World Vision

Annual Review 2017

World Vision International
Health and Nutrition

Introduction

The new World Vision strategy - *Our Promise 2030* - refreshed our health and nutrition focus in 2017. It renewed our dedication to serve the most vulnerable children, expand our health and nutrition targets firmly into the adolescent cohort, and grow investment into fragile contexts. It also continues to reaffirm our commitment to community, our greatest and steadfast strength.

Additionally, our current global campaign - I*t Takes a World to End Violence Against Children* - offered enhanced opportunities to leverage World Vision's multi-sector capacity to holistically address the diverse determinants of health and nutrition outcomes. The coverage detailed in this report on our integrated approach toward ending child marriage in Nepal provides an excellent example. In fact, most programme examples in this report demonstrate the power of integrated development approaches, as well as innovation.

In 2017, World Vision continued to meet its commitments to Every Woman Every Child (EWEC) and Nutrition for Growth initiatives, investing $254 million in health and nutrition interventions, plus an additional $133 million in Water, Sanitation, and Hygiene (WASH). At the September EWEC High-level Steering Group meeting, World Vision President and CEO Kevin Jenkins committed to invest $2 billion in health and nutrition programming in fragile contexts between 2017 and 2030. During 2017, we reached over 18 million children with health and nutrition interventions in 58 countries through nearly 3,000 communities, with which we partnered.

A review of World Vision work in 2017 demonstrates our dedication to longstanding initiatives:

1. World Vision has invested deeply in the global fight to end malnutrition, evidenced by compelling innovations addressing some of the most challenging aspects with sustainable methods. In fact, during the last five years, 89% of the more than 250,000 severely malnourished children treated with Community-based Management of Acute Malnutrition (CMAM) by World Vision and its partners made a full recovery.
2. With an emphasis on holistic early child development approaches over a decade ago, our operational research now shows significant positive outcomes in the 0 - 3 cohort.
3. Following nearly 70 years of long-term engagement in fragile contexts, our capacity to partner and coordinate development initiatives in the most challenging locales is unparalleled.
4. Leveraging faith for positive public health outcomes has been highly effective, particularly in regard to sexual and reproductive health practices.

As we move toward the 40th anniversary of the Alma Ata declaration establishing primary health care, we reflect on community system strengthening approaches, noting challenges in implementation fidelity, sustainability and scale. We believe that this self-assessment will help us improve initiatives moving forward.

Please take a few minutes to review our work. We look forward to talking with you about it in more detail!

Tom Davis
Partnership Leader, Sustainable Health

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Early Child Development Doesn't Fit in a Box

The 1,000-day window of opportunity just got bigger.

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The United Nations Secretary General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) set the stage for a global expansion in maternal and child health strategy from "survive" to also "thrive" and "transform". A Lancet series on early child development (ECD) in 2016 provided a compelling and critical narrative for this expansion, noting that 249 million children under five are not on course to reach their full potential due to gaps not only in health and nutrition, but in caregiving, early learning, and protection. In 2017, World Health Organization (WHO) and UNICEF began spearheading a new advocacy framework: Nurturing Care Framework, calling on holistic action across these domains, as well as targeting the pregnancy to three-years cohort.

Envision, for a moment, stepping outside your role, setting aside your hat, and focusing on what we're highlighting here: children. For our own children, we are concerned not only with their health and nutrition, but with their education and security. Every child deserves every opportunity and assets to thrive: That is equity.

Community Health Workers CAN do more.

World Vision is critically assessing varied opportunities to expand and integrate our developmental interventions. For example, in 2013, Johns Hopkins University evaluated the impact of our core community health worker (CHW) approach – Timed and Targeted Counselling – in Palestine, and found that by promoting six key behaviors using this approach[1], an estimated 200 to 270 life years were saved at very low cost.[i] Shortly thereafter, we decided to build on this success, enhancing the CHW approach with psychosocial first aid for primary caregivers and mother-infant stimulation components. Last year, our randomised control evaluation implemented in partnership with Al-Quds University found significant developmental improvements for both mothers and children (see results right). This evidence strongly suggests that CHWs interacting with families at the household level can address the maternal and under-five cohort more comprehensively.

