ten years have seen a rapid proliferation of new global health initiatives and partnerships, most of which focus on a small number of specific diseases. These new aid channels frequently bypass government health plans and fail to provide the long-term, comprehensive support needed to build the capacity of health systems to deliver into the future. While in recent years the share of health aid devoted to communicable diseases such as HIV and AIDS has more than doubled, the share received for primary health care dropped by almost half.<sup>4</sup>

This critical obstacle to meeting the health MDGs has been recognised by some major players in international development,

including the World Bank, Development Ministers, and the World Health Organization.<sup>7</sup> However, if we are to have any hope of meeting the MDGs, it is essential to have a more coherent framework for health and co-ordinated global aid.

The 2007 G8 presented a genuine and timely opportunity to tackle the problem head-on and take a major step towards the goal of health care for all. At the African Union Health Ministers meeting in April, African governments committed to comprehensively expand and cost their national health plans, including national health worker recruitment strategies. The G8 must commit to launch a health systems initiative to co-ordinate support at the global and national level behind these country-led plans. The initiative must also mobilise extra resources to fill known funding gaps for the full implementation of health systems plans. The G8 must seek to ensure that where strong national health plans exist, they will not fail due to lack of money.

Health is a basic human right denied to millions in Africa. Oxfam and its allies are calling on the G8 to move beyond a long history of rhetoric on health systems and finally commit to action. ■

*Ms Anna Marriott is Research and Policy Officer, and Mr Max Lawson is Head of Policy, for Oxfam GB's Essential Services Campaign.*

*This article was written just prior to the 2007 G8 meeting. Read Oxfam's post-G8 statement at [http://www.oxfam.org.uk/applications/blogs/pressoffice/2007/06/g8\\_miss\\_mark\\_as\\_new\\_announcement.html](http://www.oxfam.org.uk/applications/blogs/pressoffice/2007/06/g8_miss_mark_as_new_announcement.html), and details for health campaigning at [http://www.oxfam.org.uk/get\\_involved/campaign/health\\_and\\_education/index.html](http://www.oxfam.org.uk/get_involved/campaign/health_and_education/index.html)*

<sup>1</sup> Oxfam International/Water Aid, *In the public interest: Health, education, and water and sanitation for all*, Oxford, Oxfam Publishing, 2007. [http://www.oxfam.org.uk/what\\_we\\_do/issues/debt\\_aid/downloads/public\\_interest.pdf](http://www.oxfam.org.uk/what_we_do/issues/debt_aid/downloads/public_interest.pdf)

<sup>2</sup> WHO Statistical Information System <http://www.who.int/whosis>

<sup>3</sup> Oxfam International/Water Aid, *op cit*.

<sup>4</sup> WHO, the World Bank and OECD-DAC, *Proposal to use health as a "tracer sector" for tracking progress on the Paris Declaration*, DCD/DAC/EFF, 2007, p 18

<sup>5</sup> *ibid*.



# WORLD VISION HEALTH: RE-FOCUSED AND RE-INVIGORATED

*World Vision's Director for Global Health explains how the agency is seeking to maximise its contribution to improving children's health.*

World Vision's vision "for every child, life in all its fullness" recognises our long-held desire to improve the well-being of children. During the last 50 years, **children** have been the lens through which World Vision has addressed needs in areas such as education, peace-building, food security, water and of course, health.

As the organisation has grown exponentially, so has the variety and scope of our projects. Today, World Vision's programmes in almost 100 countries include some 1300 Area Development Programmes (ADPs), funded mainly through child sponsorship, which reach more than 10 million children in communities, and numerous grant-funded projects and disaster response programmes. The vast majority of these programmes have significant health components.

Over the past several years, World Vision has critically examined its structural organisation. Core values state that the organisation

is Christian, child-focused and community-based. We are continuing to move away from service delivery towards a community-empowering, sustainable, holistic development approach.

In conjunction with these changed directional priorities, World Vision several years ago established "transformational development indicators" (TDIs), which measure the status of all children in the communities where we work. Many of these TDIs are measures of child health: nutritional status, key disease and water indicators, and immunisation as a measure of access to public services. As might be expected, given World Vision's calling to work with the poorest of the poor, the baseline TDIs show that in many of the developing communities where we work, disease and malnutrition rates for young children are unacceptably high. We are seeing in our own ADPs too many of the 30,000 children who die every day.

