World Vision

Year in Review 2016

World Vision International Health and Nutrition

Introduction

At World Vision, we have celebrated and been inspired by the modern miracle of dramatic global decreases in maternal and under age five child deaths. We are proud to have played a role in these triumphs. In the new era of Sustainable Development Goals (SDGs), we remain devoted to ending preventable maternal, newborn, child and adolescent death, and disease and malnutrition. In this *2016 Year in Review*, we aim to share notable observations on persistent challenges to these goals, alongside key examples and innovations demonstrating how World Vision is tackling them.

Where tremendous strides have been made in public health and nutrition, our final frontier is also our greatest challenge: extending our gains to the most vulnerable in the most difficult and fragile contexts - moving the needle on equity. At World Vision, we understand that investment is needed in both strengthening the capacity of duty bearers, service providers and civil society as well as in making communities more resilient. The themes of community system strengthening, health system strengthening, and working in fragile contexts present forcefully in our report, as do our deep partnerships with those communities to whom we have made long-term commitments, and with national ministries of health.

During the last five years, World Vision has been a leader modelling transparent accountability in our commitments, in particular to the UN Secretary General's Every Woman Every Child movement, and the Global Nutrition for Growth compact. Our desire to play an integral role in the global effort to end preventable mortality and malnutrition is why we aligned our 2016 review with nine specific SDG targets. In 2016, we pledged to invest $3 billion over four years to achieve these targets; in the past year, we achieved 17% of this commitment. As a result, millions of mothers and children have received health services, and thousands of communities are empowered to take greater control of their own health and nutrition outcomes.

This review is written to our partners as an offering of our lessons learned. Like what you read? Disagree? We invite you to contact our experts highlighted in each section. In the spirit of SDG17, we will become stronger and achieve new heights when we share, learn, and work together. So, please do get in touch! We look forward to hearing from you. For further information about our work and to download a PDF of this report, go to http://www.wvi.org/health/2016-year-review

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Contents

Target 2.2: By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.

The world is hungry for better nutrition

As our latest contribution to filling the nutrition capacity gap, we are pioneering a new form of e-learning

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The Sustainable Development Goals (SDGs) put nutrition in its proper place: not just an essential component of ending hunger and improving health, but vital to overcoming poverty and successfully addressing education, gender, inclusive and sustainable economic growth, and sustainable consumption and production patterns. World Vision contributes to achieving these SDGs by improving nutrition with a multi-sectoral approach including health, agriculture, livelihoods, water-sanitation, education, and social protection. Yet, we see that nutrition policies and strategies remain weak, integration of critical government challenging, and trained nutrition workforces scarce.

Addressing the nutrition workforce capacity gap of low-and middle-income countries is critical to achieving the SDGs and other global targets on nutrition, health, and development. Urgent need remains for new and innovative approaches because traditional face-to-face cascade trainings proved largely ineffective filling the capacity gap. To address this gap at the community level, World Vision has offered three innovative facilitated distance-learning courses to reduce stunting and anaemia. To broaden reach and collaboration with nutrition distance-education efforts globally, World Vision leads a small external working group of academics, programme, and distance education partners piloting a blended learning approach for in-service training in nutrition at national scale. We intend to provide easy access for sub-national and more remote workforces, often working in fragile contexts.

A blended (instructor-led and self-study) online approach is recommended by education experts as the most cost-effective method to expand workforce capacity in nutrition. World Vision has pioneered a blended approach for sub-national level practitioners, combining online self-study with professional mentoring for on-the-job training, prioritising stunting and anaemia, both requiring multi-sectoral approaches. An e-learning Readiness Survey screens learners; training is applied through webcasts, practical field assignments, and online discussion forums with peer learners on a low-bandwidth platform. Technical experts tailor support and coaching to learners' needs, mentor in critical analysis skills, and provide expert feedback. This eliminates travel expenses, per diems, and extended absences from the workplace.

Strong completion rates (56%, with 107 graduates since 2012) and applied learning (98% apply learnings to job)[i] of World Vision nutrition courses suggest the blended delivery method has high potential to address the large workforce capacity gap to implement nutrition programmes. Partnering with other agencies (academic, implementing, and private sector) and movements (Scaling Up Nutrition), as well as expanding World Vision's nutrition courses to reach more practitioners and cover broader topics, enables coordinated and sustained capacity strengthening of the workforce to tackle malnutrition multi-sectorally.

"By closing the capacity gap that exists in frontline nutrition work, we can fully realise the potential impact on current investment on nutrition. We need solutions now that take learning opportunities directly to where they are needed. The World Vision Distance Learning in Nutrition programme does exactly that."

Anna Lartey
Director, Nutrition and Food
Systems Division, Food and Agriculture Organization

The secret to success? Community

Genuine community involvement is a game-changer in ending extreme malnutrition

Responding to the needs of women and children, the skills and opinions of community members must be evaluated and applied within existing programmes and new interventions for optimal outcomes. Whether enhancing our mobile app for Community Management of Acute Malnutrition (CMAM) to improve programme quality, or screening children for extreme malnutrition, we have learned – and documented – that listening to and involving community members improves results.

In 2016, World Vision continued to provide lifesaving treatment for children suffering from acute malnutrition in 16 countries, of which half are in the top 20 fragile states. World Vision uses the CMAM model, which strengthens communities, to both identify and treat malnourished children. Performance outcomes exceeded global Sphere Standards[ii].

World Vision has developed and deployed a mobile application for CMAM programming in over 100 health facilities across five countries: Afghanistan, Niger, Chad, Mali, and Kenya. This application was evaluated in 2016 with implementing partners Save the Children and International Medical Corps. Key learnings included better adherence to clinical protocols by health care workers, improved defaulter/absentee tracing, and notable improvements in beneficiary-health worker communication. The evaluation also noted that developing an application to match the complex clinical protocols for CMAM required an iterative user-centred design process, a time-consuming but essential process. Developing interoperability between the government health management information system (HMIS) and the mobile application is the next frontier.

Despite effective CMAM programmes, many children with acute malnutrition are still diagnosed too late, significantly increasing their mortality risk. Mother-led mid-upper arm circumference (MUAC) screening trains mothers to screen for acute malnutrition in their children by measuring MUAC and testing for bi-lateral oedema, developed and researched by the Alliance for International Medical Action, in Niger. In 2016, World Vision launched this approach within a CMAM project in the Assaba region of Mauritania, including both CMAM and water, sanitation and hygiene (WASH) components heralding the first use of mother-led MUAC screening in Mauritania. Today, 1,879 mothers have been taught to screen their six- to 59-month-old children for malnutrition. In 2017, World Vision will build on this success by expanding to other countries.

183,865
Children Under Age Five Treated For Acute Malnutrition in 2016

78,000
Pregnant and Breastfeeding Women Supported Through Targeted Supplementary Feeding in 2016

1.5 Million
Women and Children Under Age Five Treated in CMAM Programmes Since 2010

"This project had probably the highest impact potential of any project I have worked on. If you go to these project sites, you immediately understand why the intervention is needed. You can see the food insecurity; it's very visible. When you observe the nurses, you see the mistakes they make using paper forms, and the on-the-fly decisions they make that have serious impact on the child's health. So you could understand from the beginning how the app would really add structure and eliminate a lot of mistakes. And we have been able to observe real value on the ground; real value added to such an important programme."

