

Theory and Practice

Scientific Series regarding poverty alleviation, humanitarian relief, and developmental advocacy



Sarah Rowena Einloth

Building Strong Foundations

World Vision's Focus on Early Childhood Development and Child Well-being

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by

Sarah Rowena Einloth

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on behalf of the World Vision Institute for Research and Development
in co-operation with the Child Development and Rights Team
within World Vision International's
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Abstract

Prevention is the key to sustainable transformational development in tackling the root causes of child poverty. In this context, this paper has been produced by the World Vision Institute for Research and Development in co-operation with the Children in Ministry Department (Child Development and Rights) to bring attention to the importance of an early childhood focus within international World Vision (WV) programming. Anchored in the framework of WV's *Child Well-being Outcomes* (CWBOs), our objective is to fuel the present discourse on early childhood development (ECD) within the global World Vision partnership. This paper should thereby provide a first basis to understand the crucial need to emphasize early childhood development in WV programmes and to encourage further research and ongoing steps to develop practical guidelines for WV programme staff. This document focuses on children under five years of age (pre- and post-natal stages), a period of life which is most crucial in determining later development processes. **A lack of basic needs during early childhood can lead to severe negative impacts in later lifecycle stages; some deficits have irreversible consequences.** This research paper is based on a broad review of past and recent literature in addition to support provided by experts within WV International and science. The scope of the study has proved itself to be very comprehensive and revealed complex interconnections between different subject areas. All WV's CWBOs - with regard to health, education, spiritual nurture and child protection, care and participation - are essentially interlinked and pose a similar set of questions, namely: to what extent have issues on ECD been directly incorporated into the existing set of WV's CWBO indicators? How are the different forms of 'well-being' in early childhood to be defined and measured? How can these indicators be contextualised on the local level? Our findings provide a broad overview of relevant themes relating to early childhood and leave much room to investigate individual topics more in-depth. That is, while WV has worked intensively to develop a good knowledge base in some areas (such as in maternal and early childhood health and nutrition), other areas (in particular spiritual nurture, early stimulation and participation of children under five (U5s)) have been less researched and implemented. In this context, one major challenge will be to not only work with quantitatively measurable (i.e. objectively observable) patterns of U5s well-being, but also to strengthen young children's sense of 'self', i.e. an underlying subjective awareness of certain attitudes and behaviours. Generally, we will have to find ways to effectively integrate different CWBOs, to merge traditional with scientific knowledge on early child rearing practices, to apply multiple-level interventions and to be aware of socio-cultural, economic and political power structures. Most importantly, however, is that we will have to start taking young children seriously and learn to correctly interpret their needs. Subsequently, focusing on early childhood will be a most useful and cost-effective strategy for World Vision's goal to reduce child poverty as a whole. The starting point is to raise awareness of the importance of children's early development stages as the best time to start tackling this overall objective.

Preface

With its new emphasis on *Child Well-being Outcomes* (CWBO), the international development NGO World Vision has recently introduced a whole new set of development indicators that will not only determine the organization's work of poverty alleviation for the coming years but also set important criteria for how development success will be measured and evaluated. As an organization with a strong emphasis on the child, the Child Well-being Outcomes appear to be a serious attempt at placing the child where it belongs: at the very center and focus of our work.

By introducing the four pillars (health and nutrition, early stimulation and education, spirituality and responsibility, protection and participation), World Vision is reflecting in its developmental practice the scientific recognition that child well-being must be seen to be holistic, coherent, and multi-faceted. Child well-being has to do with a child's physical, mental, psycho-social, spiritual and even judicial (rights-based) development.

The introduction of World Vision's Child Well-being Outcomes are not to be considered to be an irrevocable or unalterable set of criteria. On the contrary: they need to be further tested, verified, evaluated and, if need be, modified – as experience is gathered and evidence is collected. The CWBOs are “work in progress”. World Vision experts are sure: The CWBOs are leading us into the right direction although we do not yet know exactly where they will take us and what the actual outcome will be.

One of the important scientific findings regarding child well-being is the realization that the earliest years in a child's life are particularly crucial to a child's later development, which is true not only with regard to nutrition and health, but also in terms of the other aspects of a child's life. What is neglected during a child's earliest years, will be difficult to compensate later in life. The first five years are of key importance, and the first two years are especially crucial. It is for this reason that World Vision Germany has decided not only to adopt the CWBO strategy but to also place special emphasis on early childhood development (i.e. on children under 5). However, when the senior management took that decision, they did not claim to be aware of all the repercussions involved. As it turned out, the decision was well-founded and scientifically sound, but it needed more focused attention, a more solid scientific base, and a well-suited strategy to follow it through all the way to its eventual success.

We were fortunate enough to enjoy, at the World Vision Institute for Research and Development, the presence of Sarah Einloth who spent several months with us surveying not only the scientific data but also World Vision's current state of affairs with regard to early childhood development and to collect all this into an extensive paper that might serve as the foundation for further research and practical implementation. The quick reader will find the abstract and summaries just as helpful as the recommendations and the open questions which demonstrate that the present paper, too, is “work in progress” needing further research and refinement.

I would like to take this opportunity to thank Sarah for the invaluable work she accomplished. Her paper may serve as a kind of guidepost for those having to take decisions with regard to early childhood development and for those implementing programs designed to achieve child well-being.

Kurt Bangert

Director Research

World Vision Institute for Research and Development

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Sarah R. Einloth

List of Acronyms

ADEA	Association for the Development of Education in Africa	DADD	Do, Assure and Don't Do (<i>World Vision</i>)
ADP	Area Development Programme	DeRT	Development Resources Team (<i>World Vision</i>)
AED	Academy for Educational Development	ECD	Early Childhood Development
AIDS	Acquired Immune Deficiency Syndrome	ECCD	Early Childhood Care and Development
ANC	Antenatal care	ECCE	Early Childhood Care and Education
ARI	Acute Respiratory Disease	EFA	Education for All (<i>UNESCO</i>)
ART	Anti-retroviral treatment	ENHANCE	Expanding Nutrition and Health Achievements through Necessary Commodities and Education
ARV	Anti-retroviral	FGD	Focus group discussion
BCC	Behaviour Change Communication	GAM	Global Acute Malnutrition
CC	Christian Commitment	GER	Gross Enrolment Ratio
CCC	Community Care Coalitions	GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
CCF	Christian Children's Fund	HBLSS	Home Based Life Saving Skills
CDOPC	Children deprived of parental care	HI	Hope Initiative
CFS	Child Friendly Spaces	HIV	Human Immunodeficiency Virus
CGECCD	Consultative Group on Early Childhood Care and Development	H/N	Health and Nutrition
CHV	Community Health Volunteer	HOME	Home Observation for Measurement of the Environment
CHW	Community Health Worker	HPC	High-prevalence context
CIM	Children in Ministry	HSS	Health System Strengthening
CMAM	Community-based Management of Acute Malnutrition	ID	Infectious Disease
CoH	Channels of Hope	INGO	International non-profit Organisation
CRC	Convention on the Rights of the Child (<i>United Nations</i>)	IPM	Integrated Programming Model
CtC	Child-to-child	IQ	Intelligence Quotient
CWBO	Child Well-being Outcome	IRC	International Rescue Committee
CWI	Christian Witness Initiative	IRS	Indoor residual spraying
CYP	Children and young people	IAWGCP	Inter-Agency Working Group on Children's Participation

ISCED	International Standard Classification of Education	SAM	Severe Acute Malnutrition
ITN	Insecticide-treated bed net	SC	Stabilization Centre
KCS	Keeping Children Safe	SCF	Save the Children Fund
LEAP	Learning, Evaluation, Accountability and Planning	SCN	Standing Committee on Nutrition
LLIN	Long-lasting insecticidal net	SD	Standard Deviation
MAM	Moderate Malnutrition	SFP	Supplementary Feeding Programme
MCHN	Maternal and Child Health and Nutrition	SNPolicy	Spiritual Nurture Policy (<i>World Vision</i>)
MDG	Millennium Development Goal	SO	Support Office
MICAH	Micronutrient and Health	SOWC	State of the World's Children
MoH	Ministry of Health	STH	Soil-transmitted Helminthes
MoM	Model of Ministry	TB	Tuberculosis
MTCT	Mother-to-Child Transmission	TBA	Traditional Birth Attendant
MUAC	Middle Upper Arm Circumference	TDI	Transformational Development Indicator
MVC	Most vulnerable children	ttC	Timed and targeted counselling
NBTL	New Breakthrough to Literacy	UDHR	Universal Declaration of Human Rights
N-CoE	Nutrition Centre of Expertise (<i>World Vision</i>)	UN	United Nations
NGO	Non-profit Organisation	UNESCO	United Nations Educational, Scientific and Cultural Organization
NO	National Office		
OAU	Organisation of African Unity	UNFPA	United Nations Population Fund
ORT	Oral Rehydration Therapy	UNICEF	United Nations International Children's Fund
OTP	Outpatient Therapeutic Programme	VAD	Vitamin A deficiency
OVC	Orphans and vulnerable children	WB	World Bank
PMTCT	Preventing Mother-to-Child Transmission	WeD	Well-being in Developing Countries
PNC	Postnatal Care	WFP	World Food Programme
PRP	Primary Reading Programme	WHO	World Health Organisation
PTA	Parent Teacher Association	WV	World Vision
R&D	Research and Development	WVI	World Vision International
RO	Regional Office	WVInst	World Vision Institute
RUTF	Ready-to-use therapeutic food		

Summary of World Vision’s “Child Well-being Outcomes”

In accordance with World Vision’s holistic approach on child development and child well-being, the partnership has developed a framework of *Child Well-being Outcomes* (CWBOs) which has been approved by the World Vision International Board in 2009. The CWBOs are based upon Christian principles and supported by human rights conventions.

WV’s biblical foundation for defining the CWBOs is expressed in Luke 2:52: “*And Jesus grew in wisdom and stature, and in favour (grace) with God and with people*”.¹

He grew in **Stature** - In the Jewish tradition, the body is the object of special care because it is God’s creation and special gift of grace. Growing in stature implies growing caring for the body and for healthful nutrition, for recreation and play and healthy conditions at home.

He grew in **Wisdom** - In the Hebrew culture this word meant more than only intellectual and academic knowledge. Not only knowing more, but living better, with virtues and character formation, and the ability to make good choices for life

He grew in **Grace** with God and with the community- Jesus’ parents guided him by modelling a coherent life, by instructing him in knowledge of the scripture, and in being faithful to their faith traditions. Jesus enjoyed relationship with God the father, but also with the community in which he lived. He enjoyed the affection, admiration, solidarity, love, sympathy and expressions of grace from the community that is so necessary for all human development.

Source: WV n.d., *Contributing to the well-being of children: World Vision’s Way of Contributing to Child Well-being*, slide 4.

World Vision’s main framework for promoting children’s rights is the UN Convention on the Rights of the Child (CRC). The CRC provides the minimum standards not only for children to ‘survive’ by means of access to adequate health and nutrition. It also gives guidelines to any other relevant elements that are important for children to actually ‘live’ in a way that they are able to develop their full potential in their individual intellectual, mental and social capacities. An awareness of children’s rights has also contributed to increased participation of children in WV programming.²

¹ WVI 2009, *World Vision’s Way of Contributing to Child Well-being: Child Well-being Outcomes and Indicators*.

² Stephenson 2007.

Essentially, World Vision’s *Child Well-being Outcomes* are defined as: Children 1) enjoy good health, 2) are educated for life, 3) love God and their neighbors, and 4) are cared for, protected and participating (see table below). Foundational principles are that children are citizens and their rights and dignity are upheld (including girls and boys of all religions and ethnicities, any HIV status, and those with disabilities).³

Girls & Boys:			
Enjoy good health	Are educated for life	Love God and their neighbours	Are cared for, protected and participating
Children are well nourished	Children read, write, and use numeracy skills	Children become aware of and experience God's love	Children are cared for in a loving, safe, family and community environment with safe places to play
Children are protected from infection, disease, and injury	Children make good judgments, can protect themselves, manage emotions, and communicate ideas	Children enjoy positive relationships with peers, family, and community members	Parents or caregivers provide well for their children
Children and their caregivers access essential health services	Adolescents ready for economic opportunity	Children value and care for others and their environment	Children are celebrated and registered at birth
	Children access and complete basic education	Children have hope and vision for the future	Children are respected participants in decisions that affect their lives

The CWBOs do not only provide a framework for a common understanding of child wellbeing. They are also practical guidelines for front line staff that can be used as a tool in ADP development programming. Generally speaking, the CWBOs are an effective strategy to contribute not only to ameliorate the consequences but also to prevent the causes of child poverty and low living standards. Prevention is the key to WV’s approach to long-term sustainable development. Thus, focussing on early childhood is a major contributor in identifying and countering potential risk factors early. It is the objective of this paper to look at each of WV’s CWBOs and link them to early childhood development issues.

The CWBOs are not a rigid pattern of rules; rather they should be understood as a dialogical tool to facilitate ongoing discussions between different stakeholders that are involved in development programming processes (including the children themselves, families, communities, churches, local governments and other organisations). In particular, as ADP staff is working closely together with

³ WV 2009, *LEAP and Child Well-being*, World Vision International, California, USA, p. 9.

local people in diverse cultural settings, the CWBO indicators need to be contextualised according to the specific needs of the individual communities.

Underlying the CWBO framework, World Vision has developed a compendium of indicators to measure WV's contribution to children's wellbeing in different sectors. Those indicators have been put together by WV teams across the partnership and are further supplemented by data from external organisations (e.g. UNICEF, WHO). The compendium of indicators comprises a list of indicators (including information and tools) to support WV programmes in measuring progress towards the CWBOs.⁴ These indicators can be selected by WV staff according to regional and national office (RO/NO) strategies, programme objectives as well as the specific local context. This flexibility in applying different indicators is particularly relevant for an early childhood focus, because certain CWBOs as they are defined now may have to be adapted in relation to this specific age group (i.e. children aged -9 months to 5 years). Contextualisation requires continuous revision of indicators to identify those ones that are locally most relevant. However, although suggestions for extensions can be made, programme staff in ROs and NOs should not add new indicators to their contextualised version of the compendium directly.⁵ Those last two points also emphasize the need for more profound research in early childhood development in order to make empirically-based decisions to effectively realize WV's child wellbeing outcomes.