In a similar evaluation of our health programme in Armenia, conducted by Aga Khan and Harvard Universities, we compared control sites receiving only our core health and nutrition package with intervention sites that added mother-infant stimulation interventions. We found a 12.2% increase in development outcomes in interventions sites, per the Bailey assessment index (language, cognitive and motor sub-scales). We also found this intervention most effective in higher poverty areas.

We are continuing to expand these integrated efforts into new countries to include Sudan, Indonesia, Haiti, and Thailand. With 220,000 CHWs serving in 50 countries, we have an incredible opportunity to help children to not only survive, but thrive and transform their lives.

Results from World Vision Palestine Integrated CHW-ECD Programme:

- **Maternal Post-Natal Attachment Scale: +13.1%**
- **UNICEF ECD-KAP test: +21.4%**
- **Edinburgh Post-Natal Depression Scale for mothers: -21.4%**

[1] Exclusive breastfeeding, duration of breastfeeding above a year, introduction of food at six months, newborn care practices, recognition of danger signs and care seeking, and increasing fluids during diarrhea.

Go Baby Go - An Integrated Model For Early Childhood Development:
https://www.wvi.org/publication/go-baby-go-integrated-model-early-childhood-development

Go Baby Go FactSheet:
https://www.wvi.org/publication/go-baby-go

A reflection on our commitment:

World Vision is working with partners to steadily advance understanding of integrated intervention impact on early child development, and rapidly expanding integrated approaches based on success.

Recommendations

Based on our experience, we believe:

1. The next-generation health workforce must be early childhood development (ECD)-qualified. Health sector workers, professional and volunteer, have a privileged relationship with pregnant women, mothers and young children; they are often the only service providers some mothers and children see. As such, it is imperative that these workers are skilled addressing holistic maternal and child development needs. This is likely even more true in fragile contexts.
2. The public health sector must change its culture of "survival" focus. Survival outcomes are not independent of "thriving" and "transforming", they are one inter-linked phase of that cycle. Furthermore, this cycle is inter-generational, determining the greater health of a community.
3. Our interventions must focus on family. We must engage families, as well as identify barriers to improved behaviours and decision-making, enabling environments in which families can thrive.

It's Time to Move from Emergency to Urgency Addressing Malnutrition

Out of the frying pan and into nutrition.

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Today's development challenges of household food insecurity, poor care and feeding practices, unclean environment, and insufficient health services lead to future consequences in children's nutrition status, morbidity, mortality, and cognitive ability. Vulnerability and fragility for these children means swinging back and forth on a continuum from bad to worse. Lines between what is humanitarian crisis and what is development challenge lose meaning when witnessing 155 million stunted, 52 million wasted, and 41 million overweight children, globally.[ii] As an agency implementing Community Management of Acute Malnutrition in 23 countries in 2017, including those in low- and middle-income contexts, World Vision acutely feels we must prevent malnutrition before it occurs. That is a child's right.

Prevention is the mother of innovation.

World Vision is doing things differently on the ground. When we observed that mothers' infant and young child feeding decisions were highly influenced by their own mothers, we piloted The Mamanieva Project in Sierra Leone. This programme demonstrated that focusing behavior-change counselling on grandmothers significantly increased consumption of nutrient-rich diets in mothers by 30% and in infants by 25%, as well as attained significantly higher average infant birthweights in intervention versus control sites. Realising that under-five children with severe acute malnutrition were often diagnosed too late, World Vision successfully trained nearly 2,000 mothers in Mauritania to screen for malnutrition using mid-upper arm circumference (MUAC) measurement and bilateral oedema testing – the first use of mother-led MUAC screening in the country. Struggling with the low level of workforce nutrition expertise globally, we developed e-learning courses to build foundational capacity in stunting and anaemia, and saw that 98% of graduates apply learning to their jobs. In the Philippines, in conjunction with the Department of Health, our Crowd-Based Monitoring of Milk Code Compliance project (funded by Bill and Melinda Gates Foundation) developed a web-based platform to monitor and improve compliance to the Philippine Milk Code and Expanded Breastfeeding Promotion Act.

Fragility does not mean impossibility.