Carla Legros
Project Manager, Dimagi

Nurse for her children

Aichata, a mother of four, lives in the town of Boumdeid in Mauritania's Assaba Region. During a routine monitoring visit, she was proud to show her skills in malnutrition screening with a MUAC tape. Learning these skills just a month-and-a-half before, she subsequently assisted a mass screening in her district. At least once each month, Aichata measures two of her children within the age range for screening, and describes both in the green range, signalling their health. She says she is now a nurse for her children.

When the going gets tough, we keep going to end malnutrition

When most organisations abandoned the Positive Deviance/Hearth model, we simplified it with successful reimplementation

The major criticism of the Positive Deviance/Hearth (PDH) model for reducing malnutrition is that it is too technical for implementers and this impacts quality at scale. Most other NGOs stopped implementing this community-based, multi-sectoral intervention for families with underweight preschool children due to this observation from donors. Yet, World Vision continued to invest in PDH – primarily because studies show contextualised messaging (versus generic messaging) is more effective in rehabilitating malnourished children, and multiple studies demonstrate efficacy in nutrition outcomes. Secondly, although PDH addresses underweight children and feeding practices, it also is a multi-sectoral approach including water sanitation and hygiene, child caring, and health-seeking practices. We also encouraged PDH-strengthening communities to capitalise on their knowledge and resources for child growth. With positive outcomes, World Vision implemented PDH in 30 countries in 2016[iii].

We addressed criticisms by revising the capacity building and implementation strategy, as well as developing tools that simplify technical components. The result? World Vision achieved large reductions in underweight levels within just three months, and continued reduction at six-month follow-up.

From seven countries[iv] that submitted data for 2016, over 56,000 underweight children under five years of age were admitted into PDH, with 65% gaining adequate weight[v] in three months and 54% fully rehabilitated[vi] and graduated from PDH. In Bangladesh alone, over 49,800 underweight children were admitted into the two-week PDH programme[vii]. Participating children were followed up in their homes three months after discharge, and underweight (WAZ<-2) decreased from 81% (n = 40,170) on admission to only 46% (n = 15,271), indicating not only sustained, but ongoing improvement in nutritional status. At six months, further improvements were documented, with only 37% (n = 7,604) underweight among those who participated in PDH, providing further evidence of participant caregivers' sustained behaviour change to improve their child's nutrition.

World Vision's outcomes standardising implementation and scaling up PDH in Bangladesh were presented at the World Nutrition Congress in South Africa[viii] and Micronutrient Forum in Mexico[ix] and welcomed by ministries of health, implementing agencies, donors, and academic partners. Buoyed by positive response, we are initiating studies assessing the effectiveness of PDH to address chronic malnutrition—an unprecedented initiative.

"I am honoured to work with the World Vision team on a PDH child malnutrition programme in Cambodia. This project will provide evidence-based guidance on how to maximise impact on child nutrition and increase potential reach and scalability of World Vision's innovative approach."

Melissa Young
Research Assistant Professor,
Emory University

Making the future bright with PDH

Vajira Lakmal and Mandushani joined World Vision's PDH programme in Sri Lanka in 2014 when their daughter, Mulamimanodya, now five, was malnourished. They learned to prepare nutritious food from local resources to help her quickly recover, but that was only the start. The family was linked with government extension services to learn how to grow the diverse food needed in the household, in addition to making small but significant changes to improve hygiene and sanitation around the home. In addition, they enrolled in World Vision's Graduation Programme, receiving support to identify and build a small business. Today, they have a successful dairy business and participate in a local savings group. They bought a motorcycle to transport the milk, and intend expanding to include yogurt. Their regular income from milk sales is in vast contrast to the irregular income Vajira Lakmal earned as a day labourer. Their second child was born a year ago, and Vinuthadunsara is a healthy boy who has shown no signs of growth faltering. Mandushani is part of a mother's support group, and a community mobiliser makes regular visits to their home. The parents proudly display their children's growth charts at home and are confident that, with their knowledge from PDH and increased income, the future is bright.

Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

In the fight on maternal mortality, attack on all fronts

In a complex world, World Vision's holistic approach is making the difference

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Among the advantages of a one-issue organisation is recognition for doing one thing well, often leveraged to attract donors. World Vision, however, takes pride as a holistic agency; our deep experience with communities has shown time and again that complex problems mandate multifaceted solutions.

This approach is especially advantageous when addressing pregnant and postnatal women in high mortality contexts. In some places, it is community attitudes, beliefs, practices, and behaviours that are harmful to maternal health and nutrition. In others, such as fragile contexts, the most vulnerable pregnant women, including adolescents, the poorest families, and those with disabilities are those who miss out on much needed services. There is no single solution to the variety and complexity of challenges.

World Vision's package of community system strengthening interventions directly addresses maternal health. The synergy of delivering these interwoven interventions amplifies outcomes. This package includes community health workers (CHWs) trained to map, register and perform multiple visits to all pregnant women; community health committees supported for every health centre to enable local governance of maternal health services, with focus on access and quality; local level advocacy or social accountability approaches to dialogue on service provision gaps with duty bearers; and faith leader mobilisation to engage congregations to change social norms supporting maternal health.

World Vision's Citizen Voice and Action approach works by educating citizens about their rights and equipping them with tools to protect and enforce those rights. First, communities learn about basic human rights and how they are articulated under local law. Next, communities work collaboratively with government and service providers to compare reality against government's own commitments using an adaptation of the "social audit" tool. Communities also rate government performance against subjective criteria that they themselves generate, using an adaptation of the "community score card". Children play a critical role identifying service-delivery gaps at schools. Finally, communities engage in constructive, local, multi-stakeholder dialogues in which citizens, government, and service providers commit to an action plan to improve the service monitored.

We also support health system strengthening to improve maternal health services by supplying obstetric drugs and equipment, community links to the Health Management Information System, referral support, midwives clinical skills training[x], and maternity unit infrastructure such as water and power, in collaborative partnerships with the Ministry of Health.

33%
Increase in Antenatal Care and Postnatal Care in EAMNeCH Programme

32,144
Additional Births Attended by Skilled Birth Attendants in EAMNeCH Programme

52,682
Additional Women Accessing Family Planning in EAMNeCH Programme

33 Countries
Where Community Health Workers are Reaching Pregnant Women

48 Countries
Where Local Level Advocacy is Supporting Maternal Health Programmes

9 Countries
Where 247 Community Health Committees are Supported

Measuring our multifaceted interventions demonstrates their effectiveness. In 2016, World Vision evaluated two five-year, multi-country Maternal, Newborn Child Health (MNCH) programmes: the Access-Infant and Maternal Health (AIM-Health) programme implemented in Kenya, Uganda, Tanzania, Sierra Leone, and Mauritania from 2012 – 2015, and the Australia Africa Community Engagement Scheme-supported East Africa Maternal, Newborn Child Health (AACES – EAMNeCH) programme implemented in Kenya, Uganda, Tanzania, and Rwanda from 2011 - 2016. During the life of these programmes, 3,000 CHWs were supported and trained to visit pregnant and postnatal women in their homes. In four countries, World Vision supported district and sub-district health services to train 606 facility-based nurses and midwives to improve their clinical maternal health care skills including active management of the third stage of labour and emergency neonatal and obstetric care training. Ultimately, 47,000 pregnant women were reached in mostly rural areas with high-burden maternal mortality, poor access to services, and sometimes fragile contexts.