## WHERE ARE WE NOW?

World Vision has some great work to celebrate: successful pilots in malnutrition, established best practices such as community-based integrated management of children's illness (IMCI) in Honduras, and even model national programmes that could be considered Centres of Excellence (for example, Peru and India's tuberculosis programme). The programmes showing the greatest impact are primarily grant-funded areas where technical oversight and rigorous implementation have been required.

In contrast, in many of our Area Development Programmes, World Vision has often followed a reactive response to urgent visible health needs, rather than pro-active programmes addressing underlying broad community prevention opportunities. With TDI baselines and new planning and monitoring systems, sponsorship-funded ADPs can begin to implement work with a rigour approaching that of grant-funded programmes.

## MOVING FROM "GOOD" TO "BEST"

The growing body of health development literature (in particular, the oft-referenced *Lancet* series) affirms strongly

that the most cost-effective and sustainable interventions are those population-based preventive interventions that provide a healthy environment for the entire community. What parents would not choose to protect and keep their child healthy rather than wait for sickness, injury or near-death to seek expensive curative care? There are many "good" things to do in health, but fewer that are "best" – effective, affordable and therefore sustainable within community resources.

Through an extensive consultation process with diverse stakeholders, a strategic framework for health has been developed to achieve improved health outcomes for children within areas where World Vision works. This framework emphasises World Vision's areas of comparative advantage and shifts away from a retrospective response towards intentionality, and the opportunity to build investment and excellence into core endeavours.

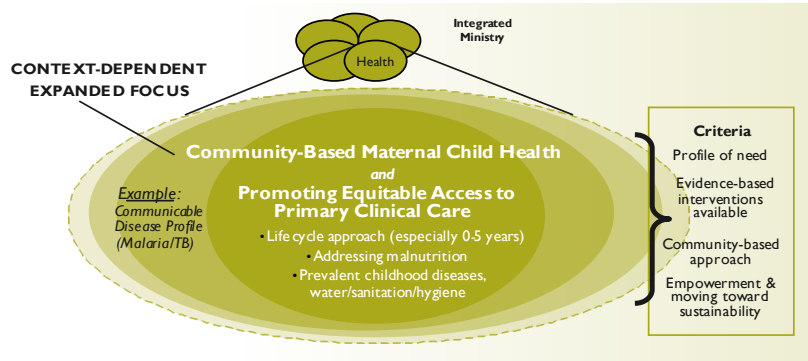
World Vision works in widely diverse settings, so it is essential to address that diversity flexibly, yet within a defined and narrower role for the organisation. What has become clear is that there can be consistency on **what** needs to be done – children should be well-nourished, healthy and have access to care – but that **how** we accomplish those goals will look very different in different parts of the world.

## A DUAL FOCUS

There are two major elements to the newly approved core health focus:

1. A community-based **Maternal and Child Health (MCH)** approach – the public health/preventive approach to promoting the well-being of mothers and children. This is basically a sub-set of the *Lancet* interventions that can be implemented in a community, non-clinical setting. Using a "life cycle" approach will encourage addressing key issues for older children, adolescents and mothers, while still allowing special attention to children under age 5 (a measure of the great need in young children, but also as a marker of health determinants important to all ages). There





World Vision "Achieving health outcomes" diagram

is also a strong emphasis on addressing malnutrition, which underlies more than 50% of the deaths of young children. Highly prevalent communicable disease, such as TB, malaria, avian influenza and certain areas of maternal/reproductive health that vary in geographic distribution, are captured in the "context-dependent core focus".

2. Promoting and facilitating **equitable access to primary clinical care**. There will always be acute care needs. World Vision can play a vital role in ensuring that the safety net functions, through advocating for, supporting, and facilitating – but not supplanting – other partners and especially government ministries. To this end, we engage in advocacy work at the local, national and global policy level and participate in coalitions such as the Global Movement for Children and the Partnership for Maternal, Newborn and Child Health.

### What parent wouldn't choose to keep their child healthy, rather than wait until expensive curative care is needed?

"Re-focus" implies that World Vision will make some hard choices to stop doing, or very rarely do, certain things, such as clinical care or construction – "good" activities that fall outside our defined niche and are better done by partners or Ministries of Health.