Serving the most vulnerable children in the world requires development of the evidence-base for nutrition programming in fragile and conflict affected contexts. We have a lot to learn. In Somalia, we saw one partner supporting Outpatient Therapeutic Programmes in their coverage area and another partner supporting Target Supplementary Feeding Programmes in theirs, resulting in malnourished children's access to one or the other programme with no referral mechanism between the two. We are not surprised; we also implemented incomplete interventions. In Somalia, we resolved to support the nutrition cluster system to address coordination gaps. Along the way, we also determined to expand the mother-led MUAC initiative and improve nutrition survey quality, as well as translate and disseminate Integrated Management of Acute Malnutrition technical guidance.

When some in the global community concluded that the Positive Deviance Hearth (PDH) approach for addressing underweight children was not scalable, we scaled it to 50,000 children in Bangladesh and documented the decrease of underweight children six months after programme discharge: from 81% underweight at baseline to 37%. Following our presentation of this success at the World Nutrition Congress in South Africa and the Micronutrient Forum in Mexico, UNICEF and the Ministry of Health and Child Care (MoHCC) in Zimbabwe adopted PDH to complement their growth monitoring and promotion programme in that country, and now are further researching efficacy there.

> The 2017 Global Nutrition Report states that we must reject "business as usual". We agree.

Nutrition is everyone's business.

We celebrate this year's continuing Scaling up Nutrition progress, the strengthening of the Global Emergency Nutrition Cluster, and integrated UN ownership of the Decade of Action to End Malnutrition. We celebrate countries that have reduced their stunting prevalence. The prevention of malnutrition requires, ultimately, prioritisation by all development actors. We need educators to educate on nutrition, farmers to prioritise diet diversity and household food security, and water engineers to ensure water quality at household point-of-use. When we note the deplorable gap in nutrition expertise globally, our solution is not just to increase nutritionists, but build nutrition capacity across the multi-sector workforce.

Operational Factors for Integrating Nutrition with Agriculture/Livelihood Programmes:
https://www.wvi.org/publication/operational-factors-integrating-nutrition-agriculture-livelihood-programmes

ENRICH News:
https://www.wvi.org/publication/enrich-news-january-2018

Mamanieva Project Executive Summary:
https://www.wvi.org/nutrition/publication/mamanieva-project-executive-summary

Recommendations

Based on our experience, we believe:

1. The global community must move beyond the historic humanitarian-development schism to ensure a continuum of care for and prevention of malnutrition.
2. Multi-stakeholder, and multi-sector coordination to address underlying causes of malnutrition must be in place in every country.
3. A far more proactive investment is urgently required to build nutrition-specific and nutrition-sensitive workforce capacity.
4. Nutrition indicators, inclusive of exclusive breastfeeding prevalence, need to be prioritised as national-level indicators for development to significantly advance the global nutrition agenda, as well as development, more broadly.

A reflection on our commitment:

To achieve our commitment to Nutrition for Growth, World Vision will invest $1.2 billion and work with more and more partners in nutrition-specific and nutrition-sensitive programming between 2013 and 2020.

2018: The 40th Anniversary of the Alma Ata Declaration

The clock is ticking for millions of the most vulnerable.

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Despite reducing child deaths by 56% between 1990 and 2016,[2] a child born in Sierra Leone today is still 30 times more likely to die before their fifth birthday than a child born in the UK.[iii] About half the world's population does not have full coverage of essential health services.[iv] Many people genuinely want to correct this inequity, but are hindered by a $33 billion global health sector funding gap[v], and a 40 million health and social workforce shortfall.[vi] These are similar conditions that led to the 1978 Alma Ata declaration and the new concept of primary health care (PHC). Fundamental to PHC were principles of the human right to essential health and the responsibility of communities themselves to assume ownership of their health outcomes.

It is time for the next generation of improved community approaches.

Approaching the Alma Ata anniversary, we see both a renewed call to action for PHC and community system strengthening (CSS), as well as more systematic evaluation of the past 40 years' efforts. One assessment of 36 peer-reviewed studies on PHC impact found that "Reductions in infant mortality (the most frequently studied outcome) attributed to PHC actions averaged about 40%, and varied from 0% to as high as 71% over intervention periods ranging between 2 and 10 or more years."[vii] This is compelling for PHC, and should give us pause regarding the efficacy of intervention consistency. The same assessment reveals that interpretation of PHC impact is hampered by poor operational conceptualization and inadequate peer-reviewed evaluation, as well as highlights the importance of "accurately measuring variations in the technical quality of primary care delivered".