The AIM-Health programme's goal was to reduce maternal mortality ratios by 20%. Lives Saved Tool (LiST) modelling was used to estimate changes to the maternal mortality ratio at each site from baseline to evaluation. All programme areas demonstrated reductions from baseline with three sites exceeding the 20% target. Results are attributed to large increases in postnatal care and skilled birth attendance uptake, as well as modest increases in prenatal care and family planning. Increases in demand are attributed to a better functioning, supported, and motivated community health-worker workforce. Another contributing factor, acknowledged by evaluators, was improved male partner engagement in maternal health care. In one project area in Rwanda, 3,465 men accompanied their pregnant partners to antenatal care visits in 2015, up from 46 in 2013.

Local level advocacy and social accountability were also credited for contributing to reduced maternal mortality ratio in these programmes, which also included World Vision training 725 community participants. A review of these initiatives in 10 countries demonstrated consistent increases in health staffing, including improvements in midwife availability, and a joint NGO lobbying effort in Uganda that led to an increase of $19.8 million in the national health budget to fund 6,172 additional health workers. Additional outcomes included improved maternal health commodity/drug supply, investments in maternity unit infrastructure, and helping staff realise and change their attitudes toward women.

The complexity inherent in tackling the contributing factors of maternal mortality demands that we are committed with our partners to initiatives and programmes that prioritise multi-sectoral, multi-country approaches.

Target 3.2: By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births.

When health systems fail, what's your backup plan?

Our plan is building local capacity of community systems, committees, and leaders

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In World Vision's new global strategic plan, reaching the most vulnerable community members is among our key priorities with precedence to newborns, especially babies born at home. Community engagement and community system strengthening have the highest positive impact on newborn survival—in particular, when aggravated by weak or failing health systems.

Health systems can collapse during emergencies, as exhibited during the Ebola crisis. Community health systems provide a buffer. Building the capacity of community health workers, community health committees, and community leaders to assume responsibility for local health outcomes provides an engagement platform for humanitarian intervention. Perhaps more importantly, these initiatives equip a trusted indigenous workforce to continue supporting their communities during crisis.

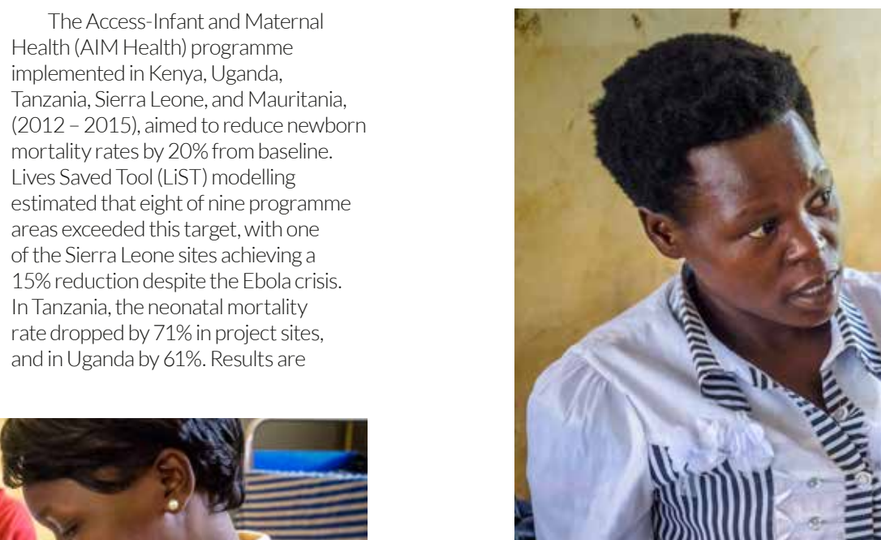
Recognising its unique potential to reduce newborn and child mortality rates, World Vision strengthened its core approaches by prioritising community health worker (CHW) capacity for home visits in the postnatal period. For the under-five group, we bolstered our CHW programme to better address the most vulnerable children: those born to adolescents or HIV positive mothers, preterm and small, and into fragile context or humanitarian crisis.

A review of three World Vison evaluations (completed in 2016 in seven countries), demonstrates that community-based integrated approaches, in particular postnatal care delivered by CHWs, are integral to improving newborn and child health. More than 3,060 CHWs were trained to visit new mothers and babies during the postnatal period and continue home visits until the child turned two. 84,500 children under age five were reached.

The Access-Infant and Maternal Health (AIM Health) programme implemented in Kenya, Uganda, Tanzania, Sierra Leone, and Mauritania, (2012 – 2015), aimed to reduce newborn mortality rates by 20% from baseline. Lives Saved Tool (LiST) modelling estimated that eight of nine programme areas exceeded this target, with one of the Sierra Leone sites achieving a 15% reduction despite the Ebola crisis. In Tanzania, the neonatal mortality rate dropped by 71% in project sites, and in Uganda by 61%. Results are credited to improved practices at home such as breastfeeding in the first hour (77% increase), sustained exclusive breastfeeding, increased skilled birth attendance, and increased postnatal care—all attributed to a strengthened CHW workforce.

The Australia Africa Community Engagement Scheme – East Africa Maternal, Newborn and Child Health (AACES – EAMNeCH) programme implemented in Kenya, Uganda, Tanzania, and Rwanda (2011 – 2016) demonstrated that postnatal care (PNC) consultations increased by more than one-third, and early initiation of breastfeeding increased from 46.1% to 72.2%. These practices are reputed to impact newborn and child mortality and were attributable to CHW increased activity over the life of the programme.

These results illustrate why World Vision designates community system strengthening a critical and non-negotiable aspect of its approach to end preventable deaths of under-fives – especially for the most vulnerable.



30%
Increase in Exclusive Breastfeeding in EAMNeCH Programme/Tanzania

30%
Increase in PNC in EAMNeCH Programme/Uganda

70%
Increase in PNC in EAMNeCH Programme/Rwanda

"We thank World Vision because they help Village Health Teams in many ways."

Dr. Ruhakana Rugunda
Prime Minister, Republic of Uganda
– quoted when he was Cabinet Minister for Health

Ending preventable child deaths alone is impossible

World Vision is increasingly facilitating partnerships with a common goal: saving the most vulnerable children

As one of the world's largest privately funded non-governmental organisations with more than 45,000 staff in 100 countries and a turnover of over $2 billion a year, there is an inclination to "go it alone"—to singlehandedly assume solutions to the world's child mortality problems. Yet, experience has taught us to join forces with our valued partners to provide the most impactful programmes.