Health and Nutrition

The first *Child Well-being Outcome* is: "Children enjoy good health". With regard to early childhood development, this is the area that has been most thoroughly researched and analysed by WV. The issue of health has experienced much attention also in connection with WV's just recently launched *Child Health Now* campaign as well as its *7-11 Health and Nutrition Strategy* that reflect a profound commitment to tackle issues of illness and disease in young children. Focusing on ECD (ranging from children aged -9 months to 5 years) implies that we need to develop frameworks that involve supporting both mothers and children (i.e. maternal and child health and nutrition (MCHN) interventions). In this context, treatment is certainly important, but preventive measures are the key to improving children's health in the long term. This paper refers to the major 'child killers' in children under five. It further discusses nutrition as a separate topic due to its major relevance (also in connection to other CWBOs). HIV and AIDS also require special attention, in particular with regard to efforts to prevent mother-to-child transmission (PMTCT). Fundamentally, we need to recognize not only the immediate causes of young children's ill health and malnutrition, but most

⁴ The compendium of indicators is a revised version of WV's originally applied Transformational Development Indicators (TDIs) that were however no longer sufficient to measure progress towards newly introduced CWBOs.

⁵ WV 2010, *Indicators for Measuring Child Well-being Outcomes: Global Level Guidance*, World Vision.

importantly we must tackle the underlying reasons that are essentially rooted in a society's organisational structures.

Early Education and Foundational Life Skills Development

The second *Child Well-being Outcome* is: “Children are educated for life”. However, ‘education’ in early childhood should not only be understood as formal pre-school education. With regard to ECD this sector needs to be considered from a much broader perspective. Thus, early childhood education is as much about ‘care’ as it is about general ‘life skills development’, which may be promoted either through centre-based or home-based programmes. Early childhood education starts at the household level through early stimulation provided by a child’s caregivers and is directly influenced by the quality of the home environment as well as by parents’ educational and economic status. Early childhood care and development (ECCD) programmes can further assist children’s transition to primary school and thereby prevent later deficits in children’s intellectual wellbeing. Generally, we have to acknowledge that learning already begins from the moment of birth (major brain functions actually start developing in pre-natal stages) and in addition early childhood education is closely interconnected with other CWBOs that are required for a child’s cognitive development processes.

Spiritual Nurture and Social Relationships

The third *Child Well-being Outcome* is: “Children love God and their neighbours”. The issue of spiritual wellbeing and nurture has been a much debated subject. As a faith-based organisation, World Vision has a clear mission statement and core values in relation to its Christian Commitment (CC) and Ministry framework. However, it appears that there are still ongoing discussions with regard to how we define children’s understandings and perceptions of ‘God’s love’. There has been a recent survey conducted among children in which they expressed their own views on WV’s *Policy on the Spiritual Nurture of Children*. This may help to gain a better insight into children’s perspectives as well as concerns about WV’s CC frameworks. However, especially in early childhood it may be difficult to gain a valid understanding on how young children subjectively experience spiritual wellbeing. With reference to the Compendium of indicators, spiritual development very much emphasizes the importance of interpersonal relationships and care for others as well as children’s personal identity and hopes about the future. However, it seems that there is still much need to develop specific tools of measurement in order to actively support children in their spiritual growth, right from the start.

Child Safety, Protection and Participation

The fourth *Child Well-being Outcome* is: “Children are cared for, protected and participating”. Most fundamentally, the understandings of early childcare, protection and participation differ depending on a culture’s specific norms, values and belief systems. This implies that WV staff has to work closely together with local people in order to gain an understanding of their cultural ways of life, attitudes and behaviours. In this context, child care practices differ cross-culturally and so do particular notions of what is acceptable or not acceptable in terms of appropriate punishments for young children. Furthermore, there exist various types of abuse that can negatively affect young children’s wellbeing, with long-lasting consequences in their later lives. In this context, early childcare and protection is also connected to other CWBOs. For example, it is a fundamental right of any child to be aware of his or her own personal identity. Birth registration is crucial to grant children this right. However, where children are not registered, they can experience severe emotional as well as physical harm as they may be denied access to important health care and educational services. In terms of care, WV acknowledges that the family is the preferred setting for a child to grow up. Still, alternative care models exist, however choosing the one that is most suitable for a child depends on the individual context in which he or she lives. Responsibilities for young children’s protection fall onto the child him- or herself, caregivers, institutions, governments as well as WV staff operating in the field. Practical learning games may help raising awareness about child protection within communities. With regard to participation, we need to acknowledge children - even the very young – to be active participants within their family and community environment (not passive observers), who should also be involved in the planning and design of development programmes. There is still need for clarification about how to promote participation in early childhood.

It is important to stress that all four CWBOs are essentially interlinked. At present, the health and nutrition sector seems to be predominant within WV programming focusing on early childhood (see WV’s recent *Child Health Now* campaign and *7-11 Health and Nutrition Strategy*). Admittedly, the first CWBO is an essential prerequisite for positive outcomes in any of the other sectors. However, in order to improve children’s overall wellbeing, we need a much broader understanding of children’s physical, intellectual, social and spiritual development in the early stages of their lives.

Focusing on early childhood is a cost-effective strategy for World Vision’s overall goal to reduce child poverty. The starting point is to raise awareness of the importance of the early childhood stages for any development sector. One major challenge will be to not only work with quantitatively measurable (i.e. objectively observable) patterns of child wellbeing, but also to strengthen children’s sense of ‘self’, i.e. an underlying subjective awareness of certain attitudes and behaviours. The best time to start tackling these goals is in early childhood.

Recommendations for Action

The following is a summary of recommendations for action that are drawn from the individual chapters of this paper on World Vision's child well-being outcomes.

CWBO I: Recommendations for Action

1) Recommendations for policy makers

- ◆ Bring early childhood health and nutrition into the political discourse!
- ◆ Invest in basic services and safety nets for mothers and young children.

2) Recommendations for ADP staff

- ◆ Identify the *underlying* determinants of child malnutrition and ill health: poverty, hierarchical power structures on the community and household level etc.
- ◆ Improve people's awareness on the local level regarding the importance of early childhood and maternal health/nutrition (e.g. see WV's 7-11 H/N Strategy).
- ◆ Approach women, because their decision-making power in early child health and nutrition is a crucial determinant for young children's well-being.
- ◆ Consider traditional norms and values that might interfere with development interventions, e.g. traditional child feeding practices that could harm an infant's health.
- ◆ Consider a range of multiple determinants that can influence children's physical well-being
 - 1) People's ways of life (standard of living, behaviour etc.)
 - 2) Children's environment (community support, a safe social setting etc.)
 - 3) Children's age (different caring and nutritional needs etc.)
- ◆ Provide adequate nutrition, safe drinking water, sanitation and hygiene for U5s to prevent infectious diseases *before* any treatment becomes necessary.

- ◆ Facilitate capacity building and knowledge exchange: promote community-based solutions through active involvement of beneficiaries in programme design and implementation processes, e.g. through community groups (such as CCCs) and training of CHWs/TBAs.
- ◆ Use multiple-level interventions to tackle early childhood sickness and disease; i.e. consider the individual, community and environmental level.
- ◆ Use integrated programming models for programme delivery, e.g. combine nutritional schemes, disease prevention and treatment.
- ◆ Identify the most vulnerable groups among infants and young children (e.g. newborns, children with disabilities, orphans, girls, ethnic minorities etc.) within any given context.
- ◆ Promote equal opportunities for everyone regarding the availability and accessibility of services.
Ask:
 - 1) How can MCHN services be delivered most effectively (e.g. through public services or home-based care)?
 - 2) Who does WV staff need to approach on the household level (i.e. who is predominantly responsible for early child care within the family setting)?
 - 3) Who decides about whether a child receives particular health care and nutritional services, or not?

CWBO 2: Recommendations for Action

1) Recommendations for policy makers

- ◆ Bring early childhood education into the political discourse!
- ◆ Invest in early childhood teacher/caregiver training and formal educational institutions.
- ◆ Promote equal opportunities to access ECCD programmes; if projects only reach the more advantaged groups, the inequality gap between poor and better-off people widens.

2) Recommendations for ADP staff

- ◆ Be aware that early childhood education does not necessarily mean 'formal pre-schooling'. Instead, education for U5s is very much linked to general child care practices to foster broader development processes.
- ◆ Promote children's early stimulation - i.e. psychosocial support through primary caregivers - on the household level and in institutions to improve their later cognitive development.
- ◆ Work closely together with parents to promote children's early stimulation within the family; there is more research needed for mechanisms to support parents in this matter.
- ◆ Consider the quality of the home environment, educational status and support of parents/caregivers when planning early childhood education programmes.
- ◆ Adapt your programme design to the particular socio-cultural context of a community's setting:
 - 1) Consider different ideas and practices regarding early childhood education
 - 2) Use an integrated approach to early childhood care and development (ECCD) that responds to the needs of the individual child while involving families and the wider community in programme implementation
 - 3) Combine early childhood development programmes with health services and nutritional schemes
- ◆ Be aware of context-specific social issues and aim to reach the most disadvantaged children (e.g. orphans, girls, children affected by HIV and AIDS, ethnic minorities, non-registered children, children deprived of parental care, children living in remote rural areas etc.).
- ◆ Address gender stereotypes through acknowledgement and inclusion of female roles in early childhood education. In addition, promote active involvement of men into programmes, safe transport for children to centre-based institutions, training of female teachers and so forth.
- ◆ Bring together children from diverse backgrounds in order for them to learn mutual acceptance and to avoid later discrimination and social exclusion.
- ◆ Consider issues of verbal communication in educational settings (i.e. inclusion of official and/or minority languages).

- ◆ Consider issues of curriculum design:
 - 1) Acknowledge and integrate a society's context-specific norms and values
 - 2) Focus on early foundational and essential life skills development that supports children's sensory awareness, physical coordination, the learning of certain social competencies (e.g. taking on responsibilities) and interpersonal skills
 - 3) Find more research on defining early literacy and numeracy skills and determine whether they are constructive for U5s development; consider how those may be implemented in diverse social settings
 - 4) Ask: Are current CWBO 2 indicators applicable to *early* childhood education? And, how can we adapt present indicators to make them age-appropriate for U5s?

- ◆ Do more research on other themes, including education in emergency situations, children with disabilities and early childhood education staff training.

CWBO3: Recommendations for Action

1) Recommendations for policy makers

- ◆ Bring early childhood spiritual nurture into the political discourse!
- ◆ Work together with churches and spiritual leaders to develop concrete ideas of how to best integrate young children into religious activities.

2) Recommendations for ADP staff

- ◆ Carry out more in-depth research on spiritual nurture in U5s considering WV's child well-being outcomes. Create an understanding of U5s spiritual experiences and needs. Find answers to:
 - 1) How do we define and measure young children's subjective experiences of God's love / spiritual wellbeing?
 - 2) How do young children see themselves within the context of the environment in which they live - i.e. what are U5s concepts of their own identity as well as the meaning and purpose in their lives?
 - 3) How do children interpret their relationships with God and other people through narratives, beliefs and traditions?

- ◆ Be aware that *spiritual development* and *spiritual nurture* mean different things to different people. Start promoting WV values that may be more or less universal:
 - 1) Encourage children's love for others and positive human interrelationships (with family, peers and community members)
 - 2) Empower children, build their resilience and increase their hopes through strengthening their positive self identities
- ◆ Develop frameworks that acknowledge local belief systems as well as support WV's commitment to facilitate young children's spiritual development in getting to know Christian values; WV's CWBO indicators may have to be contextualised, i.e. culturally appropriated depending on the individual socio-cultural context.
- ◆ Use spiritual nurture in connection with other CWBOs; e.g. promote U5s developing assets such as determination and willpower, basic life skills and positive interactions with others, engagement in learning as well as healthy lifestyles.
- ◆ Integrate early childhood spiritual nurture within other dimensions of development, e.g. health services or ECCD programmes.
- ◆ Facilitate forums for open discussions regarding general ideas about early childhood care and spiritual nurture; this includes building rapport between WV staff and local communities as well as bringing together people from different faith backgrounds.
- ◆ Integrate early childhood groups into already existing programmes and activities in local churches.

CWBO 4: Recommendations for Action

1) Recommendations for policy makers

- ◆ Bring early childhood care, protection and participation into the political discourse!

2) Recommendations for ADP staff

- ◆ Be sensitive to culturally-determined differences in early child care practices, because they are not universally the same; e.g. what may be considered to be an acceptable way of punishing

young children in one context might not be acceptable in another (see also different forms of child abuse).

- ◆ Take on a cultural relativist approach:
 - 1) Gain an understanding of other people's values in terms of their own culture
 - 2) Engage in a dialogue with community members to achieve a mutual understanding among all stakeholders (i.e. beneficiaries as well as programming staff) of how young children ought to be treated in ways that is in their own best interest; e.g. use focus group discussions (FGDs) on early childhood care and protection
 - 3) Do NOT tolerate abusive behaviours towards young children
- ◆ Be aware that a community is not a homogenous unit, i.e. adults and children within the same community may experience their environments very differently (depending on factors such as gender, ethnicity, social class and so forth).
- ◆ Be aware of socio-cultural, economic and political power structures on the local level that 1) include or exclude certain individuals, and 2) influence the adoption or rejection of early child care models.
- ◆ Raise awareness on the individual, family and community level about *all* children's rights to be protected and participating:
 - 1) Identify infants and young children that are particularly at risk of lacking protection and social inclusion (e.g. migrants, ethnic minorities, girls, children with disabilities, orphans, children affected by HIV and AIDS and so forth)
 - 2) Develop ways of better protecting and integrating marginalised U5s into their families and community daily life
- ◆ Use practical learning games that involve community members from all different levels in order to communicate issues on child protection to adults as well as children.
- ◆ Improve birth registration (i.e. availability and accessibility) for infants and young children to provide them with an identity as well as with access to basic social services.
- ◆ Implement care models that are in the best interest of the young child
 - 1) First preference: Strengthen existing family bonds and relationships between young children and their key attachment persons; i.e. the family as primary unit in which a child should grow up
 - 2) Alternative models of care: Contextualize possible solutions for the individual child if the family setting does not provide children with adequate protection; i.e. parents are unable to

care for their children properly or children are getting abused (physically, emotionally or spiritually)

- ◆ Ensure high child protection standards when carrying out fieldwork locally; be responsible for the protection of the children you are working with.