Recommendations

Based on our experience, we believe:

1. To realise the dream of Alma Ata, we must invest much more deeply in the implementation science of community system strengthening.
2. We must take on the challenges of discovering, building, and sustaining monetary and non-monetary incentives for community self-mobilisation.
3. We must lower the cost and complexity of health interventions, while maintaining results and impact to enable scale up in the poorest and most fragile contexts.
4. We must improve intervention quality and functionality.

Scale what is effective; stop the rest.

World Vision has found these same results and conclusions in our Child Health and Nutrition Impact Study, a quasi-experimental evaluation over three years in four countries of two core health and nutrition CSS approaches (CHWs implementing a household timed and targeted counselling approach and a community-level social accountability approach). The study confirmed a positive impact on delivery of a complete continuum of care to improve newborn survival. Comparing intervention with comparison sites at end-line, the Johns Hopkins evaluation team found that, in Zambia, the chance of mothers receiving adequate continuum of care was six times greater in intervention versus comparison areas. In Cambodia it was three times greater, and in Kenya mothers had a 38% greater chance of receiving adequate care.

And yet, the evaluation also demonstrated inconsistent and sub-optimal intervention quality and platform functionality. Like so many other CSS evaluations, measurement was only focused on health and nutrition outcomes, missing the opportunity to capture improvements in community capacity and social capital, as well as potentially many more exponential outcomes.

Community system strengthening should be addressed scientifically.

Since World Vision supports 220,000 CHWs, we take their functionality very seriously.[viii] Toward this end, we have found the CHW Assessment and Improvement Matrix extremely helpful, and have implemented it across numerous programmes.[ix] Within the tool's four-level scale ranging from "non-functional" to "highly functional", we have found many programmes to lie between "partly-functional" and "functional." Applying this assessment in a timely manner has allowed us to course-correct many of our programmes. Subsequently, we replicated this implementation quality-assurance approach for five other programme types including the Community Health Committees (CHC) and Health Facility Management Committees (HFMC): Program Functionality Assessment to assist ministries and supporting organisations in assessing CHC and HFMC programme functionality – now evaluated in five countries.

[2] See http://www.who.int/mediacentre/factsheets/fs178/en/.

Community Health Committees and Health Facility Management Committees:
https://www.wvi.org/hiv-and-infectious-diseases/publication/community-health-committees-and-health-facility-management

Applying An Equity Lens to Maternal Health Care Continuum in Rural Communities of Cambodia, Guatemala, Kenya and Zambia:
http://internalmedicinereview.org/index.php/imr/article/download/666/pdf

A reflection on our commitment:

In 2017, World Vision reached over 18 million children in 58 countries with community system strengthening programmes – in nearly 3,000 communities.

2017 was a Milestone for Women's and Girls' Empowerment, as well as Sexual and Reproductive Health Rights

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We have faith in rights realisation.

The year 2017 witnessed a coalescence of three inter-related movements: sexual and reproductive health and rights (SRHR), women's and girls' empowerment, and a focus on adolescents. Each movement has distinct priorities, though SRHR cuts across them strongly. The Every Woman Every Child initiative has a dedicated advocacy strategy for each. The Canadian government put feminism unambiguously at the center of its international assistance strategy.

World Vision's work on the ground, together with our global advocacy, has made significant contributions on every level of this agenda. And yet, from time to time, we find ourselves excluded from partnering spaces because of a singular issue: access to safe abortion. World Vision actively advocates 99% of the SRHR agenda, and 100% of women's, girls' and adolescents' empowerment. We have the programmatic record to attest to our leadership. We believe that as a faith-based organisation, we have a right to conscientiously abstain from abortion support. And we are certain that faith community exclusion from the SRHR agenda is extremely shortsighted.

Our metaphor for bringing the best of public health science and religious belief together is a bridge.

Working with partners, we aim to be a bridge between these communities, connecting them, and shaping the most effective shared agenda for women, girls, young children, and adolescents.