BabyWASH

In 2016, World Vision led the development of a global platform called the BabyWASH Coalition to enable integration for a more profound impact on maternal, newborn, and child health, and nutrition, addressing maternal and newborn sepsis, cognitive development, diarrhoea, and stunting. In the same spirit as the UN Secretary General's Every Woman Every Child (EWEC) initiative, and the Partnership for Maternal, Newborn, and Child Health, the BabyWASH Coalition was launched during the UN General Assembly in September 2016. Today, the coalition is a collective of more than 32 organisations with World Vision providing leadership and a secretariat role.

The momentum continues … enabling World Vision to share its sector integration lessons. While two (or more) BabyWASH pilot programmes will proceed in East Africa in 2017, as facilitator we forecast the larger long-term impact, estimating that integrated programming may save an additional 500,000 mothers' and children's lives.

Born On Time

With an ever-increasing appreciation of the potential of public-private partnerships, in 2016 World Vision joined the Government of Canada, Johnson & Johnson, Save the Children, and Plan International to help address what is now the biggest killer of children under the age of five: preterm birth. Born On Time targets risk factors related to unhealthy lifestyles and behaviours, maternal infections, inadequate nutrition, and limited access to contraception that can lead to premature birth. The partnership aims to empower women and adolescent girls, as well as engage men, boys, and community leaders, to tackle gender-based discrimination and barriers impacting maternal and newborn health. The programme supports women and adolescent girls before, during, and between pregnancies by strengthening health systems with training, equipment, and supplies to provide quality, responsive care.

The partnership supports the Every Newborn Action Plan (ENAP) and aims to contribute to the EWEC movement and Sustainable Development Goal 3.2 in three high-burden countries. Following the inception workshop and baselines study, implementation is now underway. World Vision is responsible for implementing in Ethiopia and expects to impact directly on 74,000 newborns. This programme also intends to improve maternal, newborn, and child health skills for 736 health workers such as doctors, nurses, and midwives, 900 health extension workers, and 4,500 Health Development Army women volunteers.

World Vision's growing portfolio of partnerships across a range of sectors are emerging as one of our most important assets as we work toward the new sustainable development agenda.

Target 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases.

You're on a disease treadmill if communities don't become resilient

Bed nets and drugs are only one kind of solution for complex challenges

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Tackling multiple epidemics in many countries reveals that horizontal system strengthening efforts are much more effective than vertical disease programming. While evidence illustrates efficacy of direct interventions such as bed nets, house spraying, diagnostics and treatment, making health systems stronger and communities more resilient ultimately saves more lives, as well as improves cost-effectiveness and sustainability of direct disease diagnosis and treatment interventions.

For optimal results, communities, especially the most vulnerable, must learn to address punitive laws and harmful traditions that marginalise most-at-risk groups, and prevent key populations from accessing evidence-based compassionate prevention and treatment services. Families must be empowered to strengthen resilience in preparation of times of food insecurity and when increasingly vulnerable to infectious disease.

We believe in "holistic resilience" and work with community groups to strengthen their capacity to protect themselves from disease, and advocate for quality health services. World Vision mobilises faith leaders and the faith community to stand against stigma and discrimination to vulnerable and at-risk groups.

Mothers work together to combat HIV

A key example is access to treatment and adherence to anti-retroviral therapy (ART): World Vision works with Mother Support Groups and associations of those living with HIV and AIDS, who provide psychosocial support, home-based care as needed, and regular follow-up on treatment adherence. A community prevention of mother-to-child transmission (PMTCT) project in Ethiopia demonstrated a high level of treatment adherence among HIV-positive mothers and their spouses, and zero HIV transmission to newborns mainly due to the psychosocial support and follow-up for treatment adherence they received from Mother Support Groups.

In 2016, 20 World Vision programmes in East and Southern Africa, Bosnia, Haiti, and India contributed to the global 90-90-90 strategy[xi] to end AIDS as a public health threat. These projects included behaviour change communication and support to health facilities and community-based organisations, building capacity and systems to improve service quality.

64,000 new tuberculosis cases detected

In 2016, World Vision contributed to national tuberculosis (TB) responses in nine countries: Kenya, Somalia, Senegal, Papua New Guinea (PNG), India, Mongolia, Myanmar, Thailand,

13
Programmes Scaling Access to HIV Testing

11
Programmes Promoting PMTCT

9
Programmes Ensuring Treatment and Care for People Living with HIV or AIDS to Enhance ART Adherence

and Bosnia Herzegovina, reaching underserved populations with the highest TB rates in the world. In the extremely challenging context of Somalia, World Vision continued its strengthening of three separate ministries of health, scaled TB services up to 73 TB facilities throughout the three government authorities, and expanded services to detect and treat TB in children, multi-drug resistant TB, and TB-HIV co-infection.

In Somalia and other countries listed above, core interventions included community mobilisation for TB prevention, case detection including contact tracing, screening and referral by community volunteers and community health workers, community managed Directly Observed Therapy efforts for treatment adherence and strengthening of health systems including lab capacity, monitoring and evaluation, and local level advocacy. It is the component of community system strengthening that proves vital to improved uptake of services, demand for increased quality, adherence to treatment, and ultimately success.

14 million benefit from malaria prevention and treatment

World Vision supported national malaria control programmes in 10 countries: Mozambique, Malawi, Angola, Democratic Republic of Congo (DRC), Chad, Senegal, Sierra Leone, Myanmar, Thailand, and Indonesia. Vector control was a key intervention with 1,880,000 long-lasting insecticide treated bed nets distributed in Mozambique, Thailand, Myanmar, and Indonesia, and 900,000 houses sprayed in DRC and Malawi.

This was, however, the first year that World Vision contributed to the national scale up of community-based case management (CCM) of malaria in Angola, Malawi, DRC, Chad, Sierra Leone, Myanmar, and Indonesia. CCM provides training, supervision, and medicines for community health workers (CHWs) to ensure accurate and rapid malaria diagnosis and treatment at the community level for women and children under-five who commonly have scant access to health services. Critically, community groups are also trained in citizen advocacy strategies to increase local oversight of clinics and health facilities for improvements in service quality and prevention of drug stock-outs. Community groups also learn how to undertake local behaviour change campaigns to promote health-seeking behaviour of mothers and caregivers. In all projects, World Vision emphasised community systems strengthening, with 17,241 CHWs and other service providers trained, and 1,507 primary health facilities, and 3,289 community groups strengthened.

"I named my son Tamirat, which means 'miracle', because it is a real miracle to have a HIV-negative child from HIV-positive parents. I am grateful to World Vision and the health centre for helping us to live above our health problem."

Chaltu Bekele
Member of Inchini Mother Support Group, Adaberga Wereda, Ethiopia

"World Vision has proved beyond reasonable doubt that they are a key and reliable partner; no wonder they were nominated as a Global Fund Principle Recipient."