- ◆ Train yourself and others to understand the specific needs of infants and young children; avoid to only making assumptions about what children's preferences are.
 - 1) Listen to children and take them seriously
 - 2) Develop tools that enable us to correctly interpret children's needs; i.e. see the world with children's eyes
 - 3) Involving children more actively in decision-making processes

Open Questions

The following is a summary of some of the key questions that may be considered in further research on early childhood development and child well-being.

CWBO 1

- ◆ Who does WV staff need to approach on the community level? Consider: who is responsible for early child care? In particular, who decides about whether a child receives particular health care services and adequate nutrition, or not?
- ◆ Behaviour Change Communication (BCC): How can we communicate 'scientific' knowledge about H/N on the local level?
- ◆ Nutrition: How can we promote better child feeding practices (e.g. exclusive breastfeeding)?
- ◆ HIV & AIDS: How can we improve issues on counselling services, life-skills training for U5s, gender (i.e. stigmatisation of mothers) and fragmentation of PMTCT monitoring?

CWBO 2

- ◆ Is there empirical evidence for the benefits of early reading, writing and numeracy skills? Are there alternatives measurements?
- ◆ How can we adapt present indicators for 'intellectual well-being' more specifically to early childhood development?
- ◆ How can parents/caregivers best support an infant or young child? E.g. through play, reading books to children, telling stories, singing songs etc.
- ◆ Who is traditionally responsible for young children's upbringing? How do caregivers' attitudes, behaviours and childrearing practices encourage/impede children's cognitive development?
- ◆ How can WV programming strengthen the capacities of caregivers without interfering in traditional cultural structures

CWBO 3

- ◆ How do we practically measure young children's self identity?
- ◆ How can we analyse and evaluate young children's subjective experiences of God's love and spiritual well-being?

- ◆ How can spiritual nurture be achieved through both educational programmes as well as community-level daily interactions?
- ◆ How can WV support young children in their individual context-specific spiritual development, but at the same time not promote other religious beliefs?
- ◆ How can U5s be involved in religious practices?
- ◆ How can parents and other caregivers be involved in programmes, in particular when their views differ from our values?
- ◆ What will WV do if children want to convert, but their parents disagree and/or choose another religion for them?

CWBO 4

- ◆ How may children from different backgrounds experience their environments differently (e.g. migrants, ethnic minorities, girls vs. boys etc.)?
- ◆ Who do orphans identify with? What can be done to strengthen their sense of 'self'?
- ◆ What are the reasons for children not telling about their abuse? What does stop adults from responding to child abuse within the home environment and the broader community?
- ◆ How can children with disabilities be better protected?
- ◆ To what extent are different child care models applicable to U5s?
- ◆ How do we measure participation in children under five years of age?

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Introduction

I. World Vision's Commitment to Improve Child Well-being

I.1. World Vision's Child-focused Approach

World Vision (WV) is an international non-profit organisation (INGO) with a special commitment to support children deprived of basic human needs and thus denied to live a life in all its fullness. WV's global partnership is based on Christian values and a mission statement to working with the poor and oppressed, regardless of their religion, race, ethnicity or gender. WV's child-focused approach is part of the organisation's integrated Model of Ministry (MoM) and is defined as follows:

“Child focus prioritizes children, especially the poorest and most vulnerable, and empowers them together with their families and communities to improve their well-being”

(WVI Board approved Integrated Focus document, 2007)

Community empowerment works according to the principle: ‘helping people to help themselves’. Fundamentally, this encapsulates collaboration between WV and several stakeholders through multiple level interventions. WV works through transformational and sustainable development, emergency relief and advocacy. On the one hand, WV cooperates with policy makers and the public at the regional, national and global level. On the other hand, WV works directly together with children, families and communities on the local level to develop and improve people's capacities and resilience to risk factors. This requires a sharing of resources, sensitivity towards the individual contexts and an approach that is non-discriminating towards different socio-cultural systems. Most importantly, bringing about continuous and long-lasting positive changes towards the eradication of poverty and injustice can only be achieved through a profound *bottom-up* perspective (rather than *top-down* ideologies) in which children are regarded to be the key active agents for shaping their own future.

WV's child-focused approach is based on a holistic and integrated view of child well-being. The ecology of the child describes this perspective in terms of outside influences of children's broader environment as well as intra-communal relationships. All in all, these interrelations take place between the individual child, his or her family and peers, civil society and institutions as well as broader systems and structures. In addition, outside forces - such as natural disasters, economic crises, armed conflicts and pandemics - can have negative effects on children's well-being. Early

childhood is the first phase within World Vision's lifecycle approach that aims to maximise children's development at particular life stages. Supporting children from the very beginning of their lives has a cumulative effect as it leads to sustainable improvements of benefits and well-being outcomes for the individual child as well as for following generations.⁶

The Ecology Working Group emphasizes that child well-being can only be understood and hence improved if we "integrate scholarship associated with research and application that encompasses the organisation of the physical and social environment, motivation and personal efficacy, biological systems that regulate behaviour, and the particular ways individuals engage themselves in their setting".⁷ In fact, we need to keep in mind that focussing on children does not mean to centre our attention only on the individual child, but rather to focus our attention on the child 'in context'. This requires a broader perspective and complex analysis.

1.2. Child-focused and Child-centred

Developing programmes are both *child-focused* as well as *child-centred*. Fundamentally, child-centred programming is associated with discrete sector interventions that are directed towards particular lifecycle stages (i.e. WV's work centres on improving children's positive development and well-being). However, having children at the centre of WV programming does not mean that they are isolated from their environment. In order to achieve sustainable development it is therefore crucial to strengthen social networks as a key strategy to improve children's well-being as an inclusive ongoing process.⁸ A *child-focused* approach may therefore be understood as *primarily targeting* or *giving priority* to children without ignoring, but integrating, the broader context.

This contextual approach is particularly important in relation to early childhood, because at this stage children are most dependent on their families and community support. An early childhood focus emphasizes a future-oriented perspective on preparing children for a healthy and productive life later on. However, it is important to not consider young children as merely passive recipients of charity support. An early childhood focus is not just about making preparations for later development stages. It does not exclusively focus on a state of 'becoming', but it should also acknowledge children as present human 'beings'. This is only to stress WV's commitment towards child *well-being* and not necessarily *well-becoming* (notably with the former as a prerequisite for the latter).⁹ In short, small

⁶ WV 2009, *World Vision's Way of Contributing to Child Well-being: Child Well-being Outcomes and Indicators*, slide 14.

⁷ Andrews et al. 2002, *Ecology of Child Wellbeing: Advancing the Science and the Science-Practice Link*, p. 8.

⁸ Stephenson, P. 2007, *Child Focus Survey: A Review of WV Staff Perspective on Child Focus*, Children's Rights and how to increase WV's Child Focus, World Vision.

⁹ Woodhead, M. 2006, *Changing perspectives on early childhood: theory, research and policy*, UNESCO, p. 28; See also Lansdown 2004, 'Participation and young children', in Jim Smale & Teresa Moreno, *Young children's participation: rhetoric or growing reality?*, *Early Childhood Matters*, vol. 103, pp. 4-14.

children need to be considered as full persons as well as active participants within their communities in the here and now.

1.3. The World Vision Institute for Research and Development

1.3.1. *Early Childhood Focus*

The World Vision Institute for Research and Development (WVInst) was established in 2009 as a research facility within the WV Germany office. The objective of the WVInst is to seek ongoing improvement in the organisation's working processes through knowledge pooling of existing WV expertise as well as the incorporation of new scientific insights. This paper has been produced as a contribution to one of the Institute's main subject areas: Early Childhood Development (ECD).

The WVInst recognizes early childhood to be the most crucial lifecycle stage and starting point in determining children's progressive growth and well-being. ECD provides the foundation for tackling the root causes of later development deficits in the broad areas of health, education, social relations, spirituality, child protection and participation. This strategy has been proven to be highly cost-effective in particular as its predominant focus is on prevention, rather than treating the symptoms of child poverty.

The staff at the WVInst focus their research specifically on children aged -9 to 0 months (prenatal stages and birth) and 0 to 5 years (postnatal and early childhood stages). This is because the first few years of a child's life have a determining and irreversible impact on his or her future development and well-being. In particular, health and nutrition, early attachment relationships, sensory learning, gross and fine motor skills, coordination, language formation, the ability to think and reason as well as social skills develop very rapidly until the age of five years. There are certainly some characteristics of early childhood development stages, including specific basic needs (e.g. food, shelter, medical care, positive relationships, early stimulation, opportunities for play and exploration etc.), that are more or less universal or 'natural'.¹⁰ However, early childhood development is also very much a socio-cultural process. Socialisation (i.e. the acquirement of context-specific social norms, values and behaviours) within and outside the home environment has a significant influence on children's capacity building.¹¹

¹⁰ See also Hyde & Kabiru 2003, 'Early Childhood Development as an Important Strategy to Improve Learning Outcomes', *Working Document DRAFT*, ADEA Biennial Meeting (Mauritius, December 3-6, 2003), Paris, France, pp. 65-66; WV 2005, *Guide to Mobilising and Strengthening Community-led Care for Orphans and Vulnerable Children*, p. 149.

¹¹ CGECCD n.d., *Principles of Child Development*, The Consultative Group on Early Childhood Care and Development, viewed 26 February 2010, http://www.ecdgroup.com/principles_child_development.asp

Consequently, early childhood development is not a simple and straightforward concept to be incorporated into development programming. The primary reason for this is that the idea of ECD is both holistic as well as socially constructed. There are many different dimensions contributing to the outcomes of a child's early formative years. That is young children have particular needs that are required for their physical, intellectual, emotional, social and spiritual well-being. Positive outcomes in one area cannot compensate for another area lagging behind; rather, all developmental dimensions are interdependent and affect one another in both positive and negative ways. Furthermore, ideas about particular child rearing practices as well as children's capabilities and competencies during early life stages vary cross-culturally. In addition, broader themes (such as gender, ethnicity, social class, religion and so forth) also shape a society's expectations on young children and the individual's experiences of early childhood. Thus, one of the major challenges in developing ECD programmes will be to contextualise general frameworks in specific social settings and to be sensitive in local-level communication.

Generally, there is a need to develop a more comprehensive knowledge base concerning the under-five age group, in particular with regard to developing countries. Research on early childhood development so far has predominantly focused on North America and Europe. However, children's upbringing differs considerably with regard to socio-cultural, economic and political circumstances. We therefore need to take into account that issues such as severe lack of basic necessities, poor housing and sanitation, HIV and AIDS, armed conflict, forced migration and the like are usually not the main concern of psychological discussions on ECD. The major obstacle preventing young children in developing countries to reach their full potential are issues associated with child poverty.¹² The fight against poverty is World Vision's primary concern and the WVIInst strongly supports this effort within its early childhood development focus.

1.3.2. *Child Poverty*

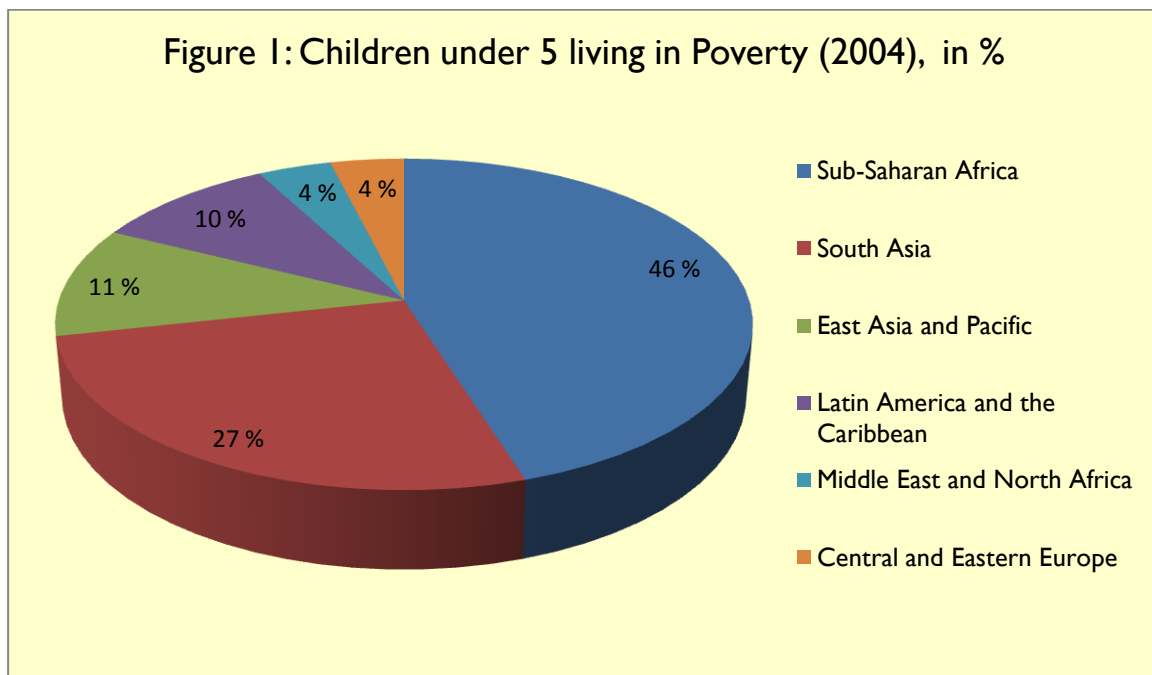
Child poverty is the key indicator that we need to consider in measuring child well-being. However, child poverty is a very broad and complex topic that needs to be considered from different perspectives. Gordon et al. (2003) explain that absolute poverty has been defined as "a condition characterised by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to social services".¹³ They further state that children are living in absolute poverty only if they suffer from two or more of those indicators. The point is that children in developing countries in fact often deal with multiple deprivation issues on a regular basis.¹⁴

¹² Grantham-McGregor et al. 2007; Penn, H. 2004, pp. 16-17.

¹³ Gordon et al. 2003, p. 5.