Fundamentally, we believe that faith communities worldwide continue to represent the social capital required to fully achieve this agenda. In line with the ethos of universal and primary health care, community is the key to universal health outcomes.

With generous support from the Templeton Foundation, World Vision recently put this assertion to test, employing a quasi-experimental design used to determine knowledge, practice and coverage related to healthy timing and spacing of pregnancy, and contraception among 4,350 mothers of children under two years of age in Kenya and Ghana. The evaluation followed implementation of the World Vision Channels of Hope (COH) faith leader engagement model. The results showed 30% greater odds of contraceptive use in the areas where engagement with faith leaders was implemented. Modern contraceptive method mix, which denotes contraceptive availability and accessibility, showed a 40% increase in intervention areas in Kenya. Based on these results, we are scaling the COH-SRHR work from one to six counties in Kenya.

COH is a wonderful example of bridging the faith-science divide. In practice, it brings faith and health experts together to meticulously explore how to develop positive health key messaging based on theological foundations, enabling faith leaders to responsibly guide their congregations, whether they are Christian, Muslim, Hindu or another faith. In 2017, we engaged nearly 10,000 faith leaders with this approach.

Our Healthy Timing and Spacing of Pregnancy programme in Kenya, Mobilizing for Maternal and Neonatal Health Through Birth Spacing and Advocacy (co-funded by Bill and Melinda Gates Foundation), also employed the COH intervention, alongside household-level behavior-change counselling, health workforce capacity building, and our Citizen Voice and Action social accountability approach.[x] The final evaluation showed that over 6,000 women were referred to health services for family planning counselling by 136 trained faith leaders, of which 3,847 decided to use a contraception method. Following three years of intervention, this programme saw a 20% (49.5 to 69.5) increase in modern contraception use. Knowledge of community members regarding the key message "delay the first pregnancy until the girl is at least 18-years-old" increased 25% (52 to 77).

Recommendations

Based on our experience, we believe:

1. There is need for an agenda of inclusiveness amongst global SRHR stakeholders. Exclusion of faith-based actors is a high-risk strategy that can only isolate and create conflict in communities.
2. Faith-based actors must advocate positive, evidence-based public health recommendations. The faith community must transparently acknowledge historic errors, alongside the critical primary health care contributions they have made. And we must hold each other and ourselves accountable for our impact, positive and negative.

Channels of Hope - Kenya's MOMENT Project:
https://www.wvi.org/publication/channels-hope-kenya

Evaluation of Healthy Timing and Spacing of Pregnancy and Family Planning Project in Garba Tulla Ward:
https://www.wvi.org/publication/evaluation-healthy-timing-and-spacing-pregnancy-and-family-planning-project-garba-tulla

Mobilizing for Maternal and Neonatal Health Through Birth Spacing and Advocacy:
https://www.wvi.org/publication/mobilizing-maternal-and-neonatal-health-through-birth-spacing-and-advocacy

A reflection on our commitment:

World Vision is a global SRHR champion and leader addressing multi-sectoral and social capital development required to empower women and girls.

Fragile Contexts Challenge Sustainable Development Goals Attainment

People are key to breaking the fragility cycle.

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As the world made great progress in development, particularly in the significant decline of under-five child mortality, our attention increasingly shifts toward the intransigent corners of vulnerability - the most fragile contexts. Women, children and adolescents are uniquely and disproportionately affected by conflict and fragility: Over half of global maternal and child mortality now occurs in these contexts. The world has taken note; the need to increase reach and investment into fragile contexts is a well- established priority. World Vision strategy has called for doubling its resource allocation to fragile contexts by 2030, representing one-third of its global expenditure.

A history to be proud of.

World Vision has a long history of championing health and nutrition in fragile and conflict-affected contexts stemming from our support for orphaned children following the Korean War, to our provision of medical aid to Vietnamese boat people in the aftermath of the Vietnam War, and our management of the only paediatric hospital in Phnom Phen during the Khmer Rouge years. Today, World Vision supports health and nutrition work in 14 of the 20 most fragile states.[3]

In 2016, Aga Khan University concluded a meta-analysis of seven of our maternal, newborn, child health and nutrition programmes implemented in Afghanistan between 2007 and 2015, reaching nearly a quarter-of-a-million people. In 2017, we subsequently conducted a Lives Saved analysis on three of those programmes, finding average reductions in maternal, under-five, and newborn mortality respectively of 2.6% (range 0 to 6.8), 16% (range 13 to 19), and 18.8% (range 14.4 to 24.4).

