

Maternal and Child Health

Goal Statement

World Vision is committed to realising the objectives of the Millennium Development Goals within its partnering communities. Within those communities, we work to improve household preventive health practices and care-seeking behaviours to positively impact maternal and under-five health indicators. We believe that in our partnering communities, healthy children should be the norm, and disease the exception.

Problem Statement at Community-Level

Approximately 10 million children under 5 and 500,000 women die each year from preventable diseases and childbirth-related causes. Millions more suffer marginalised health conditions that leave them vulnerable to recurring diseases, and lock them into a poverty cycle. This mortality and morbidity is a function of poverty, where the poorest 20% of the world's population have a 10 times greater chance of dying before they reach the age of 14 than the richest 20%. World Vision works pre-dominantly in the communities hardest hit by this injustice.

World Vision's Strategic Approach

- **Programming through a Lifecycle Approach:** World Vision aligns integrated health and non-health interventions with life stages of Adolescence (lifeskills training), Pre-pregnancy (reproductive health), Pregnancy (Antenatal care seeking), Birth (Skilled attendance), Postnatal (Skin to Skin care), Infants to 28 days (Exclusive Breastfeeding), Infants to 24 months (Immunisations) and Children to age 5 (care seeking for ARI and diarrhoea).
- **Prioritisation of Maternal and Child Health (MCH) programming in Area Development Programme designs:** World Vision has established MCH as a central element of its global health strategy. This priority reaches through subsequent regional and national strategy development to the communities in which we work.
- **Monitoring of MCH Transformational Development Indicators (TDIs):** Globally, every World Vision country programme evaluates impact using six core indicators. One of the six measures is immunisation rate; others include stunting, access to improved water sources, management of diarrhoea, completion of formal education and adoption of coping strategies. World Vision's direct and indirect incorporation of nutrition-related indicators in its central impact evaluation system indicates the organisation's high prioritisation of nutrition.
- **Mainstreaming evidence-based, best practice relief and development interventions:** World Vision is scaling up well-known MCH models such as Integrated Management of Childhood Diseases and Home Based Lifesaving Skills, and focusing on globally prioritised interventions such as exclusive breastfeeding, immunisation and antenatal counselling and care.

World Vision's Principles

World Vision believes that good health is a strategic investment in breaking generational cycles of poverty and risk, and a fundamental element of children's well being. It seeks to improve upon the greatest shortcomings of developing country primary health care, which are the creation of demand and the extension of services and resources to the poorest and marginalised segments. Our emphasis is thus on community-level work, and on partnering with the communities themselves, local government, non-governmental organisations and community-based organisations and private sector service providers to assure that basic health needs are met. Our legacy will be that communities and families are able to prevent poor health, and advocate for the services that they deserve.

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Intervention Example

The World Vision India Pragati Child Survival project has pioneered a community-based MCH model that brings preventive primary health care assistance to the household level. The Pragati project recognised that for behaviour change to happen, messages needed to be targeted to those in the household who would practice those behaviours, and to those who would influence the decision to change them. Moreover, the messages needed to be appropriately timed: neither too early, lest they be forgotten, nor too late for the behaviour to be practiced. Finally, they needed to be communicated in an environment that allows for open discussion of the behaviours, facilitated by a provider that is empowered to counter prevailing myths and customs with facts. To address these needs, a model referred to as Timed and Targeted Counselling with Cohort Registers was developed.

The Timed Counselling model is founded on a 'continuum of care' approach, beginning in early pregnancy, and continuing through the end of infancy. Implementation is assisted through:

1. A cadre of staff or volunteers who identify women in early months of pregnancy, and visit their houses as per the schedule of timed Behaviour Change Communication.
2. A register to track cohorts, plan visits and track outcomes.
3. Training to these workers in the technical and implementation aspects of the timed and targeted counselling.
4. A simple job aid that details the benefits of each behaviour, and helps dispel myths that keep people from practicing the behaviours.
5. A system of capacity building support for effective supervision of the implementers.

Outcomes from the Pragati final evaluation indicate significant household behavioural change. Expanded Programme on Immunisation coverage increased from 33 to 53.2%; timely initiation of semisolids from 38 to 81.2%; use of modern contraception from 12 to 27%. In addition, the approach, with embedded quality assurance, contributed to extensive capacity building of the project staff, its local partners and the government health system.