Malawi Parliamentary Committee for Health

666,683
Women and Children Reached with Parasitological Tests

638,356
Women and Children Treated

77,439
Pregnant Women Received Preventive Treatment

Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Improving sexual and reproductive health outcomes: Timing is everything

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The secret is identifying contextual opportunities to overcome socio-cultural barriers

Like all primary health care needs, improvement in sexual and reproductive health (SRH) outcomes requires increased access to quality health services. SRH is unique in its added reliance on the highly contextualised addressing of socio-cultural barriers for success. Therefore, World Vision programmes are based on the best medical knowledge available and positive medical ethics, as well as respect for people's traditional, cultural, and religious beliefs. Programmes provide complete, accurate, and unbiased information disseminated in a caring, respectful, empowering, cultural, and age-appropriate manner.

From a technical perspective, World Vision promotes evidence-based Healthy Timing and Spacing of Pregnancies and Family Planning (HTSP/FP) as a life-saving intervention, integrated within community maternal and child health programmes, in approximately 30 countries. HTSP/FP focuses on using contraception to time pregnancies during a mother's healthiest years, and spacing pregnancies for optimal outcomes, with an emphasis on mothers breastfeeding for two years. Four key HTSP messages resonate with community gatekeepers, health workers, mothers and fathers, and faith leaders: 1. *Too young:* Delay pregnancy until a girl is at least 18-years-old; 2. *Too old:* Limit pregnancies to a mother's healthiest years, ages 18-34; 3. *Too close:* Wait at least three years post-birth before pregnancy; and 4. *Too soon:* Wait at least six months after miscarriage before pregnancy.

We also seek to leverage socio-cultural opportunities, aiming to ensure that such messages are delivered and alter behaviour. In Burundi, for example, World Vision-trained community health workers innovated the use of Positive Peer Couples (couples already using contraception to space pregnancies) to counsel other couples on HTSP/FP. Concurrently, the Ministry of Health integrated HTSP/FP counselling and services with antenatal and postnatal care with both immunisation and nutrition projects. The Contraceptive Prevalence Rate (CPR) increased from 18.9% to 50.6% within one year.

In Uttar Pradesh, India, World Vision trained female volunteer health workers to make household visits and male volunteers to advocate for HTSP with community leaders, clerics, and fathers. Women participating in self-help groups were trained to be HTSP counsellors. Within 14 months, there were a staggering 67,989 new contraceptive users with an estimated prevalence rate of 77% in targeted communities.

In Fatick District, Senegal, World Vision trained Ministry of Health staff, village health committees, and health hut staff on counselling, service delivery, and forecasting of contraceptive demand. Religious and political leaders catalysed community support for HTSP. Contraceptive use at health posts increased from 12% to 17% in just one year.

In Isiolo County, Kenya, Imams in one large Muslim community recognised that support for birth spacing is supported in the Qur'an. Subsequently, they included HTSP messages in their sermons and community conversations with men and women. Male faith leaders speaking to men about family planning had unanticipated consequences: One-third of contraceptive users are now men, and one-third of these men report using the Standard Days Method. CycleBeads® are compatible with prayer beads, and men track their wife's menstrual cycle to know when to abstain or use condoms.

It is evident that many solutions to socio-cultural barriers for improved sexual and reproductive health outcomes are found in communities themselves.

Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Universal health care requires better collaboration, counting, and citizen empowerment

Important lessons learned from World Vision's Child Health Now campaign

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The concept of Universal Health Coverage (UHC) is based on the principle that all individuals and communities should receive the quality health services they need without suffering financial hardship[xii]. During the last few years, a growing global movement has succeeded in positioning UHC as a realistic and affordable objective for all countries, a victory that led to its adoption as a central target in Sustainable Development Goal 3. But will governments deliver on their promises? How can we hold them accountable? What does progress toward UHC look like in the hardest places?

Over the last seven years, Child Health Now, World Vision's global advocacy campaign focused on ending preventable child and maternal deaths, has consistently advocated for the development of strong accountability mechanisms spanning local to global levels and include effective participation from communities, civil society, and all relevant stakeholders. Implemented in more than 70 countries, the campaign contributed to nearly 300 policy changes, budget increases, and improved implementation with positive impact for millions of children.

Based on this experience, World Vision believes that the global movement for UHC should focus on three key areas:

Data collection beyond national averages

Developing a precise global view of progress toward UHC (and the potential policy and funding gaps) requires that international organisations, donors, and governments agree on accountability framework. The new Unified Accountability Framework proposed to monitor progress toward the Global Strategy for Women's, Children's and Adolescents' Health is a critical element. Measuring improvements in access to essential health services is especially important for vulnerable and marginalised groups. Many countries have seen significant increase in the proportion of the population with access to essential health services over the past few years. However, others have shown less political will, either making slow progress or widening the "health gap", leaving vulnerable groups behind. The key recommendation from World Vision's 2013 report The Killer Gap[xiii] was to look beyond national averages to collect data concerning the uncounted and unreached. World Vision strongly believes that UHC should be measured by access for the most vulnerable populations. Collecting data about these groups will require "going local" to involve communities in data collection and leverage new technologies, allowing the consolidation of data from multiple sources and stakeholders. Better data, used effectively, can drive improved strategies, targeted responses, and ultimately increase impact.

The essential role of empowered citizens

Citizens positioned to obtain the most from enhanced funding and health policies are best placed to monitor the quality and availability of services for which they are entitled and to demand more action from duty bearers. Awareness of their rights and opportunities to dialogue with those who design and implement policy are critical for efficacy. The challenge is how to involve citizens at the local level in the implementation of such ambitious concepts as UHC without creating unrealistic expectations. How do we encourage recognition that developments likely encompass limits of health services at the local level?

Our experience shows that Citizen Voice and Action (CVA) can contribute by encouraging an ongoing cycle of accountability, so that demands from empowered citizens lead to local and national governments delivering on their promises, often fuelling further productive dialogue. Today, World Vision has expanded CVA to 45 countries. Citizens' Hearings offer a complementary approach. This movement (started in 2015 by a coalition led by the board members of the Partnership for Maternal, Newborn and Child Health civil society constituency including World Vision), has involved close to 10,000 participants in grassroots and national-level consultations across 19 countries. Citizens' Hearings provide a forum for citizens to participate in identifying problems, seeking solutions, setting priorities, and in monitoring and reviewing progress for maternal, newborn, and child health. This initiative has intentionally focused on strengthening citizen-led accountability in, and the connections between, local, national, and global accountability mechanisms.

An expanded global platform

No organisation on its own can spur the changes in funding and provision of quality health services for every woman, man, and child across every country, nor hold all leaders accountable for their pledges to ensure quality, affordable health services for all. Working in coalition and partnership is essential. Child Health Now pursued partnering with others, often playing a critical role in advising, creating, and supporting national coalitions to enable building capacity and finding sustainable traction and funding. The campaign worked with national coalitions in 90% of countries in which it operated. World Vision's emphasis on the power of partnerships includes engaging non-traditional stakeholders, such as faith groups, children, and youth. The movement for UHC has made great strides, but it requires much stronger alignment and coordination with other movements and partnerships, particularly Every Woman Every Child and Scaling Up Nutrition. As an active stakeholder across multiple movements and partnerships, World Vision can support and encourage the alignment of strategies and promote joint planning to break down existing silos. This will also require strong leadership from donors and international organisations. Strengthening global movements for UHC and ending preventable maternal, newborn and child deaths demands a joint global platform, building on local and national efforts, with an aligned approach.