Singular contributors to these reductions included 322% increase in contraception use, as well as increases in antenatal care (36%), skilled birth attendance (37%), early initiation of breastfeeding (37-59%), and tetanus toxoid vaccinations (50%). These achievements were largely the result of building the capacity of midwives and community health workers to deliver quality service. Aga Khan's evaluation found that these programmes all had partial to high probability of sustainability.

Effective national coverage in Somalia.

World Vision has managed the Global Fund-funded tuberculosis (TB) programme in Somalia for 14 years, with national coverage. In that time, we have seen the number of treatment centres grow from 34 to 95, 156,000 people treated with 88% success rate, and 83% of those tested for TB also tested for HIV, resulting in 63% of the HIV-positive patients receiving anti-retroviral treatment. This level of success achieved in one of the world's most unstable countries requires, above all else, negotiation. The Somalia TB success story is founded on a deep investment into consensus building among multiple stakeholders countrywide, including the three separate Somali governments, and development of inclusive stakeholder coordination through the Somali Aid Coordinating Body and the TB Coordination Team.[xi]

While it is true that international funding modalities for fragile contexts urgently require review, addressing not only the total gaps, but issues of duration, continuity and geopolitical prioritization, funding will never be a comprehensive response to the humanitarian and development needs of these countries. The World Vision theory of change for fragile contexts recognises the continuum of capacity building and resilience forming investments needed from system strengthening to demand creation and individual behaviours. We believe in the power of individual, family and community agency alongside strengthening service delivery.

[3] Per the Fund for Peace Fragile States Index.

Hope In Fragility - Improving health outcomes for women and children:
https://www.wvi.org/maternal-newborn-and-child-health/publication/hope-fragility

Role of an international non-governmental organisation in strengthening health systems in fragile-state context: Evaluation results from South Sudan :
https://aejonline.org/index.php/aej/article/view/162/205

A reflection on our commitment:

World Vision has committed to Every Woman Every Child Movement to invest $2 Billion in health and nutrition programming in fragile contexts from 2017 to 2030.

Recommendations

Based on our experience, we believe:

1. There is a need for greater and more consistent coordination between government and civil society development actors in fragile contexts. It is the fundamental step toward planning consensus, effective task allocation, and accountability.
2. Development in fragile contexts will not occur in the absence of community agency. While acknowledging the critical role of service system strengthening, it must be accompanied by responsibility for development in the community itself. In every case, we must support communities to manage their developmental needs effectively, within their resources, and to hold duty bearers accountable for their rights.
3. We must acknowledge the low levels of human resource capacity in fragile contexts and invest in people. Systems management and service delivery must be task-shifted to the local workforce. In these contexts, human resource development may be the single greatest and most sustainable investment we can make.

It Takes Health to End Violence Against Children

It's time to smash old development stereotypes.

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Incredibly, one billion children across the globe experience violence every year. This is why World Vision advocated for the 2016 World Health Assembly Resolution adopting the Global Plan of Action to strengthen the role of the health system in addressing interpersonal violence, in particular against women and girls, and against children. The action plan acknowledges the diverse physical, psychological, reproductive and behavioural outcomes of violence – outcomes that catalyse inter-generational instability.

It is clear that it takes public health investment to end violence against children.

And it is why, in 2016, World Vision launched a five-year global campaign: It Takes a World to End Violence Against Children. During campaign implementation planning across our national offices, three issues were most frequently cited requiring prioritisation: child marriage, domestic violence, and sexual violence. It is no surprise that globally, 12 million girls are married each year before the age of 18.[xii] It is not difficult to see the relevance of these issues to health outcomes; they are deeply intertwined with our broader sexual and reproductive health, adolescent, and empowerment agendas.

Adolescent girls help each other.