There is urgency for World Vision to act swiftly to improve the health of children in places where we work, but we also know that change is slow and there are no

"quick wins" in development. However, having defined World Vision's niche and priorities, we can identify catalytic investments that can "jump-start" change. It is possible that as much as half of the US\$200 million that World Vision invests in health every year can be re-prioritised to fund proven cost-effective interventions – moving us from good to "best practice" as we keep abreast of global learning. We have examples in World Vision programmes addressing malnutrition where in just three years, wasting has been reduced by half. And one of World Vision's strengths is our 23,000 staff, most of whom work closely with communities. Whether officially in "health" or in another sector that helps "achieve improved health outcomes", they are dedicated to improving the health of children. Upgrading their capacity and skills to address health issues, sharing best practices from within World Vision and from global learning, can bring increased effectiveness sooner.

### WORKING TOGETHER

Working with partners within and outside of our own organisation will maximise flexibility, efficiency and coherence with national and global agendas. Working outside sector "silos" also brings diverse community development activities together to synergistically achieve improved well-being of children. Addressing malnutrition is a perfect example of high need where World Vision can bring many strong sectors, like water, sanitation, education and food security to bear on achieving a specific health outcome.

World Vision's greatest asset, and key to sustainability, is our partnership with communities. Listening to them, while also

learning from and implementing global best practice, is possible and it is essential. There is huge opportunity for measurable improvements in health for the millions of children in World Vision-assisted communities, through focusing the capacity of World Vision and our partners at a community, national and global levels. Our hope and prayer is that all children will indeed experience "life in all its fullness" and retain their full God-given potential for learning and life. ■

**Dr Anne Peterson is World Vision International's Director for Global Health.**

## Do you know?



- ▶ A child dies every 3 seconds from preventable diseases.
- ▶ Approximately two-thirds of all child deaths are from preventable causes such as pneumonia, diarrhea, malaria and measles. Malnutrition is the single greatest underlying contributor to child mortality, and is associated with more than half of all child deaths.
- ▶ US\$5.1 billion in new resources is needed annually to save 6 million child lives in the 42 countries where 90% of all child deaths occur. This cost represents \$1.23 per head in these countries. (Bryce, Black et al. "Can the world afford to save the lives of 6 million children each year?" *The Lancet* (365), 25 June 2005)
- ▶ Recent studies show that up to 97% of water is contaminated at the household level. Killer diseases such as diarrhea could be greatly reduced by ensuring that clean community water is clean when it reaches the child's mouth.
- ▶ Optimal breast-feeding is the most cost-effective means of reducing child deaths. If every child was exclusively breast-fed for the first 6 months of life (i.e. no other food or liquids) and continued breast-feeding from 6 to 11 months, an estimated 13% of all child deaths could be prevented.
- ▶ Tuberculosis affects over 14 million people, 1.6 million of whom die each year from the disease. TB is easily transmitted between family members sharing close quarters.
- ▶ Under-nutrition among pregnant women in developing countries leads to 1 out of 6 infants being born with low birth weight. This is not only a risk factor for neo-natal deaths, but also causes learning disabilities, mental retardation, poor health, blindness and premature death.
- ▶ Nearly 7.5 million deaths from measles were prevented through immunisation between 1999 and 2005. (Wolfson, Strabel et al. "Has the 2005 measles mortality goal been achieved? A natural history modelling study". *The Lancet* (369), 19 January 2007)

# the Back Pages

...spiritually speaking

## WISDOM, STATURE AND GRACE

*A reflection on biblical dimensions of children's development*

In Latin America and the Caribbean, WorldVision has been working for over 30 years alongside children living in conditions of poverty. During this time, the region as a whole has experienced significant development progress. In the last decade, net enrolment of children in primary education has grown from 86 to 96%.<sup>1</sup> In the last five years, mortality rates for children under five have decreased from 54 to 32 deaths per 1000 live births,<sup>2</sup> and nutrition has also improved, with the prevalence of underweight children declining from 11 to 7%.<sup>3</sup>

Yet while there is much to celebrate in these achievements, the Latin American and Caribbean region is characterised by the greatest socio-economic inequity in the world. Over 56 million children still live in poverty and do not benefit from the wider improvements seen in health and education.<sup>4</sup> Less than 50% of the poorest children living in Guatemala, Honduras and El Salvador ever finish their primary education.<sup>5</sup> In Bolivia, infant mortality in the poorest segment of the population is above 100 per 1000 live births, while for the richest 20 % it is less than 30 per 1000.<sup>6</sup> Regional statistics tend to mask these socio-economic inequities, making the true plight of children invisible. Social exclusion is a reality faced by all too many children among us.