All countries can make progress toward UHC, even in the most fragile contexts. Advocacy at the sub-national level and technical support to ensure the adoption and scale up of evidence-based programmatic models are the approaches used in Afghanistan by the Child Health Now campaign. For decades, women in this country had to gamble against one of the world's highest maternal mortality rates. Poor access to maternal and newborn care services due to geography, insecurity, and constraints against women leaving the home without male companionship and receiving care from male health workers contributed to an especially difficult situation for the poorest and most marginalised women. In this context, Child Health Now centred its activities in the western provinces of Herat, Ghor and Baghdis. Following a grant-funded World Vision programme to increase the number and standard of midwives assisting with delivery at the Herat Maternity Hospital, data showed that the change led to reduced maternal deaths, as well as the increased survival of newborns at the facility. Child Health Now used the data to advocate for the establishment of neonatal units at hospitals in Ghor and Badghis, with midwives trained at Herat before their appointment to regional facilities. In 2013, both hospitals agreed to equip neonatal wards, allowing access to specialist care for the first time in those provinces.

"World Vision has been a key partner in the Every Woman Every Child movement since it started."

David Nabarro, UN Secretary General's Special Adviser on the 2030 Agenda for Sustainable Development

Target 3.b: Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

Crucial ingredients in a successful vaccination campaign?
Trust and data

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Our long-term relationship-building with communities made us a partner of choice in Sierra Leone

Vaccination campaigns are dangerously jeopardised when local populations are inadequately sensitised and reject the service. It is vital to gain buy-in from local community, traditional, and faith leaders prior to vaccination programmes. Engaging early with communities to develop cultural understanding, awareness, and appreciation, as well as strengthening lines of communication for rapid response, is a prerequisite for success. World Vision has grappled with community vaccination and disease treatment acceptance through its long-term polio work, HIV and AIDS campaigns, Sierra Leone Ebola response, and Latin America Zika programme. In every context, we have seen the need to listen to and address people's fears, and to work with local champions and leaders to create positive opportunities for dialogue and trust-building.

The following are becoming standard operating procedures for World Vision regarding vaccination or disease treatment: 1. Finding innovative ways of engaging communities to build trust, inform, and educate on the benefits of vaccines and helping to dispel false rumours that impact on vaccine uptake; 2. Employing digital technology that supports vaccine deployment, especially in remote and underserved communities and 3. Building meaningful and sustainable public-private partnerships with the private sector and governments to promote vaccine and essential medicines coverage.

Ebola vaccine

World Vision is part of the consortium supporting the Ebola vaccine trial in Sierra Leone. The Ebola Vaccine Deployment, Acceptance and Compliance (EBODAC) consortium is comprised of World Vision, Janssen Pharmaceutica N.V., Grameen Foundation, and the London School of Hygiene and Tropical Medicine. The consortium is funded by the European Union (EU) Innovative Medicines Initiative (IMI), a joint undertaking between the EU and European Federation of Pharmaceutical Industries and Associations, as one of the Ebola+ programmes which contribute to efforts to tackle a wide range of challenges in Ebola research. The EBODAC consortium supports the clinical trial of an investigational Ebola vaccine in Sierra Leone, while also preparing to maximise the impact of the potential deployment of a future Ebola vaccination programme. World Vision was selected as a consortium member for two reasons: local presence in Africa and experience with the use of mobile technology for health programming, and a subsequent understanding of policy, regulatory, and privacy requirements in handling sensitive health data in that context. World Vision is also known for its ability to mobilise communities, and to advocate for and enable community engagement through communications.

Working with partners in Sierra Leone, the consortium has engaged local communities to address the suspicion of vaccines in general and the stigma surrounding Ebola, that may deter people from participating in the vaccine trial. Communication strategies and tools have been developed to build awareness and trust, and mechanisms created to rapidly respond to any concerns or rumours related to the vaccine study. World Vision has supported community sensitization and mobilisation for the vaccine trial working closely with local, traditional, and faith leaders in support of the implementation of the EBODAC.

Vital statistics

Inadequate vaccination data collection, management and reporting systems for decision-making, and timely, efficient and effective vaccine delivery can adversely impact vaccine roll-out. The launch of vaccination programmes is often hampered by a lack of personal identification (e.g. ID card or unique ID number), and lack of experience targeting specific populations. World Vision, with the EBODAC partnership, is leading development of a standardised gap-analysis approach to support optimal deployment of Ebola vaccination programmes in Sub-Saharan Africa. This analysis will be conducted in Sierra Leone and one or two other Sub-Saharan African countries to allow triangulation of the findings and strengthening of the credibility of the standardized approach that will be recommended.

As the Ebola vaccine trial involves a prime-boost vaccine, it is critical that trial participants are accurately identified. To address this need, the vaccine trial clinics are using state-of-the-art biometric technology to uniquely identify and register individuals (fingerprint and iris scan). World Vision staff received specialised training on this technology and are at the forefront of its deployment and refinement, as it is being used during the vaccine trial. As part of the refinement of the iris scan technology, World Vision is working closely with Janssen Pharmaceutica N.V. to undertake evaluation (sensitivity and specificity) of iris-scanning and the feasibility and usability in the identification of children one to four years-of-age. This involves field testing of the modified and miniaturized iris scan tool to register minors. If successful, not only will this be used in the vaccine trial for this age group, but may expand future paediatric care options in trial and non-trial settings.

Target 3.c: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.

Why can't we all get it together when it comes to community health workers?

Disappointed with fragmented approaches to community health workers, we did something about it.

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While the need for dramatic increases in developing country health workforces is clear, projections for when this may be achieved are not. Not surprisingly, community health workers (CHWs) have received global attention because: 1) they represent a fast path to health service expansion, and 2) they span clinical primary health care and social work needs, which the formal health workforce will not achieve in any scenario. Fragmentation of government, NGO, and donor approaches to CHW programmes, however, continues to be an industry pain point, and policy guidance hard to achieve in weak health systems. Vertical and parallel CHW initiatives continue to proliferate. Refusing to accept the status quo, in 2015 World Vision developed harmonisation guidance: *CHW Principles of Practice - guiding principles for non-governmental organisations and their partners for coordinated national scale-up of community health worker programmes* with the Core Group, and continues to advocate this approach, promoting collective stakeholder action aligned with national strategies and policies.

Supporting 220,000 CHWs in 48 countries

World Vision's major health workforce investment is focused on CHW programming. In 2016, World Vision continued to expand this portfolio, focusing on fragile contexts and advancing two core initiatives: Timed and Targeted Counselling (TTC), a comprehensive behaviour change approach for Maternal, Newborn and Child Health (MNCH), and harmonisation, a process of building consensus and partnership for scaling up national CHW programmes.