One of the best embodiments of integrated programming addressing the nexus of violence and health is the Determined, Resilient, Empowered, Aids-Free, Mentored and Safe (DREAMS) Initiative administered by the US Department of State and the President's Emergency Plan for AIDS Relief (PEPFAR). World Vision implements DREAMS programming in four countries (Kenya, Mozambique, Uganda, and Swaziland) and is a proud winner of the DREAMS Innovation Challenge for its Strengthening School Community Accountability for Girls Education (SAGE) project in Uganda.

Our baseline survey with 45,000 adolescent girls in Uganda sadly revealed that 70% had experienced school-related sexual and gender-based violence within the previous six months. SAGE aims to reduce secondary school dropout among these girls (targeting those 13-19 years), in 151 schools in 10 districts. The project utilizes a two-pronged strategy of an Early Warning System (EWS) and Stay in School Committees (SISC) to transform social norms and practices, reduce risks of early marriage, pregnancy, GBV, and HIV infection, and support girls to stay in school. The EWS is an adolescent-led evidence-based monitoring system that identifies critical vulnerabilities and risk factors (attendance patterns, behaviour, and academic performance) and triggers quick actions to reduce dropout. The SISCs serve as a school-community body tackling the EWS-identified causes of absenteeism, as well as monitors and supports girls to stay in school through development and implementation of school-community action plans. To date, 14,334 girls have been supported to stay in school - a 98% retention rate across all 151 schools; 815 girls have been flagged and successfully been referred to the SISC for follow up.

Together, we will end child marriage.

To address child marriage in Nepal, where 37% of girls marry before the age of 18, World Vision implemented a highly integrated programme-approach in five districts:

Health	Health personnel and primary female health workers were trained on child rights, protection, and psychosocial support.
Education	The school management committee, teachers and school-based child protection clubs were supported to raise awareness on stopping child marriage.
Protection	27 village child protection and promotional committees were strengthened and assisted to prepare plans of action and improve their case management on addressing child marriage and other protection issues.
Faith	Hindu, Buddhist, Islam and Christian faith leaders were trained to become advocates on child rights and protection, as well as educate children, parents and the community on child protection issues.
Advocacy	Village child protection committees were trained to prepare action plans with budgets, which were presented to the local planning governance body.

"I'm so happy and relieved. I want to encourage the girls suffering like me that they should not lose hope. I appreciate the donor (PEPFAR) and World Vision and encourage them to continue programmes like these because I was suffering and they have given me the capacity to achieve my goal and helped me believe that life can change."

Rebecca, 17
Lira-Uganda (SAGE-DREAMS girl participant whose situation was identified and was supported to return to school).

Recommendations

Based on our experience, we believe:

1. Violence against children is a significant impediment to health and nutrition outcomes and must be addressed within the health system.
2. Using the right approaches, significant reductions can be made in early marriage and other child protection problems.
3. Children must be involved in violence reduction programme design and implementation.
4. Programmes addressing violence against children should take a highly integrated approach.

Independent evaluation of this programme conducted by the International Institute for Child Rights and Development and Columbia University found that in intervention areas, there was a greater than 70% reduction in early-marriage incidence.[xiii] The qualitative evaluation demonstrated strong local ownership of the changed social norms. Evidence of the work of child protection actors on stopping child marriages was shared at the national level and contributed to the development of the National Strategy to Eliminate Child Marriage in Nepal.

Something Old, Something New: The Evolving Social Norms of Child, Early and Forced Marriage:
https://www.worldvision.org.uk/files/8114/7793/5797/The-Evolving-Social-Norms-Of-Child-Early-And-Forced-Marriage.pdf

What Works To End Violence Against Children? Seven Things We Have Learned:
https://www.wvi.org/publication/what-works-end-violence-against-children-seven-things-we-have-learned

Positive Discipline Alternatives To Corporal Punishment Training Manual To End Violence in Schools:
https://www.wvi.org/publication/positive-discipline-alternatives-corporal-punishment-training-manual-end-violence

Training Manual On Early Warning System: a strategy to prevent school dropout in Uganda:
https://www.wvi.org/publication/training-manual-early-warning-system-strategy-prevent-school-dropout-uganda

A reflection on our commitment:

World Vision intends to help over 100 million children escape violence through its five-year campaign (2017-2021) It Takes a World To End Violence Against Children.

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viii Cisney, Michaela. 2015. Expanding World Vision's impact through community health workers: A global census of progress to scale. World Vision International.

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