¹⁴ Gordon et al. 2003.

Infants and young children are particularly vulnerable to the negative effects of severe deprivation and child poverty is a serious problem worldwide. However, in a global comparison, early childhood poverty is particularly prevalent in developing countries. In 2004, about 559 million children under five years of age were living in developing countries. Of this total number about 126 million children lived in absolute poverty (that is about 22% of all children in developing countries). Regionally, most of these children lived in Sub-Saharan Africa (46%) and South Asia (27%), (see also Figure 1, p. x).¹⁵



Source: Grantham-McGregor, S. et al. 2007, 'Developmental potential in the first 5 years for children in developing countries', *The Lancet*, vol. 369, no. 9555, p. 65.

Generally, we can say that severe deprivation causes poor developmental outcomes. In early childhood, these issues are particularly critical due to children's vulnerability to the detrimental impact of lacking basic needs. Though, an early childhood focus also requires us to ask whether there are certain poverty indicators that are particularly relevant for this specific age group. For example, early social attachments and sensitive care are crucial determinants for a child to develop a positive self image, healthy emotional bonds, intellectual competencies, resilience and empathy towards others.¹⁶ In fact, World Vision's perspective on poverty emphasises *deprivation* as well as *broken relationships* (with each other, the environment and God) as causal determinants for human sufferings and thus mirrors the importance of interpersonal relations.¹⁷ Fundamentally, analysing indicators for early childhood poverty requires us to not only consider most commonly used income measures

¹⁵ Grantham-McGregor et al. 2007, pp. 64-66.

¹⁶ Sinclair 2007.

¹⁷ WV 2008, *Development Thinking and Practice in historical Perspective: Understanding Poverty and Development*, Paper No. 1 (First Draft), p. 18.

(these are important, though not sufficient). Instead, we also have to take into account quality of life measures, in particular those that specifically relate to young children's basic needs. Those quality measures are best defined by means of *Child Well-being Outcomes (CWBOs)* which are the core focus of this paper.

1.4. WV's Approach to Child Well-being

Fundamentally, World Vision's Ministry Framework states that the organisation's primary goal is "the sustained well-being of children within families and communities, especially the most vulnerable".¹⁸ The Wellbeing in Developing Countries (WeD) Research Group broadly defines well-being with regard to three different components:¹⁹

- 1) What a person *has or does not have* (i.e. material resources such as food, shelter, physical environment, economic assets or income)
- 2) What a person *does or cannot do* (i.e. social interactions determining the distribution of resources, based on particular power structures)
- 3) What a person *thinks or feels* (i.e. cultural values and belief systems influencing people's subjective experiences)

These dimensions are all inextricably interlinked. In particular, as with poverty, it is not only the material aspects that need to be taken into account. Instead, we also need to consider the significant influence of local-level social interrelationships as well as people's personal experiences and evaluations of their own circumstances. World Vision's holistic approach on child development therefore specifically defines child well-being as:

"...successful individual functioning (involving physical and mental health, social and spiritual dimensions of development), positive relationships and a social ecology that provides safety, social justice, and participation in civil society".²⁰

Child well-being thus needs to be considered from multiple perspectives drawing from different disciplines and professions. 'Successful individual functioning' may also be understood in terms of children's personal capabilities concerning their opportunities for positive development. In this context, a child's social environment also greatly influences his or her capacity building.²¹ However, the most important point is that infants and young children experience their environments very

¹⁸ WV 2009, *LEAP and Child Well-being*, World Vision International, California, USA, p. 2.

¹⁹ WeD n.d., *Wellbeing Research in Developing Countries: What is Wellbeing?*, Wellbeing in Developing Countries Research Group, viewed 8 April 2010, <http://www.welldev.org.uk/wed-new/about/what.html>

²⁰ Stephenson 2007, p. 3.

²¹ Tsegaye 2008, p. 8.

differently compared to older children and adults. Thus, taking into account a range of different points of view is essential in planning ECD projects.

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Penn, H. 2004, 'What does 'child development' tell us about early childhood programming and the participation of children?' in *Early Childhood Matters*, Jim Smale & Teresa Moreno, *Young children's participation: rhetoric or growing reality?*, no. 103, pp. 15-20.

Sinclair, A. 2007, '0-5: How Small Children Make a Big Difference', *Provocation Series*, vol. 3, no. 1 *The Work Foundation*, London, UK.

Tsegaye, S. 2008, *Short Lives and Limited Life Chances: An Overview of Child Wellbeing in Africa*, The African Child Policy Forum, Addis Ababa, Ethiopia.

Woodhead, M. 2006, *Changing perspectives on early childhood: theory, research and policy*, UNESCO.

WV 2010, *Indicators for Measuring Child Well-being Outcomes: Global Level Guidance*, World Vision.

WV 2009, *LEAP and Child Well-being*, World Vision International, California, USA.

Additional Online References

<http://www.ecdgroup.com/> - The Consultative Group on Early Childhood Care and Development

<http://www.welldev.org.uk/> - Wellbeing in Developing Countries Research Group

Chapter I: Child Well-being Outcome (I) - “Children Enjoy Good Health”

First Pillar: Early Childhood Health and Nutrition

1. Why Focus on Early Childhood Health and Nutrition?

2. Scientific Background

2.1. Facts and Figures

Over the last decades, there have been quite some positive improvements regarding the efforts to reduce the health and nutritional status of mothers and young children in developing countries. However, most recent data confirms that we still have a long way to go in eradicating the root causes of hunger and disease among the most deprived people in this world.^{22,23,24}

Table I: Life Expectancy at Birth (2007)²⁵

Region	Life expectancy at birth (in years)
Industrialised countries	79
Developing countries	67
Least developed countries	55
Sub-Saharan Africa	50
South Asia	64
Latin America and Caribbean	73

The data in Tables I-3 provides a first overview of the urgency of an early childhood focus in development assistance and humanitarian aid. However, crude numbers are only the result and first indicators of poor health and nutrition among children under five; the underlying reasons are much more complex. In this context, World Vision’s focus on the poorest and most vulnerable people means to particularly paying attention to those groups most at risk of ill-health and

²² WV 2008, ‘Last chance for the world to live up to its promises? - Why decisive action is needed now on child health and the MDGs’, *Policy Briefing*, UN high-level event on the MDGs.

²³ UN 2007, *The Millennium Development Goals Report*, New York, pp. 14-17.

²⁴ UNICEF 2008, *Progress for Children: A Report Card on Maternal Mortality*; UNICEF 2009a, ‘Child Mortality’, *Childinfo: Monitoring the Situation of Children and Women*, viewed 8 February 2010, http://www.childinfo.org/mortality_overview.html

²⁵ UNICEF 2008, p. 121; The ‘life expectancy at birth’ is the number of years a newborn infant would be expected to live if health and living conditions at the time of its birth remained the same throughout its life.

malnutrition, including infants and young children as well as pregnant and breastfeeding women. This is because many health issues and nutritional deficiencies in pre-natal, post-natal and early childhood development stages can have long-lasting negative consequences in later life, even up until adulthood. Moreover, some of those problems are irreversible if not detected early enough to respond to their adverse effects.

Table 2: Under-five Child Mortality Rate (2008)²⁶

Table 3: Infant Mortality Rate (2008)²⁷

Region	Under-five mortality rate (per 1000 live births)
Industrialised countries	6
Developing countries	72
Least developed countries	129
Sub-Saharan Africa	144
South Asia	76
Latin America and Caribbean	23

Region	Infant mortality rate (per 1000 live births)
Industrialised countries	5
Developing countries	49
Least developed countries	82
Sub-Saharan Africa	86
South Asia	57
Latin America and Caribbean	19

2.2. Scientific Research

WHO (2003) describes *health* as “a state of complete physical, mental and social well-being.”²⁸ This definition recognizes that health is more than just the absence of hunger and disease. Rather, good health has to be understood in connection to other well-being outcomes. In this chapter we will predominantly be focusing on the consequences of physical ill health for young children under five. In the following chapters we will be discussing the issue of health in connection to early childhood cognitive development, spiritual well-being and child care practices. *The Lancet* series on ‘Child Development in Developing Countries’ (2007, three volumes), ‘Neonatal Survival’ (2005, four volumes) and ‘Maternal and Child Undernutrition’ (2008, five volumes), provide a good basis of comprehensive data on maternal and child health and nutrition (MCHN) and has also been used for

²⁶ UNICEF 2008; UNICEF 2009b, ‘Under-five mortality’, *Childinfo: Monitoring the Situation of Children and Women*, viewed 8 February 2010, http://www.childinfo.org/mortality_underfive.php

²⁷ UNICEF 2008; UNICEF 2009c, ‘Infant mortality’, *Childinfo: Monitoring the Situation of Children and Women*, viewed 8 February 2010 http://www.childinfo.org/mortality_infantmortality.php

²⁸ WHO 2003, ‘Skills for Health - Skills-based health education including life skills: An important component of a Child-Friendly/Health-Promoting School’, *Information Series on School Health*, Document 9.

World Vision's theoretical frameworks. There are many other accounts that have dealt with specific aspects of early childhood health and nutrition development issues. As we go along, we will refer to several other sources including information that may or may not yet have been integrated into World Vision development programming.

3. World Vision Background

3.1. World Vision's 'Child Health Now' Campaign

World Vision recently launched the *Child Health Now* campaign which draws attention to the urgency of tackling the issue of preventable deaths among infants and young children. The reality is that each year 9.2 million children under the age of five die due to preventable health-related causes. In this context, World Vision is particularly addressing the poor progress in reaching the United Nations (UN) Millennium Development Goals (MDGs) 4 and 5 and speaks of a 'silent emergency' in order to bring more attention to the issue within the political discourse.^{29, 30} The MDG targets were set for the period between 1990 and 2015 and are aiming to:

- 1) Reduce under-five child mortality by two thirds (MDG 4, target 1)
- 2) Reduce maternal mortality by three quarters (MDG 5, target 1)
- 3) Achieve universal access to reproductive health (MDG 5, target 2)

Despite these ambitious targets, up to this point only 30 percent progress of cutting under-five child mortality by two thirds by 2015 has been achieved. Every day, 24,000 children are still dying before their fifth birthday due to largely preventable causes. In addition, every year 500,000 women die as a result of preventable diseases and complications during pregnancy and childbirth. The progress towards achieving the MDG 5 has been less than 10 percent so far.³¹ And, the fact that only 3 percent of the world's overall development assistance account for child and maternal health stresses the urgency of investing in this sector even more.³² In this context, and in accordance with the United Nations Convention on the Rights of the Child (CRC), World Vision is committed to promote the principles outlined in Article 24 of the child rights agenda, that is:

World Vision aims to improve children's rights to access and benefit from "*the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health*" and to encourage

²⁹ WV 2009a, *Child Health Now: Together We can End Preventable Deaths*.

³⁰ WV 2009b, 'Who's counting? 9.2 Million Children: The Cost of Inaction on Child Health', *Policy Briefing*, no.1.

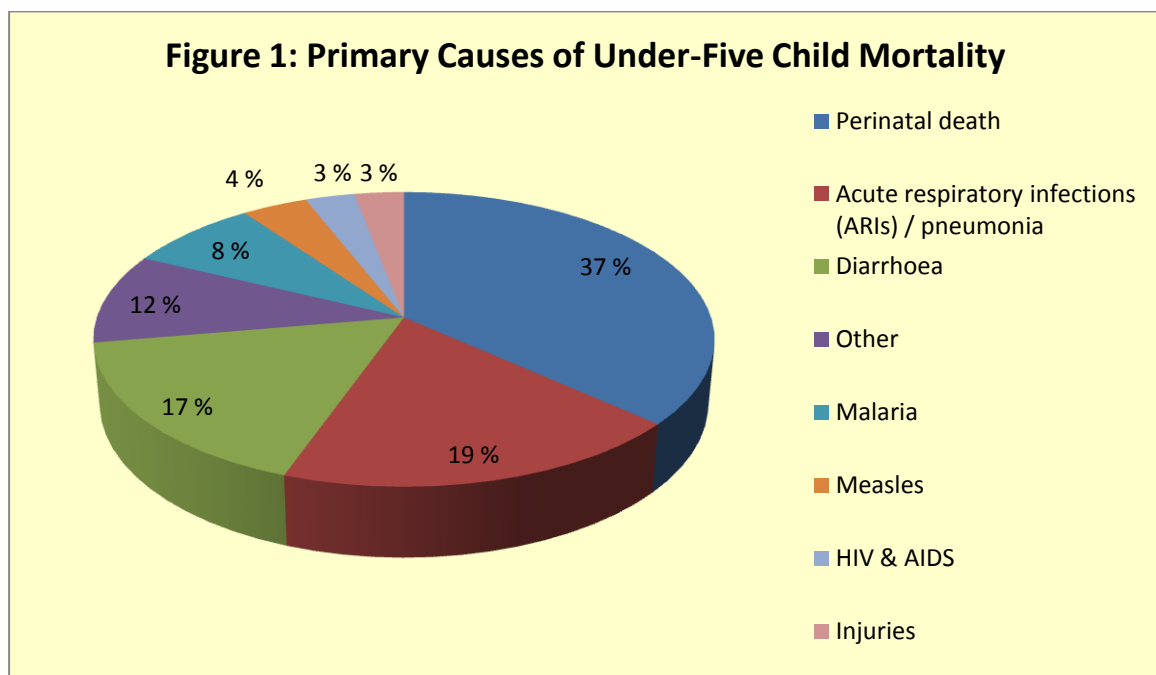
³¹ See also WV 2008, pp. 5-6. Tables 1 and 2: Summaries of regional progress towards MDGs 4 and 5.

³² WV 2009a.

states parties' responsibility to "take appropriate measures to diminish infant and child mortality".³³

In the following sections we will address early childhood health and nutrition as a fundamental concern to achieving the UN goals as well as to making progress in World Vision's programming towards the CWBO framework in general. Sections 3.3. and 3.4. provide an introduction to World Vision's most recent strategic framework on MCHN that will also be further discussed throughout this chapter. At this point, we will first be looking at the main problems related to early childhood health in developing countries.