In 2016, World Vision's support for TTC programmes grew from 29 to 37 countries, including challenging contexts such as Somalia and Sudan. In seven of these countries, TTC was formally integrated into national strategies. Following expert review, the TTC curriculum was enhanced to improve addressing newborn care, early child development, maternal mental health, supportive care for the vulnerable including HIV care, low birthweight, and adolescent pregnancy. Ongoing contextualisation for TTC is planned for fragile contexts and high HIV prevalence areas. New content developed for prevention of child marriage was tested in Sudan and Mauritania. In Haiti, prevention of violence against children was prioritised with the inclusion of content on positive parenting education, reinforcing links with ongoing World Vision early childhood education research. New content for HIV treatment support and primary prevention in youth is under development to support full implementation of World Vision's HIV strategy.

In line with the harmonisation objective, World Vision has developed a suite of tools to plan for scale, including CHW workload rationalisation, design, monitoring and evaluation tools, five-year multi-partner costing tool, budget estimator, a detailed protocol template, and implementation quality standards. This suite has been field tested in Uganda and Haiti successfully.

Bringing timed and targeted counselling to scale in Mauritania

In Mauritania, the TTC programme demonstrated impact on care with a focus on handwashing and breastfeeding practices. Maternal mortality indicators lagged behind with only a 4% change estimated using the Lives Saved Tool (LiST) for modelling. Contributing factors included access barriers for skilled birth attendance and antenatal attendance, and lack of male support. Teenage pregnancies were high across the study sites and a recent World Vision study reported over 20% of female-sponsored children age-12 and over are already married. Therefore, the government of Mauritania and Council of Imams signed a protocol for World Vision to undertake the national scaling of TTC among community health workers. A research study in Assaba region is being established jointly with the University of Nouakchott to serve as a learning lab for the national roll-out. In these sites, CHWs will conduct home visits to parents or partners of all girls ages 10-18, aiming to delay child marriage and early pregnancy.

40%
Increase in Women who Attended at Least Four Antenatal Care Visits During Pregnancy

36%
Increase in Children who Completed Their Third Dose of DPT Vaccination

51.4%
Increase in Caregivers of Children 0 – 59 Months who Sought Treatment for Diarrhoea in the Past Two Weeks

"TTC is the best approach, which Mauritania has chosen for national community health roll-out. This pilot, in Assaba, will enable us to learn how to scale up effectively."

Dr. Aly Cheibany
National Director Community Health,
Mauritania Ministry of Health

While 4,000 miles away, in Somalia…

Community Health Promoters (CHPs) were deployed to implement TTC in some of Somaliland's most underserved areas as male-female CHP pairs, aiming to ensure security and establish stronger male engagement. CHPs were salaried as mandated by the Ministry of Health, and retention was higher compared to other countries, where CHWs are not salaried. Impact was high across a range of MNCH indicators including skilled birth attendance, bed net use, immunisation uptake, and breastfeeding. Evaluation found that mothers improved recognition of CHP's capacity, and perceived quality of health services motivated the uptake.

A virtuous learning cycle

The combined results of the TTC implementation in nine countries constitute a strong evidence-package for TTC as a best practice for MNCH, and have demonstrated consistently high impact on behaviour change, which range between 10% - 50% higher than baseline for indicators such as breastfeeding practice and uptake of key health services. Qualitative studies undertaken as part of World Vision's four-country Child Health and Nutrition Impact Study (with Johns Hopkins Bloomberg School of Public Health) suggest TTC's storytelling method is popular and engaging at the household level, and key decision makers' involvement in negotiation and accountability for behaviour change are determinants of success.

However, our evaluations have revealed a consistent gap in adolescent health and that the sharpest increase in pregnancies in most programme areas over the last five years has been in the 12 to 18 age group. Poor sexual and reproductive health (SRH) practice, low access to family planning, and forced marriages of young girls are critical barriers to achieving maternal health outcomes, requiring that all those equipping and overseeing CHWs, revise our strategies rapidly and consistently.

"TTC is the perfect model for an Islamic setting like Mauritania, because the role of the father and family is emphasised and everyone gets involved."

Participant, TTC Training of Facilitators, 2017

Target 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

Proper planning peaks performance

We offer the same message to donors, governments, and communities: Get ready well in advance

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As the urban population increases by 1.2 million in Asia and Africa each week[xiv], infrastructure, services and health systems cannot develop as quickly as populations move – often into already underserved areas. The humanitarian community must rapidly learn to operate in new environments, such as populations with targeting and discrimination issues and dense, poorly planned urbanised settlements. Standards and indicators must be adapted for both governments and the humanitarian community to track and identify needs and outputs. At the same time, donors inadequately invest in critical support for preparedness and early warning programmes needed to prevent morbidity spread, despite the fact that US $1 spent in preparedness saves US $4 in response[xv,xvi]. During emergency responses, donors are more interested in treatment and vaccination campaigns than supporting information dissemination and behaviour change to slow the spread of disease.

In 2016, World Vision worked with governments and communities in early warning, preparedness, and response to Zika Virus Disease (ZIKV) (Brazil, Colombia, El Salvador, Honduras and Guatemala, South East Asia), Yellow Fever (Angola and DRC), Malaria (Burundi and Angola), and Cholera (Sudan, Haiti and Central African Republic) outbreaks. Responses were customised for each country—the gaps identified by World Vision and appropriate ministries. Health promotion and prevention activities included school-based activities, support for health workers in surveillance, medical supply, community clean-up campaigns, health worker training, and linking of other programmes to build resilience such as improved water, sanitation, and hygiene (WASH), livelihoods, and children's education. World Vision works with local authorities and community groups to strengthen families to meet their health needs. In operational areas, health, WASH, or child protection committees already trained in community engagement were quickly mobilised for public health messaging, surveillance, and integrated vector control.

Long-term community presence enables rapid response

In the ZIKV response in Latin America, World Vision engaged 400 partners including civil, military, government and private health providers, and education departments. World Vision provided 8,000 pregnant women with prevention kits, including long-lasting insecticide treated bed nets, clothing, insect repellent, and materials for safe water storage, cleaning, and waste management. Over 16,000 women of childbearing age were engaged in training and vector eradication programmes. Risk communication campaigns running through these committees were supported with media and government messaging about prevention, clean up campaigns, symptoms, and health-seeking behaviours. They reached over 3 million people in 1,000 communities, who also engaged in community clean up campaigns. Local groups in Guatemala provided mental health and psychosocial support to 900 families affected by the virus, and linkages with the Ministry of Education enabled 71,000 children to participate in workshops within schools.

World Vision's technical advisors were part of the World Health Organisation (WHO) Risk Communication and Community Engagement Interagency Coordinating Body and provided input into the Zika Communication Framework and education materials with World Health Organisation/Pan American Health Organisation (WHO/PAHO) and World Vision offices. This was linked to collaboration with WHO and the Ministry of Health in six countries to use mobile technology to survey over 3,000 participants with the WHO-modified Knowledge Attitudes and Practice for ZIKV survey in the six operational countries. This information has been used by WHO/PAHO and ministries of health to improve community messages regarding transmission beyond the basic message of not getting bitten by mosquitoes[xvii].