### **By children, for children**

Motivated by our vision of *life in all its fullness for every child*, WorldVision in Latin America and the Caribbean has decided to join with more than 700,000 sponsored children to advocate a wholistic development agenda that gives priority to children. At the core of our strategic plan for the next decade is our overall goal:

***Contribute to the development and empowerment of a network of five million boys and girls, adolescents and youth, to achieve life in all its fullness; and together with them, seek to engage in the transformation of Latin America and the Caribbean.***

WorldVision recognises that *fullness of life* is a gift from God. It is God who provides children with dignity and identity, and inspires them to share their gifts and capabilities in the context of their families, communities and wider society.

We see our contribution to children as promoting their holistic development through their **empowerment, being-well** and

**well-being** in the context of their families and communities. Empowered children are able to freely express their views on the decisions and actions that affect their individual and collective lives. We seek to empower children on two levels:

- **being-well** – a human quality in a child's own personal life, which in turn generates just, strong and transformed relationships. It can be characterised as being in harmony with God's will.
- **the child's well-being** – the socio-economic, political, cultural, religious and ecological conditions and environment that promote the best interests of children.

This integrated development model for children is articulated succinctly in a passage from Luke: ***And Jesus grew in wisdom and stature, and in favour with God and men.***<sup>7</sup> The holistic child development that we seek has its foundation on the life of Jesus as a child. He grew to bring the good news of hope, justice and deliverance for all those who were marginalised by the economic, political and religious power structures. We believe Jesus is paradigmatic for the children we serve. Wisdom, stature and grace, or favour, guide us in developing four dimensions of our work with children in Latin America and the Caribbean.

### **Wisdom**

This dimension refers to the capabilities the children have to apply their knowledge and ethical principles to their lives and their relationships to others. Wisdom is therefore applied in not only in the education sector, but also in all arenas that children influence: families, churches, recreation organisations and community youth groups, among others.

Though wisdom is an individual capability, it requires an environment that promotes and nurtures it. We promote the being-well of children when we create the conditions for them to apply the knowledge and ethical principles they learn to their personal and socio-economic development. Identity, values, ethics, skills and capacities are intrinsic to children's **being-well**.

As acquiring wisdom and learning happens in and out of school, WorldVision works with children and their families in a life cycle approach to enhance inquiry in age-appropriate levels, to develop critical thinking and life skills, and to facilitate children's access to quality education. Our holistic approach also means encouraging an environment where it is not just safe



**World Vision** is a Christian relief, development and advocacy organisation dedicated to working with children, families and their communities world-wide to reach their full potential by tackling the causes of poverty and injustice.

As followers of Jesus, World Vision is dedicated to working with the world's most vulnerable people. World Vision serves all people regardless of religion, race, ethnicity or gender.

Children are often most vulnerable to the effects of poverty. World Vision works with each partner community to ensure that children are able to enjoy improved nutrition, health and education. Where children live in especially difficult circumstances, surviving on the streets, suffering in exploitative labour, or exposed to the abuse and trauma of conflict, World Vision works to restore hope and to bring justice.

World Vision recognises that poverty is not inevitable. Our Mission Statement calls us to challenge those unjust structures that constrain the poor in a world of false priorities, gross inequalities and distorted values. World Vision desires that all people be able to reach their God-given potential, and thus works for a world that no longer tolerates poverty.

**back cover image:**  
Mothers in Mongolia learning about infant nutrition from a volunteer mother trained by World Vision.

**photographer:**  
Justin Douglass/World Vision

to go to school, but also to explore ideas and learning. Health and nutrition, intellectual capacity, economic and entrepreneurial opportunities and environment all link together to encourage the development of wisdom in children.