3.2. Major 'Child Killers' in Developing Countries



Source: UNICEF 2009a, 'Child Mortality', *Childinfo: Monitoring the Situation of Children and Women*, viewed 8 February 2010 http://www.childinfo.org/mortality_overview.html; Bryce, J. et al. 2005, 'WHO estimates of the causes of death in children', *The Lancet*, p. 1150.

Figure 1 shows the primary causes of deaths among children under-five years of age.³⁴ Ninety-nine percent of all those deaths are occurring in developing countries. World Vision mostly operates in countries with high prevalence of the four major infectious diseases (ID): pneumonia, diarrhoea, malaria and measles. Together with HIV and AIDS (which differs regionally as a major cause of death in early childhood) these diseases account for half of all under-five deaths. Pneumonia and diarrhoea alone contribute to more than one third (35 percent) of all of these deaths. We will be looking at

³³ UN 1989, *Convention on the Rights of the Child*.

³⁴ See also UNICEF 2009d, *The State of the World's Children: Maternal and Newborn Health*, p. 15; WV 2009c, *Part Two: World Vision's 7-11 Strategy for Health and Nutrition*, pp. 16-20. [Note: data may vary slightly depending on the sources]

each of these four IDs in the following sections. Child deaths related to inadequate pre- and post-natal care as well as HIV and AIDS will be investigated more in depth in later sections, in particular in relation to maternal health and nutrition.

3.2.1. Perinatal Deaths

The great majority of all under-five deaths are perinatal (see also Table 3, p...), that is they occur 'around the time of birth', approximately between 3 months before and 4 weeks after birth. Accordingly, the risk of dying is greatest within the first few weeks of a child's life. Annually almost 4 million infants die within the first 28 days of their lives, which accounts for almost 40 percent of all deaths among children under five.³⁵

Further readings on perinatal deaths

Bhutta, Z. A., Darmstadt, G. L., Hasan, B. S. & Haws, R. A. 2005, 'Community-Based Interventions for Improving Perinatal and Neonatal Health Outcomes in Developing Countries: A Review of the Evidence', *Pediatrics*, vol. 115, no. 2, pp. 519-617.

3.2.2. Pneumonia

Pneumonia is the most serious ID threatening young children's health. It causes 19 percent of all under-five child deaths. In fact, more than 2 million children under 5 years of age die from pneumonia each year, accounting for almost one fifth of all under-five child deaths worldwide.³⁶ Despite this issue, there is still wide-ranging need for better diagnoses and treatment for infants and young children.³⁷ In fact, it is estimated that with adequate measures around 85 percent of all under-five deaths related to acute respiratory diseases (ARIs) could be prevented.³⁸ Proper hand washing practices alone could reduce pneumonia deaths by 23 percent.³⁹

Risk factors for pneumonia include:⁴⁰

- Stunting and underweight
- Suboptimal breastfeeding
- Lack of immunization⁴¹
- Indoor air pollution from stoves

³⁵ WV 2009a, p. 8; Lawn, J. E. et al. 2005, 'Neonatal Survival I: 4 million neonatal deaths: When? Where? Why?', *The Lancet*, vol. 365, no. 9462, p. 893.; For more detailed information see also UNICEF 2009c.

³⁶ Wardlaw, T. et al. 2006, 'Pneumonia: the leading killer of children', *The Lancet*, vol. 368, no. 9541, pp. 1048-1050.

³⁷ WV 2009c, p. 17.

³⁸ WV 2009a, *Child Health Now: Together We can End Preventable Deaths*, p. 65.

³⁹ WV 2009a, p. 43.

⁴⁰ Niessen, L. et al. 2009, 'Comparative impact assessment of child pneumonia interventions', *Bulletin of the WHO*, vol. 87, no. 6, pp. 472-480.

⁴¹ WV 2009a, p. 65. Though, a soon to be available new vaccine could reduce pneumonia disease by one third.

Considering those risk factors, it is crucial to first and foremost apply preventative measures that may involve:⁴²

- Adequate nutrition (e.g. exclusive breastfeeding, complementary feeding and vitamin A and zinc supplements⁴³)
- Reducing indoor pollution and smoke
- Timely immunisation
- Cotrimoxazole prophylaxis for HIV positive children
- Hygienic behaviours (e.g. regular hand washing)
- Early identification and referral to medical services

Further readings on pneumonia

Mulholland, K. 2007, 'Childhood pneumonia mortality – a permanent global emergency', *The Lancet*, vol. 370, no. 9583, pp. 285-289.

Roth, D. E., Caulfield, L. E., Ezzati, M. & Black, R. E. 2008, 'Acute lower respiratory infections in childhood: opportunities for reducing the global burden through nutritional interventions', *Bulletin of the World Health Organization*, vol. 86, no. 5, pp. 356-364.

Rudan, I., El Arifeen, S. Black, R. & Campbell, H. 2007, 'Childhood pneumonia and diarrhoea: setting our priorities right', *The Lancet*, vol. 7, no. 1, pp. 56-61.

Sazawal, S. & Black, R. E. 2003, 'Effect of pneumonia case management on mortality in neonates, infants, and preschool children: a meta-analysis of community-based trials', *The Lancet Infectious Diseases*, vol. 3, no. 9, pp. 547-556.

Smith, K. R., Samet, J., Romieu, I. & Bruce, N. 2000, 'Indoor air pollution in developing countries and acute lower respiratory infections in children', *Thorax*, vol. 55, pp. 518-532.

Victoria, C. G., Kirkwood, B. R., Ashworth, A., Black, R. E., Rogers, S., Sazawal, S., Campbell, H. & Gove, S. 1999, 'Potential interventions for the prevention of childhood pneumonia in developing countries: improving nutrition', *The American Journal of Clinical Nutrition*, vol. 70, pp. 309-320.

3.2.3. Diarrhoea

Diarrhoea is the second leading cause of early childhood deaths in developing countries (about 18 percent). Every year 1.5 million children die from diarrhoeal diseases.⁴⁴ Diarrhoea can result in dehydration which can cause children to become very quiet and undemanding, to get sunken eyes, dry lips and loose skin. Investments in the availability and accessibility of safe drinking water, sanitary facilities⁴⁵ and hygiene could reduce diarrhoea by 65 percent.⁴⁶ As with pneumonia, simple hand washing with soap could reduce diarrhoeal deaths by 45 percent.⁴⁷

Regarding the causes of diarrhoea (that is viral infections and ingestion of germs through unsafe disposal of faeces, poor hygiene and lack of clean drinking water as well as replacement foods for

⁴² WV 2009c, p. 17.

⁴³ WV 2009a, pp. 65/84.

⁴⁴ WV 2009a, pp. 11/41.

⁴⁵ WV 2009a, p. 43. Lack of adequate sanitation (e.g. safe toilets) is a factor in over two million annual child deaths.

⁴⁶ WV 2009a.

⁴⁷ WV 2009a, p. 65.

infants instead of breast milk)⁴⁸, the most effective interventions that could reduce the occurrence of diarrhoea include:⁴⁹

- Adequate nutrition (e.g. extra fluid intake, exclusive breastfeeding, complementary feeding as well as vitamin A and zinc supplements)
- Proper immunisation (particularly measles vaccination)⁵⁰
- Access to and availability of clean water
- Hygienic behaviours (e.g. regular hand washing, hygienic food preparation)
- Oral Rehydration Therapy (ORT)
- Early identification and referral to medical services

ORT (essential salts dissolved in clean water) is a very effective and simple to apply treatment against diarrhoea. However, according to UNICEF (2009c), around 38 percent of all children under five in developing countries suffering from diarrhoea do not receive ORT and continued feeding.⁵¹ A new vaccine against rotavirus (the main cause of fatal diarrhoea) is planned to be introduced.⁵²

Further readings on diarrhoea

Barreto, M. L., Genser B., Strina, A., Teixeira, M. G., Assis, A. M. O., Rego, R. F., Teles, C. A., Prado, M. S., Matos, S. M. A., Santos, D. N., dos Santos, L. A. & Cairncross, S. 2007, 'Effect of city-wide sanitation programme on reduction in rate of childhood diarrhoea in northeast Brazil: assessment by two cohort studies', *The Lancet*, vol. 370, pp. 1622-1628.

Boerma, J. T., Black, R. E., Sommerfelt, A. E., Rutstein, S. O. & Bicego, G. T. 1991, 'Accuracy and Completeness of Mothers' Recall of Diarrhoea Occurrences in Pre-school Children in Demographic and Health Surveys', *International Journal of Epidemiology*, vol. 20, no. 4, pp. 1073-1080.

Clasen, T. F. 2004, 'Reducing Diarrhea Through the Use of Household-based Ceramic Water Filters: A Randomized, Controlled Trial in Rural Bolivia', *The American Journal of Tropical Medicine and Hygiene*, vol. 70, no. 6, pp. 651-657.

Crump, J. A. 2005, 'Household based treatment of drinking water with flocculant-disinfectant for preventing diarrhea in areas with turbid source water in rural Kenya: cluster randomized controlled trial', *BMJ*, vol. 331, no. 7515, pp. 478-480.

Curtis, V. & Cairncross, S. 2003, 'Effect of washing hands with soap on diarrhoea risk in the community', *The Lancet Infectious Diseases*, vol. 3, pp. 275-281.

Esrey, S. A., Feachem, R. G. & Hughes, J. M. 1985, 'Interventions for the control of diarrhoeal diseases among young children: improving water supplies and excreta disposal facilities', *Bulletin of the WHO*, vol. 63, no. 4, pp. 757-772.

Feachem, R. G. 1984, 'Interventions for the control of diarrhoeal diseases among young children: promotion of personal and domestic hygiene', *Bulletin of the WHO*, vol. 62, no. 3, pp. 467-476.

Henker, J. 2008, 'Probiotic Escherichia coli Nissle 1917 Versus Placebo for Treating Diarrhea of Greater Than 4 Days Duration in Infants and Toddlers', *The Pediatric Infectious Disease Journal*, vol. 27, no. 6, pp. 494-499.

Luby, P. L., Agboatwalla, M., Painter, J., Altaf, A., Billhimer, W., Keswick, B. & Hoekstra, R. M. 2006, 'Combining drinking water treatment and hand washing for diarrhoea prevention, a cluster randomised controlled trial', *Tropical Medicine and International Health*, vol. 11, no. 4, pp. 479-489.

Luby, S. P. 2007, 'Quality of drinking water', *BMJ*, vol. 334, no. 7597, pp. 755-756.

Lule, J. R., Mermin, J., Ekwaru, J. P., Malamba, S., Downing, R., Ransom, R., Nakanjako, D., Wafula, W., Hughes, P., Bunnell, R., Kaharuzza, F., Coutinho, A., Kigozi, A. & Quick, R. 2005, 'Effect of Home-based Water Chlorination and Safe Storage on Diarrhea Among Persons with Human Immunodeficiency Virus in Uganda',

⁴⁸ WV 2009c, pp. 17/52.

⁴⁹ WV 2009a, p. 65/84.

⁵⁰ WV 2009c, p. 17.

⁵¹ UNICEF 2009d, p. 129.

⁵² WV 2009c, p. 17.

The American Journal of Tropical Medicine and Hygiene, vol. 73, no. 5, pp. 926-933.
PATH 2006, *Diarrheal Disease: Solutions to Defeat a Global Killer*.
Rudan, I., El Arifeen, S., Black, R. E. & Campbell, H. 2007, 'Childhood pneumonia and diarrhoea: setting our priorities right', *The Lancet*, vol. 7, no. 1, pp. 56-61.
The Lancet 2007, 'Access to Toilets for All', *The Lancet*, vol. 370, no. 10, p. 1590.
The Lancet 2008, 'Keeping sanitation in the international spotlight', *The Lancet*, vol. 371, no. 9618, p. 1045.
Waterkeyn, J. & Cairncross, S. 2005, 'Creating demand for sanitation and hygiene through Community Health Clubs: A cost-effective intervention in two districts in Zimbabwe', *Social Science and Medicine*, vol. 61, pp. 1958-1970.

3.2.4. Malaria

According to recent estimates, one million people die from malaria-related causes each year. About 80 percent of all these deaths occur in Africa among children under five years of age⁵³ (that means, more than 2,000 children under five are dying each day; one child every 40 seconds⁵⁴). It is important to note that pregnant women are particularly at risk, because their immune systems are weakened during pregnancy, thus making them more susceptible to the disease. Maternal infection with malaria can lead to spontaneous abortion, stillbirth or premature delivery as well as low birth weight of the newborn infant. Further consequences for the mother include maternal anaemia which, in the worst case, can lead to a maternal death.⁵⁵ It is estimated that malaria causes around 10,000 maternal deaths annually.⁵⁶

Interventions to reduce the occurrence of malaria among children under five include:⁵⁷

- Mothers and children sleep under Insecticide-treated bed nets (ITNs) / long-lasting insecticidal nets (LLINs)
- Indoor residual spraying (IRS)
- Improved nutrition
- Vitamin A and zinc supplementation
- Early identification and referral to health care service

Simple interventions, such as distributing ITNs / LLINs can have great impacts on the improvement of children's health. A comparative survey in Africa has shown that the number of children under five sleeping under insecticide-treated bed nets increased by almost 17 percent (from only 1.8 to 18.5 percent) between 2000 and 2007. However, this also means that almost 90 million children were still

⁵³ WV 2009c, p. 9.

⁵⁴ WV 2009d, *End Malaria Campaign: Talking Points - World Malaria Day*.

⁵⁵ WV 2009c ; WV 2009e, *Expanding the net: how community initiatives and local participation improve the effectiveness of malaria control efforts*, p. 4.

⁵⁶ WV 2009d.

⁵⁷ WV 2009a, p. 84; WV 2009c, p. 9.; See also WHO 2009, *World Malaria Report*, pp. 13-26. The WHO report further discusses intervention coverage in high burden African countries as well as outside Africa considering six different interventions: ITNs, ACTs, IRS, parasite-based testing, RDTs and IPTp for pregnant women.

unprotected against the disease by 2007.⁵⁸ In terms of LLIN distribution schemes, World Vision data has shown that a community-based approach targeting families at the household level and being conducted by volunteers, can be most effective in its outcomes regarding accessibility and right application of LLINs (RAPIDS model).⁵⁹

Further readings on Malaria

AMP 2008, *A toolkit for developing integrated campaigns to encourage the distribution and use of long lasting insecticide-treated nets* (1st edition), The Alliance for Malaria Prevention.