23,586
Children Tested by CHWs for Malaria

16,741
Children Treated by CHWs for Malaria

7,000
Children Referred by CHWs to Health Centres

Community health workers (CHWs) enable community malaria epidemic response

Similar mechanisms were used in Burundi to mobilise communities for indoor residual spraying to reduce the life span and density of anopheles mosquitoes. In the first three months of this response, World Vision held meetings in 18 communities regarding indoor residual spraying and clean-up campaigns; identified, trained, and equipped over 240 sprayers; trained over 130,000 people including 87 chiefs in malaria prevention and health-seeking behaviour; and distributed 60,000 long-lasting insecticide treated bed nets. Delays in expansion resulted from holdups with supplies and customs clearance for needed products.

Globally, World Vision supports 220,000 CHWs - many of whom are engaged in home visits and Integrated Community Case Management (iCCM). World Vision is able to access this extensive cadre of health workers, who are trusted in the community and trained in surveillance and referral for treatment of cases. In Burundi, World Vision worked with the Ministry of Health to strengthen the skills of health staff and provided group monitoring and coaching. Of the 1,000 CHWs attending training in iCCM for malaria, 400 passed and are actively implementing[xviii].

Backstopping primary health care during epidemic response

In Angola, during the yellow fever outbreak, World Vision recognised the need to support health centres treating common illnesses, as main health facilities were overwhelmed with the response, and rapidly faced severe shortage of essential medical supplies and medicines. World Vision partnered with the Provincial Directorates of Health to support the operation of eight health centres in Huambo and Luanda districts to meet the community's general health needs and provide prevention messaging for yellow fever and malaria to over 3,500 patients. Even before the outbreak, these health centres had chronic shortages of medical supplies and essential drugs, so the provision of logistics plus 21 tons of medical supplies (to date) was well received. World Vision also provided training to 61 health technicians on identification and treatment of common diseases and use of malaria test kits in accordance with the Ministry of Health protocols to improve diagnosis of malaria and reduce yellow fever misdiagnosis.

It is evident that, regardless of the disease or the country, prevention is better than cure.

SUSTAINABLE DEVELOPMENT GOALS

Fragile Contexts:
The Final Frontier in Achieving the SDGs

We need a movement for urgent action to address poor health in fragile contexts

Whether addressing issues in Afghanistan, the Palestinian Territories or Somalia, health and community system strengthening go hand-in-hand

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Globally, many fragile states made significant improvements toward the Millennium Development Goals (MDGs) for maternal and child health. However, fragile contexts continue to see 60% of global preventable maternal deaths; 53% of deaths in children under-five; 60% of the world's malnourished people; 33% of the global AIDS, TB, and malaria burden; 64% of unattended births; high rates of adolescent birth and unmet need for family planning. Realising the ambitious goals set by the sustainable development agenda is challenging in contexts characterised by violence, instability, and weak and ineffective social systems with low capacity to respond and adapt to shock and stress.

Fragile contexts typically lack adequate human resources to manage effective reconstruction and development. World Vision advocates investing in a two-part strategy: First, strengthen government capacity in strategy and planning, as well as operating levels. This requires allocating technical assistance to government agencies, leveraging global planning and management experience, and providing mentorship. Second, civil society requires strengthening to assume responsibility for community outcomes and effectively engage with government.

Short-term aid allocations to fragile contexts encourage service delivery approaches at a cost to effectively sustainable system strengthening. Alternatively, World Vision advocates coordinating collective action inclusive of all key reconstruction stakeholders to improve long-term development strategy alignment, avoid duplication of investments, and enhance quality assurance of investments. Organisations with longer-term investments in these contexts should be supported.

National coverage of Somalia TB service achieved through partnership

World Vision has successfully implemented a 10-year Global Fund-financed TB programme in Somalia resulting in strengthened health infrastructure and workforce across the country. Creating trusting relationships and building the capacity of local to national level staff, World Vision has negotiated common objectives and incentives, and created a national coalition represented by more than 30 entities (international, national, and community-based partners). Results include the number of TB treatment facilities expanded from 7 to 73, well-staffed and stocked services, an increased rate of TB case-finding with 88% treatment success, service availability for TB treatment, and 73% of HIV-positive TB patients on anti-retroviral treatment.

Midwives in Afghanistan save lives

Despite significant improvements toward the Millennium Development Goals (MDGs), the three-decade long conflict in Afghanistan continues to be a barrier to development. A major factor for poor maternal and child health is low coverage of essential health services. Only 48% of women receive antenatal care one or more times; over 60% of births are attended by non-skilled personnel.

In 2015, Aga Khan University performed a meta-evaluation to evaluate World Vision health programming impact and sustainability in Afghanistan. Implemented from 2007 to 2015 in Ghor, Badghis, and Herat provinces of Western Afghanistan, programme results demonstrated significant change in maternal and child health and nutrition outcomes. Particularly, the Community Midwifery Education Program (CME) addressing the shortage of midwives reduced maternal, neonatal and child under-five mortality and morbidity rates. The programme contributed to increased access to essential services such as childbirth, postpartum, and neonatal health care. In collaboration with local and national key stakeholders, World Vision recruited midwives from local communities, built their capacity, and supported them with employment and supervision for quality performance. Lives Saved Tool (LiST) analysis demonstrated 26.4% and 22% reduction in neonatal and under-five mortality rates respectively (2010-2013). Today, more than 90% of trained midwives continue to provide skilled birth attendance. In 2016, they attended 30% of all performed deliveries in Herat Provincial hospital.

Community health workers (CHWs) and mental health counselling

In the Palestinian Territories, maternal, newborn and child health (MNCH) remains an urgent issue. In this context, World Vision, with partners in cluding the Ministry of Health, refined and validated a household-level practice known as Timed and Targeted Counselling (TTC). Through operations research and model cost-effectiveness analysis, World Vision built strong evidence on the model's effectiveness. World Vision is now scaling TTC across its operational areas in partnership with the government, which trains and supervises the CHWs. Currently, there are 150 trained CHWs delivering TTC. In 2016, this cadre reached 2,600 households with pregnant women and children under two. World Vision is now working with research partners to test the effectiveness of TTC enhancements. Innovative thinking includes adding new interventions to address the widespread challenge of maternal mental health and poor child development as key determinants of child health and nutrition outcomes.

Mental health is considered out of scope for traditional health workforces, but often also considered too much for the CHW cadres. Conversely, World Vision has found mental health and psychosocial care in such high demand that its abridged Psychosocial First Aid (PFA) version adapted for TTC doesn't adequately equip CHWs for their work. This feedback has been given in other fragile settings such as DRC and Haiti, and also high HIV settings such as South Africa, Lesotho, and Zambia. World Vision is revising the approach further, and researching the development of an expanded approach for CHWs in high-demand settings and fragile contexts.

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