### **Stature**

This second dimension is related to holistic health, as the condition of physical and emotional development. Luke, the gospel author and physician, captures in a single phrase – “grew in stature” – the breadth of physical well-being of children. A healthy child does grow in stature, showing God’s incredible design of the human body, a body “wonderfully made”.<sup>8</sup> We promote, together with families and the communities, children’s equitable access to quality health systems and to nourishing food to strengthen the growth and development of their bodies and minds.

### **Favour with God**

The third dimension, spiritual development of children, is fostered together with their families, religious organisations and faith-based communities. World Vision recognises that all people are spiritual beings; therefore, we strive to promote an environment where it is safe for children to live out their spirituality and relationship with God.

### **Favour with the community**

When a family and community favour children, they promote the best interests of children. World Vision works in association with communities and local governments to develop an enabling environment for this favour to flourish. In a social landscape, *fullness of life* for children requires integrated efforts and multi-sector public and private initiatives that seek the best interests of children. Children, as agents of change, participate in their local, national and regional networks, to promote their agenda of development and social justice.

The overall goal provides a platform of regional integration – embracing every Latin American and Caribbean child and adult around the promotion of the being-well, well-being and empowerment of children. We invite your prayers for the Latin America and Caribbean Network of Children, as they journey in becoming agents of transformation in our continent. ■

**Contributed by Dr Anna Christine Grellert, Children in Development Adviser for World Vision’s Latin America & Caribbean Regional Office, with input from other World Vision colleagues.**

<sup>1</sup> United Nations, *Objetivos de desarrollo del milenio. Informe de 2005*, New York, 2005 <sup>2</sup> *ibid.* <sup>3</sup> *ibid.* <sup>4</sup> UNICEF, *Los Objetivos de desarrollo del milenio tienen que ver con la infancia. Avances y desafíos en América Latina y el Caribe*, 2005 <sup>5</sup> CEPAL, *Objetivos de desarrollo del milenio: Una mirada desde América Latina y el Caribe*, p 95 <sup>6</sup> *ibid.* p 147 <sup>7</sup> *The Holy Bible, New International Version*, Luke 2:52: “And Jesus grew in wisdom and stature, and in favour with God and men.” (paraphrased) <sup>8</sup> *The Holy Bible, New International Version*, Psalm 139:14



## Regional Offices

### Africa

P.O. Box 50816  
Karen Road, off Ngong Road  
Karen, Nairobi  
Kenya  
Tel. 254.2.883.652 Fax 254.2.883.942

### Asia and Pacific

P.O. Box 956, Phrakhanong Post Office  
SSP Tower, 19th floor  
555 Sukhumvit 63 (Soi Ekamai)  
Klongton-Nua, Wattana  
Bangkok 10110  
Thailand  
Tel. 66.2.391.6155 Fax 66.2.381.1976

### Latin America and Caribbean

Torres del Campo  
Torre I, Piso I  
frente al Centro Comercial El Pueblo  
Barrio Tournón  
Apartado Postal 133, 2300 Curridabat  
San José  
Costa Rica  
Tel. 506.257.5151 Fax 506.257.5151 (ext. 9)

### Middle East and Eastern Europe

86 Ifigeneias Street  
2003 Strovolos  
P.O. Box 28979  
2084 Nicosia  
Cyprus  
Tel. 357.22.870.277 Fax 357.22.870.204

## Partnership Offices

800 West Chestnut Avenue  
Monrovia, CA 91016-3198  
USA  
Tel. 1.626.303.8811 Fax 1.626.301.7786

## International Liaison Office

6 chemin de la Tourelle  
1209 Geneva  
Switzerland  
Tel. 41.22.798.4183 Fax 41.22.798.6547

## European Union Liaison Office

33 rue Livingstone  
1000 Brussels  
Belgium  
Tel. 32.2.230.1621 Fax 32.2.280.3426

## United Nations Liaison Office

4th Floor  
216 East 49th Street  
New York, NY 10017  
USA  
Tel. 1.212.355.1779 Fax 1.212.355.3018

[www.globalfutureonline.org](http://www.globalfutureonline.org)

e-mail: [global\\_future@wvi.org](mailto:global_future@wvi.org)

# Global Future

A WORLD VISION JOURNAL OF HUMAN DEVELOPMENT