Hill, J. & Kazembe, P. 2006, 'Reaching the Abuja target for intermittent preventive treatment of malaria in pregnancy in African women: a review of progress and operational challenges', *Tropical Medicine and International Health*, vol. 11, no. 4, pp. 409-418.

Jagers, C. 2009, *Expanding the net: how community initiatives and local participation improve the effectiveness of malaria control efforts*, World Vision USA.

Lengeler, C. 2004, 'Insecticide-treated bed nets and curtains for preventing malaria (Review)', *Cochrane Database of Systematic Reviews*, no. 2.

Roll Back Malaria 2008, *Global Malaria Action Plan*, viewed 9 February 2010, <http://www.rollbackmalaria.org/gmap/>

Smithson, P. 2009, 'Down but not out: The impact of malaria control in Tanzania', *IHI Spotlight*, vol. 2, pp. 1-8.

3.2.5. Measles

"Measles is responsible for more deaths than any other vaccine-preventable disease, killing an estimated 750,000 children each year, with over one half of these deaths occurring in sub-Saharan Africa."⁶⁰ Most deaths related to measles occur among children under five^[61] and about 20 percent of all deaths account for infants under twelve months alone. Those children that survive still often face lifelong disabilities.⁶² The importance of immunisation against measles is reflected in WHO estimates, stating that between the years 2000 and 2007 the estimated number of child deaths related to measles dropped by 74 percent (from about 750,000 to 197,000 children). In addition, vaccinations play an important role not only in preventing measles as such, but also to avoid sickness as well as lifelong measles-related disabilities, including deafness, blindness and brain damages.⁶³ Despite this knowledge, the WHO estimates that in 2007 around 23 million children under one year of age did not receive a measles immunisation vaccination.⁶⁴

Interventions include:⁶⁵

- Improved nutrition
- Vitamin A supplements and as treatment
- Effective treatment of secondary diarrhoea and pneumonia
- Immunisation⁶⁶

⁵⁸ Noor et al. 2009, 'Insecticide-treated net coverage in Africa: mapping progress in 2000-07', *The Lancet*, vol. 373, no. 9657, pp. 58-67.

⁵⁹ WV 2009e, pp. 11-12.

⁶⁰ USAID 2003, *Immunization Essentials: A Practical Field Guide*, p. 224.

⁶¹ Ibid, p. 225.

⁶² WHO/UNICEF 2005, *Joint Statement: Global Plan for Reducing Measles Mortality 2006-2010*.

⁶³ WHO 2009, *State of the World's Vaccines and Immunization*, p. 80.

⁶⁴ Ibid, p. 125.

⁶⁵ WV 2009a, p. 84.

3.3. World Vision's MCHN Strategies and Conceptual Frameworks

In order to effectively reduce the negative impacts of those diseases, it is important to take into account the curative as well as preventive measures in WV programming. Any programme design focusing on early childhood development should thereby encompass strategies relating to both *maternal and child health and nutrition* (MCHN). It is generally crucial for the well-being if not even for the survival of an infant or young child that an illness is recognized early enough by the parents or caregivers. Once a disease is evident, caregivers have to take appropriate actions to treat the illness, which includes seeking proper medical services. For example, according to UNICEF (2009a) only 57 percent of children under five with suspected pneumonia in developing countries are taken to appropriate health-care providers (with only 40 percent in Sub-Saharan Africa).⁶⁷

It is important, however, that we particularly focus our attention on preventive measures that relate to the underlying causes of early childhood diseases. For example, unsafe water is the root cause of the annual 1.5 million children under five dying from diarrhoea.⁶⁸ In this context, education of children and adults is a fundamental preventive measure contributing to an awareness of and knowledge about appropriate hygienic behaviours, sanitation and feeding practices (see also section 6. of this chapter). For instance, only about 22 percent of children suffering from diarrhoea in developing countries are estimated to be given the most vital extra amount of fluids.⁶⁹ Furthermore, preventable diseases including measles, diphtheria, pertussis, tetanus, polio and tuberculosis could actually be eradicated as health- and life-threatening conditions for under-fives through simple vaccination.⁷⁰ Generally, all children under one year need to be immunised.⁷¹ Infants must complete the full course of immunisation for the vaccine to work, but cannot be fully immunised against all the diseases in one visit to the clinic. Older children who are not immunised as well as sick children can and should also be vaccinated.⁷²

It follows from this that awareness-raising on the individual level, regarding both basic preventive and curative care for infants and young children is a crucial element within World Vision programming. In

⁶⁶ WHO/UNICEF 2005. Consider the joint organisations' four-part strategy involving 'catch-up' and 'follow-up' vaccinations.

⁶⁷ UNICEF 2009d, p. 129.

⁶⁸ WV 2009a, p. 41.

⁶⁹ UNICEF 2009e, 'Diarrhoeal disease: Progress', viewed 9 February 2010, *Childinfo*, http://www.childinfo.org/diarrhoea_progress.html; Though, we may also evaluate whether extra fluids are available, particularly in poor rural areas; meaning that giving a child more but unclean water may in fact worsen instead of ameliorating an illness.

⁷⁰ WV 2009c, p. 19; WHO n.d., , *Immunization surveillance, assessment and monitoring: Vaccine-preventable diseases*, viewed 18 January 2010, http://www.who.int/immunization_monitoring/diseases/en/. In 2002 an estimated number of 1.4 million children under five died due to diseases that could have been prevented by a vaccination.

⁷¹ WV 2005, *Guide to Mobilising and Strengthening Community-led Care for Orphans and Vulnerable Children*. Half of the deaths from the nine immunisable diseases in most African countries (measles, poliomyelitis, whooping cough, tetanus, tuberculosis, diphtheria, Hepatitis B, Haemophilus Influenza type B and yellow fever) occur before the age of one year.

⁷² WV 2005, p. 241.

this context, we will also be discussing WV's behaviour change communication (BCC) approach in section 4. in relation to World Vision's *7-11 Health and Nutrition Strategy*.⁷³ Furthermore, we need to take into account that various diseases are contingent upon others. For example, young children suffering from measles often die from secondary complications, such as pneumonia, diarrhoea or malnutrition.⁷⁴ In order to tackle all those IDs effectively, it is important to integrate corresponding interventions into already existing health service delivery mechanisms (e.g. during antenatal care or immunisation programmes).⁷⁵

Interesting findings from a cross-country multiple regression analysis have shown that health worker density can also be a significant determinant in relation to vaccination coverage in developing countries. Community health workers (CHWs) may be able to better reach the beneficiaries on the individual level in order to raise awareness and educate people (especially mothers) about immunisation procedures. They can also play an important role in managing the availability and correct application of vaccinations as well as in training unskilled voluntary staff.⁷⁶

The core message is that all those diseases discussed above are easily preventable and in case of actual occurrence treatment is always possible and usually simple to implement. However, living in poor circumstances in remote rural areas greatly inhibits mothers and children from accessing adequate nutrition and health care services. Generally speaking, the actual problem is that poverty is still the major underlying reason in developing countries undermining people's capacities to take appropriate actions towards the root causes of hunger and ill-health in early childhood.

Questions

- ◆ Each community has its own traditional beliefs, norms and values!
 - How might WV development interventions in the health and nutrition sector conflict with already existent traditional medical knowledge as well as the role of traditional healers (e.g. shamans)? How can different knowledge bases be integrated / complement each other?
 - How can the knowledge to prevent, correctly diagnose and treat certain diseases be acquired most effectively by the beneficiaries (e.g. through adult learning groups)?
- ◆ 'Knowledge' and 'awareness' as such will not be efficient enough if the necessary means are not made available/accessible (e.g. soap, food supplements, safe water wells, child and maternal medical services)
 - How will these resources be delivered? How can an integrated service delivery most effectively be integrated?

⁷³ WV 2009c, pp. 21-22/26-27.; WV 2009d, *Part Three: Implementing the 7-11 Strategy*, pp. 3/24.

⁷⁴ WHO/UNICEF 2005.

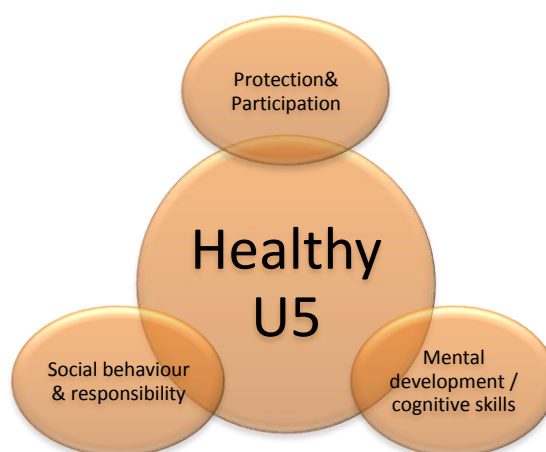
⁷⁵ WV 2009c, p. 9.

⁷⁶ Anand, S. & Bärnighausen, T. 2007, 'Health workers and vaccination coverage in developing countries: an econometric analysis', *The Lancet*, vol. 369, no. 9569, p. 1283.; Compare with WV community-based approach and projects, e.g. WV 2009c, p. 24-25 on individual- and community-level intervention.

3.3.1. *Early Childhood Health in Context*⁷⁷

In part I of this paper we already discussed World Vision's lifecycle approach and how focusing on early childhood is essential for children's cumulative development processes. Now we want to consider how this approach can be adapted particularly to early childhood health and nutrition matters. Fundamentally, only a healthy well-nourished young child fulfils the requirements for developing his or her full potential in all other realms of life. That is, pre- and post-natal good health is the precursor for children to develop sound mental growth processes (CWBO 2), to fulfil their social responsibilities (CWBO 3) and to fully participate within their community settings (CWBO 4). Community and government support are again crucial for establishing a strong base to achieve these health and nutrition targets.

Figure 2: Good Health as Basis for Young Children's Overall Well-being



3.3.2. *Continuum of Care*⁷⁸

World Vision's holistic approach to child development also translates into early childhood stages. That is to say, with regard to health and nutrition requirements we further need to distinguish between several critical stages of children's life span from -9 months to 5 years of age. The interventions that are required for the target group 'children under five' are specific to each of those stages which are defined as follows:

- **Pre-pregnancy** (reproductive health)
- **Pregnancy** (prenatal care); children aged -9 to 0 months
- **Birth** (skilled attendance)
- **Postnatal** (neonatal skin to skin care, exclusive breastfeeding)⁷⁹; newborns up to 28 days

⁷⁷ WV n.d., *Sector Theme: Maternal and Child Health*, Global Health Centre.; see also WV 2009c, p. 28.

⁷⁸ WV 2009c, pp. 27; WV n.d., *Sector Theme: Maternal and Child Health*, Global Health Centre.

- **Infancy and toddlerhood** (especially immunisations); children 0-2 years
- **Early childhood** (health precautions and care seeking); children up to 5 years of age

Figure 3: Continuum of Care



“The continuum of care framework calls for *broader approaches* (from prevention to access to treatment) and serves as a platform for delivering multiple proven interventions for the benefit of mothers, newborns and young children.”⁸⁰ World Vision recognises that early childhood care already begins before conception. It follows from this that supporting children’s physical well-being primarily starts with women’s reproductive care. Poor health and nutrition during pregnancy and early childhood can have long-lasting negative effects on a child’s later life stages in adolescence and adulthood. Equitable quality health care and nutrition for both mother and child is the first and foremost preventive measure to achieve positive well-being outcomes for children’s physical, cognitive and socio-emotional development.⁸¹

3.4. CWBO Indicators: Children are Healthy and Well-nourished⁸²

World Vision has developed a framework of Transformational Development Indicators (TDIs) measuring WV’s contribution to the Child Well-being Outcomes (see also Part I). The following list is a summary of these indicators in relation to early childhood health and nutrition.

3.4.1. *Child and Women’s Nutrition*

- Stunting, wasting and underweight in children under five
- 7-11 core interventions

⁷⁹ See references in UNICEF 2009d, p. 109 ‘The first 28 days of life’, for information on risk factors for neonatal deaths.

⁸⁰ WV 2009c, p. 34.

⁸¹ WV 2009c.

⁸² WV 2009e, *Compendium of Indicators - version 1.6: Girls and boys are cared for, protected and participating*, table 1, pp. 1-8. The WV Compendium of Indicators provides detailed information on the individual measures of each indicator (including description, dimensionality, project model, time and scale etc.); see also WV n.d., *TDI 2.0 Transformational Development Indicators for Child Well-being*

- Access to and availability of food throughout the year
- Quality and quantity of food given to children
- Child feeding practices (breastfeeding, (semi-)solid or soft foods and supplements, in particular iron, folate, iodine, zinc and vitamin A)

3.4.2. *Child and Women's Protection from Infection, Disease and Injury*

- Health care prevention, e.g. vaccinations against common childhood illnesses and de-worming
- Curative health care, e.g. treatment against diarrhoea, and acute respiratory infection (ARI)
- Clean and safe drinking water
- Access to insecticide treated bed-nets (ITNs)
- Access to hygienic sanitary facilities
- Hygienic behaviours in everyday life (e.g. proper hand washing)
- Recognizing early signs of particular illnesses
- HIV and AIDS prevention (e.g. PMTCT)

3.4.3. *Children's and Women's Access to Essential Health Services*

- Access to and availability of medical care centres (considering costs of [and distance to] health care services)
- Availability of skilled medical personnel (general practitioners and birth attendants)
- Access to and availability of affordable medication
- Prenatal and postnatal care services
- Appropriate newborn care practices
- Medical care specifically for chronically ill children and adults
- HIV and AIDS testing and treatment (consider also HIV- and AIDS-related stigma and discrimination leading to social exclusion, e.g. denied access to services)
- Counselling services
- Rehabilitation services for children with disabilities
- Family planning (including birth spacing and contraception)

4. World Vision 7-11 Health and Nutrition (H/N) Core Interventions

4.1. Purpose

World Vision has developed an operational strategy to address children's well-being in the areas of health and nutrition. These *7-11 Health and Nutrition (H/N) Core Interventions* are targeted towards

pregnant women and children under two years of age.⁸³ This specific focus is based on the understanding that these periods of the life cycle comprise most critical stages for children’s physical development. In accordance with World Vision’s Integrated Programming Model (IPM), the 7-11 H/N strategy aims to empower communities to enhance their knowledge and capacities in order to build and gain equitable access to quality primary health care services and thereby to contribute to achieving the MDGs 4 and 5. In this context we also need to understand that World Vision does not function as a provider of health service deliveries. Essential to World Vision’s sustainable self-help approach is the organisation’s main focus on empowering people at the household- and community-level in order to understand and apply preventive and curative health care practices as well as to seek and demand quality services.⁸⁴

4.2. Components and Strategies

4.2.1. Do, Assure and Don’t Do (DADD)

In 2007, World Vision created a framework described as “Do, Assure, Don’t Do” (DADD). This framework provides guidelines for a more focused health strategy to be applied by WV staff. It further includes interventions that are not supported by World Vision as they are incompatible with the organisation’s core values or programming policies.⁸⁵

Table 4: Do, Assure, Don’t Do (DADD) Framework

Components	Description
Core focus (Do)	<ul style="list-style-type: none"> Promote the well-being of women and children through community-based Maternal Child Health and Nutrition (MCHN), the public health/preventive approach Provide health in emergencies
Core focus (Assure)	<ul style="list-style-type: none"> Promote and facilitate equitable access to quality primary health care for families and communities
Phase down/transition (Don’t do)	<ul style="list-style-type: none"> Do not support reproductive health interventions that are abortive in nature Do not provide health benefits only to sponsored children at the exclusion of children of a similar status within the same programme focus area

⁸³ WV 2009i, Part One: Introduction to the 7-11 Field Guide.

⁸⁴ WV 2009g, ‘Quick Guide Global Health and Nutrition Strategy’, *Global Health and Nutrition*.; WV 2009c, pp. 3-4 / 28.

⁸⁵ WV 2009g; see also WV 2009d, pp. 59-60. Health System Strengthening DADD - components in relation to building blocks (health services, health workforce, health information, medical products / vaccines / technologies, health financing and leadership / governance).

4.2.2. Primary Outcomes and Target Groups

The strategic principles outlined in Table 4 provide the foundation upon which the 7-11 H/N core interventions are built. As we have already discussed in section 3.4. on World Vision’s CWBO indicators, we are focusing on three primary outcomes in order to reduce global mortality rates of mothers and children under five:⁸⁶

- 1) Mothers and children are well nourished⁸⁷
- 2) Mothers and children are protected from infection and disease⁸⁸
- 3) Mothers and children access essential health services⁸⁹

In order to achieve these outcomes, World Vision’s 7-11 strategy concentrates on the well-being of pregnant women and children under two years of age. The reasons for this are twofold. First, these target groups are most susceptible to disease and also show the highest mortality rates related to ill health and nutrition deficits. Second, the effects resulting from ill health on these target groups are most often irreparable in children’s later development stages with lifelong negative consequences.

Table 5: World Vision’s 7-11 H/N Core Interventions

Targets	Pregnant Women: -9 months	Children: 0-24 months
Core interventions*	<ul style="list-style-type: none"> Adequate Diet Iron/Folate Supplements Tetanus Toxoid Immunisation 6. Malaria Prevention and Intermittent Preventive Treatment 7. Healthy Timing and Spacing of Birth De-worming 9. Access to Maternal Health Service: comprehensive ANC, Skilled Birth Attendance and PNC 	<ul style="list-style-type: none"> 1. Appropriate Breastfeeding 2. Essential Newborn Care 3. Hand Washing 4. Appropriate Complementary Feeding (6-24 months) 5. Adequate Iron 6. Vitamin A Supplementation 7. Oral Re-Hydration Therapy/Zinc 8. Care Seeking for Fever 9. Full Immunisation for Age 10. Malaria Prevention 11. De-worming (+12 months)

*Details on the 7 interventions targeted at mothers and on the 11 interventions targeted at children (intervention, definition and behaviours/results) can be found on pages 38-46 and 47-54 respectively in WV 2009f.

⁸⁶ WVI 2009h, 'Start-UP Strategy: 7-11', *Global Health and Nutrition*; WV 2009g.

⁸⁷ Measured by rates of underweight, stunting and anemia

⁸⁸ Measured by rates of malaria/illnesses, care seeking for treatment of diarrhea and ARI, and immunization rates

⁸⁹ Measured by rate of skilled attendance at birth and antenatal care coverage

Part Two of *World Vision's 7-11 Strategy Field Guide* papers provides a more detailed description of the following subject matters: maternal and child major health and nutrition problems, conceptual underpinnings, underlying principles, key interventions, integrating 7-11 programming into project designs as well as programming within Phase II of the strategy model.⁹⁰

4.2.3. 7-11 Programming Principles⁹¹

1) Household and community empowerment: World Vision's role in community health and nutrition is not to deliver health services, but predominantly to facilitate an understanding of preventive health behaviours, seeking care and demanding services (details pp. 30-31). [cf. point 5 - 7-11 approaches should be carried out MoH, not by WV staff]

2) Prevention and access to health care services: World Vision's interventions in health and nutrition programming promote an integration of preventive behaviours, early detection and diagnosis with available, accessible, acceptable and affordable treatment that parallels the 'continuum of care' (details pp. 32-33).

3) Intervention bundling: World Vision aims to design programmes that are comprehensive and include multiple high-impact, low cost interventions that are 'bundled' within the continuum of care (details p. 34).

4) Working at scale: World Vision aims to achieve contextual transformation of social norms and practices through the spread of ideas on several levels within a community. The biological benefit is based on the idea of 'herd immunity', meaning blocking disease transmission by achieving high rates of immunisation coverage (details pp. 35-36).

5) Partnership with the Ministry of Health (MoH): World Vision should operate in collaboration with the MoH on the basis of certain partnership principles (i.e. effective and high-level dialogue within MoH frameworks, no duplication of MoH programming and capacity building of MoH staff) in order to make more informed decisions in relation to 7-11 programme design (i.e. addressing issues and identifying gaps), (details p. 37).

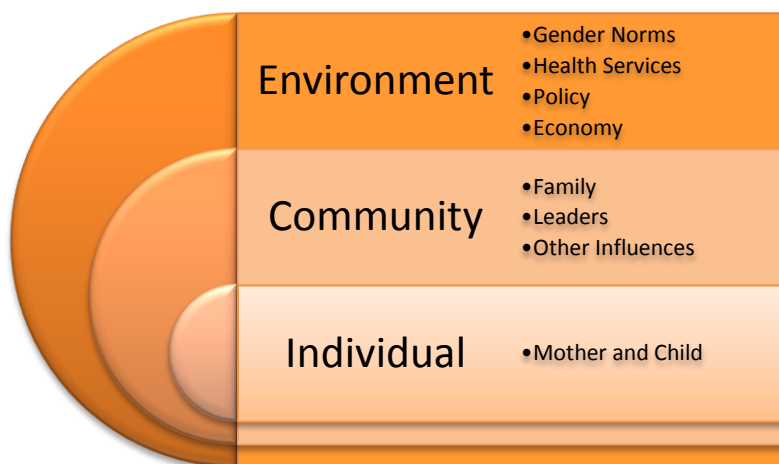
⁹⁰ See WV 2009c. Phase II of the 7-11 H/N strategy seeks to expand Phase I core focus on maternal and under-two target groups towards including other age groups into the programming model. This also relates back to WV's holistic lifecycle approach on child development regarding issues of health and nutrition (pp. 56).

⁹¹ WV 2009c, p. 28.

4.2.4. Behaviour Change for Health and Nutrition

World Vision's 7-11 H/N strategy is based on a behaviour change communication (BCC) approach, which again emphasizes the need to empower people on the individual level where early child care is practiced on a day-to-day basis. However, an individual's decision to adopt or reject specific health- and nutrition-related practices is also influenced by the community and broader environment in which the person participates, that is: the specific socio-cultural, political and economic context (see figure 3 p. x).⁹² Thus, we have to give some thought to the fact that a community is not a closed single unit, but instead incorporates a range of different voices and interest groups. It is therefore important for WV staff to first and foremost gain an understanding of a given context by applying LEAP principles (see Part I) from the assessment stage onwards, that is to "identify opportunities, vulnerabilities, capacities and resources" and to determine why specific programme intervention might or might not be successful due to prevailing power structures on the household and community level.⁹³

Figure 4: Contextual-level Interventions: The Individual, Community and Environment



Source: WV 2009, *Part Two: World Vision's 7-11 Strategy for Health and Nutrition*, p. 25.

While the BCC framework emphasizes that prevention begins within the household⁹⁴, World Vision's 7-11 delivery approach further connects caregivers, service providers and the community as a whole complex of human interactions.⁹⁵ Effective health and nutrition programming needs to be supported by community health workers (CHWs) or community health volunteers (CHVs),

⁹² Ibid., pp. 21-24.

⁹³ WV 2007a, *LEAP: Learning through Evaluation with Accountability & Planning (2nd edition)*, World Vision International LEAP Team, Washington DC, USA, p. 26.

⁹⁴ WV 2009d, p. 28.

⁹⁵ WV 2009d, pp. 23-26.

community-based mechanisms (e.g. CCCs) and MoH facilities.⁹⁶ For example, Timed and Targeted Counselling (ttC) is an important tool to address behaviour change on the household level and is carried out by CHWs and CHVs.⁹⁷

4.3. Implementing the 7-11 Strategy

Implementation processes with regard to 7-11 programming are explained in Part Three of *World Vision's 7-11 Strategy Field Guide* papers.⁹⁸ The core elements are derived from World Vision's LEAP and IPM (Integrated Programming Model) frameworks and include: assessment, design, implementation, project management and monitoring and evaluation processes.⁹⁹

Questions

- ◆ We cannot assume that a community is a closed unit. Instead, decision-making power often lies in the hands of a few authoritative people.¹⁰⁰ BCC needs to take into account profound differences in culturally-defined norms and values that require regional adaptation to specific community contexts. For example, targeting young mothers to achieve behaviour change in child rearing practices might be undermined by the influence of their own mothers and/or grandmothers who want to maintain traditional forms of child care.
 - What target groups does WV staff need to communicate with on the local level in order to achieve the most-effective programming impact? Who has the most influence and authority in a given social setting?
 - How can WV staff use this knowledge to their own advantage (i.e. targeting traditional leaders and older women (e.g. Grandmother Project Model¹⁰¹))?
 - What is the best way to establish a dialogue between WV staff, the MoH and traditional authorities/key individuals within a community?
 - How can WV reach young caregivers directly?

⁹⁶ WV 2009d, p. 26. "The Community Child Coalition (CCC) is the pre-requisite structure for operationalizing the 7-11 strategy, and the core approach for responding at the community level. While the CCC will take on much of the responsibility for overseeing 7-11 programming, it is desired that where possible local MoH staff take responsibility for training and supervising Community Health Workers to carry out ttC programming."

⁹⁷ WV 2009d, pp. 30-35.

⁹⁸ WV 2009d. See also WV's four 7-11 core approaches: CCC, ttC, Advocacy and HSS, pp. 27-41.

⁹⁹ See WV 2009d.

¹⁰⁰ Cf. WV 2009c, p. 34. WV programming principle (4): "By achieving sufficiently high coverage of [WV] interventions we take advantage of the natural social structure of a community to begin to achieve widespread shifts in attitudes and block pathways of transmission for infectious disease."

¹⁰¹ WV 2009d, pp. 74-75.

5. HIV & AIDS and Early Childhood Development

5.1. Facts and Figures

In comparison to the other major ‘child killers’, HIV and AIDS is accountable for a relatively small proportion of under-five deaths worldwide (about 3 percent). Still, there are currently 2 million children under the age of five infected with HIV; millions more live in HIV-affected households that bear a high social and economic burden, and as a result are highly susceptible to other infections.¹⁰² Most (nearly 90 percent) of all HIV- and AIDS-related deaths among children under five occur in sub-Saharan Africa.¹⁰³ However, treatment for HIV-infected children under five years is possible and starting treatment within 12 weeks of life significantly improves children’s survival rates. Over 50 percent of children with HIV are still undiagnosed by their second birthday. And, less than 40 percent of HIV positive children globally are receiving anti-retroviral treatments (ARTs).¹⁰⁴ Furthermore, the issue of HIV and AIDS is particularly crucial for World Vision’s early childhood focus because of the high risk of mother-to-child transmission (MTCT).

5.2. Major Challenges

World Vision’s main challenges in HIV and AIDS development programming targeted at children under five include:

- Improving the availability of and access to HIV testing and treatment for pregnant women, mothers and young children
- Preventing mother-to-child-transmission (PMTCT)
- Developing an integrated programme approach considering the link between HIV infection, malnutrition and ill health
- Taking into account possibilities to promote early childhood care and development (ECCD; see also chapter 2) programmes that may contribute to enhancing children’s general understanding of HIV and AIDS as well as to prepare them to develop capacities to protect themselves from HIV infections
- Addressing the issue of stigmatisation and discrimination against people living with HIV or AIDS

¹⁰² WV 2009a, p. 66.

¹⁰³ Bryce, J. et al. 2005, ‘WHO estimates of the causes of death in children’, *The Lancet*, vol. 365, no. 9465, pp. 1147-1152.

¹⁰⁴ WV 2009a, p. 66.

5.3. HOPE Initiative (HI)

World Vision's HOPE Initiative (HI) was launched in 2000 and aims to address the issue of HIV and AIDS through *prevention, care and advocacy* in order to help reducing the number of HIV infections and to ease the burden of those people that are already affected by the disease. At present, the HI does not have a specific early childhood focus. However, based on World Vision's three project models that are addressing the issue of HIV and AIDS in high-prevalence contexts (HPCs), we can reflect on how we may incorporate young children more directly into WV programming.¹⁰⁵

5.3.1. Community Care Coalitions

Community Care Coalitions (CCC) are formed to *"mobilise and strengthen community-based care and support for orphans, children living with HIV, other vulnerable children and their households."*

CCCs partner with churches and other faith communities, governments, local business as well as other NGOs to care and support those affected by HIV and AIDS. This includes AIDS orphans and sick children as well as caregivers and households. Coalitions recruit and train volunteer home visitors in identifying, monitoring, assisting and protecting HIV-affected children. "World Vision helps to mobilise these coalitions where necessary, strengthen their technical and general organisational capacities, train and equip home visitors, and connect them with material and financial support for their work."¹⁰⁶

Questions

- ◆ Area requiring more attention: Counselling services¹⁰⁷
 - How can World Vision support home visitors and CCCs to develop skills in providing psychosocial support directed towards pregnant women, HIV-positive mothers and children under five in matters concerning HIV and AIDS?

5.3.2. Channels of Hope

Channels of Hope (CoH) are formed to *"mobilise and equip churches and other faith communities to respond to the needs of people affected by HIV and AIDS in positive and powerful ways"*¹⁰⁸

¹⁰⁵ WV 2008b, *Hope Initiative: Annual Report 2008*; WV 2009i, *An overview of the HIV and AIDS Hope Initiative*; WV 2008c, *Looking back, Looking forward: Lessons learnt from HIV and AIDS Research and Programming in Africa*.

¹⁰⁶ WV 2009i, pp. 3-4.

¹⁰⁷ Ibid.

¹⁰⁸ WV 2009i, pp. 3/4-5.

World Vision's CoH approach sets out to organize sensitizing workshops for individual religious leaders because of their moral authority and influence within the community. These workshops are predominantly designed to address issues of stigmatisation of people living with HIV (PLHIV), to share experiences of HIV-affected people and information about HIV transmission, prevention, care and treatment, to identify particular needs and to evaluate possible ways to better respond to HIV and AIDS (action plans). "Faith leaders are encouraged to form Congregational Hope Action Teams in their churches, mobilise volunteers and link with sustainable, community-based organisations (e.g. CCCs)."¹⁰⁹

Questions

- ◆ Area requiring more attention: BCC¹¹⁰
 - How can World Vision better equip churches and faith communities to promote behaviour change for HIV prevention, in particular in relation to PMTCT services?
- ◆ The stigma placed on HIV and AIDS may discourage especially young mothers-to-be to practice constructive behaviour change for HIV prevention and to seek early treatment once infected.
 - What are the potential gender issues within a particular community (i.e. the role of women; also in relation to theological and ethical issues) that may prevent these women to seek PMTCT services? How can WV help empowering women affected by HIV and AIDS?

5.3.3. Values-based Life-Skills Training

Values-based Life-skills Training aims to "provide training, information and materials that enable girls, boys and youth, aged 5-24 years, to develop knowledge, attitudes, and skills to make healthy life choices and avoid acquiring HIV."¹¹¹

World Vision provides age-appropriate, values-based life skills materials and training to community members, including teachers, church and faith community leaders and children themselves. These groups should also be involved in creating supportive environment for children to stay HIV free. In targeting younger children WV emphasizes "a general understanding of HIV transmission with the goal of reducing fear and misconceptions and encouraging care and compassion for those affected." Materials used need to be culturally sensitive and acceptable according to context.¹¹²

¹⁰⁹ WV 2009i, p. 4.

¹¹⁰ Ibid., p. 4.

¹¹¹ Ibid., p. 3.

¹¹² Ibid., p. 5-6.

Questions

- ◆ World Vision approaches to HIV and AIDS prevention are directly targeted towards children and youth aged 5-24 years.
 - What opportunities are there to integrate an early childhood focus into WV's existing HIV and AIDS prevention programming models? E.g. child-to-child approach (informed children from 5 years onwards pass on knowledge to younger groups)
 - How might issues such as “self-esteem, communication and negotiation and responsible decision-making” be integrated into ECCD (see chapter 2) or other early childhood programmes for children to understand HIV-related issues in particular with the aim to encourage early promotion of acceptance and social inclusion of PLHIV as well as self-protection? E.g. through sports, drama, art, counselling services and so forth.¹¹³

5.4. Preventing Mother-to-Child Transmission (PMTCT)

Preventing mother-to-child-transmission (PMTCT) of HIV is part of World Vision's 7-11 H/N strategy and one of the most important issues that needs to be considered regarding the protection of infants and young children from getting infected with HIV. This approach is closely related to the *continuum of care* model (see p. x). More specifically, it focuses on children aged -9 to 0 months (prenatal stages) as well as on children aged 0 to 24 months (birth/neonatal and postnatal stages).

The UNAIDS/WHO (2009) joint report on *AIDS Epidemic* lists several programme interventions that can help reducing the chance of infants getting infected with HIV. These interventions include:

- The reduction of overall HIV occurrence among reproductive-age women and men
- The reduction of unwanted pregnancies among HIV-positive women
- The provision of antiretroviral (ARVs) drugs to reduce the chance of infection during pregnancy
- The delivery and appropriate treatment, care and support for mothers living with HIV (including infant feeding)

The first two points relate to World Vision's Life Skills Training approach with regard to the ABC Strategy (A - Abstain, B - Be Faithful, C - Condomize)¹¹⁴, whereas the last two points directly address the issue of WV's PMTCT approach regarding pregnant women and mothers that are already infected with HIV. Of the estimated 2.3 million children under the age of 15 living with HIV almost all

¹¹³ WV 2009h, p. 5; see also WHO 2003, *Skills for Health*, p. 3. “Skills-based health education is an approach to creating or maintaining healthy lifestyles and conditions through the development of knowledge, attitudes, and especially skills, using a variety of learning experiences, with an emphasis on participatory methods”

¹¹⁴ See also WV 2005, pp. 100-102. Modes of HIV Transmission - Most common strategies for preventing HIV transmission and infection.

had been infected through MTCT (during pregnancy, birth or breastfeeding).¹¹⁵ UNAIDS and WHO estimate that “in ideal conditions, the provision of antiretroviral prophylaxis and replacement feeding can reduce transmission from an estimated 30 to 35 percent, with no intervention to around 1 to 2 percent.”¹¹⁶ However, we have to keep in mind that these are *ideal* estimates and it is most difficult to implement programmes that will effectively reach all women in given contexts. Reasons for this may include:

- Once started, HIV-positive women need to undergo regular and ongoing treatment, which they might not be able to afford and which may temporarily interfere with their responsibilities at home
- Women living in remote rural areas may not be able to easily reach distant health care services
- Traditionally enforced social norms and values may prevent women from seeking treatment (fear of social exclusion)

5.4.1. *Indicators Relating to PMTCT and Treatment of HIV-positive Mothers and U5s*

World Vision is actively promoting the PMTCT approach in order to protect children to be born with HIV. WV monitoring and evaluation indicators for Programme Management Information System (PMIS) briefly define the outcomes and outputs of promoting PMTCT services as follows:¹¹⁷

- Outcome: percentage of women who were counselled and received results of an HIV test during their most recent pregnancy (12 months)
- Output: number of pregnant women referred for clinic-based PMTCT services

In addition, the CWBO indicators provide a first guideline for WV staff focusing on early childhood and HIV and AIDS in the field.¹¹⁸ Those indicators directly relating to PMTCT and HIV treatment of mothers and children under five are summarized below:

¹¹⁵ Lenton, C. 2009, *Using GIK to Expand Access to Prevention of Mother to Child Transmission of HIV for Infants in African World Vision Programs - a Briefing Note (Draft)*; LINKAGES 2004, *Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding: Health Providers Course*, p. 22. Estimates show that MTCT accounts for 90 of all infections in children.

¹¹⁶ UNAIDS/WHO 2009, *AIDS Epidemic Update 2009*, p. 13.

¹¹⁷ WV n.d., *HIV & AIDS M & E Indicators for PMIS*, pp. 11-13. The paper provides further information on measurements, calculation, strengths & limitations, additional information etc.

¹¹⁸ WV 2009e.

Indicators for PMTCT and HIV Treatment

- Proportion of parents or caregivers of childbearing age who know that HIV can be transmitted from an HIV-positive mother to her unborn child during pregnancy, during delivery, and through breastfeeding
- Proportion of caregivers aware of methods of preventing MTCT (maternal to child transmission) of HIV through anti-retroviral therapy and avoiding breastfeeding
- Children aged 18-24 months born to HIV positive mothers who received early diagnosis (before the age of 18 months)
- Proportion of infants born to HIV positive mothers who are started on cotrimoxazole prophylaxis within two months of birth

Indicators for Access and Availability of HIV and AIDS Health Services

- Proportion of HIV-positive parents or caregivers with access to health care equal to that of other adults in the community (i.e. no stigma or discrimination)
- Proportion of women who were offered and accepted counselling and testing for HIV during most recent pregnancy, and received their test results
- Proportion of health facilities with explicit non-discriminatory policies for people living with HIV and AIDS
- HIV affected households who were able to cover the costs of their children's health (aged 0-18 years) through their own means, without external assistance
- Population with advanced HIV infection with access to antiretroviral drugs, as per national policy

5.4.2. Problems and Solutions in PMTCT Programmes

One of the main problems related to PMTCT service delivery is the still prevailing stigmatisation of HIV and AIDS. HIV-infected women in particular often carry a label, may be accused of unfaithfulness and also blamed of bringing the virus to their families. As a consequence, shame and fear of disclosure (leading to separation, divorce and harassment) is likely to prevent pregnant women and breastfeeding mothers to adopt self-seeking behaviours. Additional problems that may prevent HIV-positive mothers from seeking care include scarce accessibility to service providers, unavailability of staff during non-work hours as well as long waiting times. Another issue is that “men listen to men” and thus there is often a lack of training in male and couples counselling. In fact, results from a survey on a World Vision PMTCT programme in Kenya have shown that few PMTCT clients (24 percent) were accompanied by a spouse to clinics, few couples were tested together (9.5 percent) and some men even said that they would not support or live with an HIV-positive partner if they were

themselves negative. The survey also found weak elements in WV supervision, specifically in relation to fragmentation of PMTCT monitoring (measuring service delivery rather than received care). In this context, a fundamental point to remember is that “socio-cultural and programmatic factors play a key role in linking service delivery and uptake, particularly in rural settings.”¹¹⁹

Recommendations for the improvement in service deliveries (drawn from the WV PMTCT programme in Kenya) include:

- Integrating PMTCT and primary care services
- Delivering HIV/PMTCT messages within men’s networks and meeting places
- Developing tools to monitor mother and child during pregnancy and postnatal stages, including follow-up support during the first six months of infant feeding
- Capacity building of community-based support groups, antenatal care (ANC) services and home-based care providers
- Training of community health workers and PMTCT promoters (especially more men), particularly in male and couple counselling
- Providing male friendly services (moonlight testing, privacy, confidentiality)
- Using male leaders as role models to reach other men

Questions

- ◆ Some HIV-infected mothers may be left by their partners and families with no protection through traditional support systems. In other cases an HIV-positive woman may be left alone because her husband has died or because he is working away from home (which increases the risk of single mothers falling into poverty).
→ What WV strategies may be developed to specifically target HIV-positive single mothers (pregnant or breastfeeding) in PMTCT programmes and HIV treatment?
- ◆ Depending on context, there exist different gender roles within matrilineal and patrilineal societies.
→ Who makes decisions on the household level about whether mothers and young children are allowed to receive HIV treatment? How do WV frameworks need to be adapted with regard to decision-making power structures between men and women (i.e. different ways of communication depending on who field staff is talking to)?

Further information on PMTCT

AED 2004, *Course on Integrated Prevention of Mother-to-Child Transmission of HIV and Support For Infant Feeding - for Community Motivators*.

¹¹⁹ WV 2010, *Factors affecting PMTCT service delivery*; Ulate, J., Thomas, A. & Mutanu. C. *PMTCT and male involvement*, World Vision. The findings result from a survey that was conducted in 2009 in relation to a WV PMTCT programme in the Taita District, Kenya (Kira Chasimwa Project).

AED 2004, *Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding - Health Providers Course*.

ITPC 2009, *Missing the Target 7- Failing Women, Failing Children: HIV, Vertical Transmission and Women's Health...*

JLICA 2008, *Integration and Expansion of Prevention of Mother-to-Child Transmission (PMTCT) of HIV and Early Childhood Intervention Services*.

Lenton, C. 2009, *Using GIK to Expand Access to Prevention of Mother to Child Transmission of HIV for Infants in African World Vision Programs - a Briefing Note (Draft)*, World Vision US.

LINKAGES 2004a, *Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding: Health Providers Course*.

LINKAGES 2004b, *Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding: Community Motivators Course*.

Okonji, F. S., Makheti, G. B. & Mulama, F. 2007, *End of Phase I Project Evaluation Report Kira Chasimwa: OVC and PMTCT Project VOI Area Development Program*, WV...

TEARFUND 2008, *Scaling up Prevention of Mother-to-Child Transmission of HIV*.

UNICEF 2008, *Prevention of Mother-to-Child Transmission of HIV - Generic Training Package DRAFT Participant Manuel*.

WV Canada n.d., *Safer Infant Feeding: An Assessment of Community Practices and Client/Provider Experience with Counselling, Kira Chasimwa Project, Voi, Republic of Kenya*.

WV Canada / Cambodia n.d., *Protecting Mothers and Children from HIV: World Vision Canda/Cambodia Project Proposal*.

WV 2009, *VOI ADP Kira – Chasimwa Project Report: Operational Research on Prevention of Mother to Child Transmission of HIV/AIDS*.

Another fundamental challenge that World Vision staff may face in programme implementation is to convince people to undergo HIV treatment even though this procedure will not lead to healing the illness. However, we need to consider that even though HIV-positive adults are not going to be cured from the disease, infants and young children may still be the major beneficiaries. That is to say HIV-treated parents or caregivers will be able to care for their children with more physical strength and for a longer period of time.¹²⁰

Question

→ What are the most effective ways to communicate the need for HIV treatment even though symptoms are not showing?¹²¹ E.g. communication through local home visitors who can help HIV-positive mothers to cope with their condition better and encourage them to:¹²²

- Seek early antenatal and postnatal care and to use PMTCT services
- Have their general health checked (weight, blood), infections treated and regular de-worming
- Monitor their nutritional status
- Practice health and safe sex

¹²⁰ See also Jakob, B. 2008, 'Leben mit HIV/AIDS - Heilung angesichts einer „unheilbaren“ Erkrankung', in K. Bangert & T. Schirmacher (eds.), *HIV und AIDS als christliche Herausforderung*, pp. 133-140.

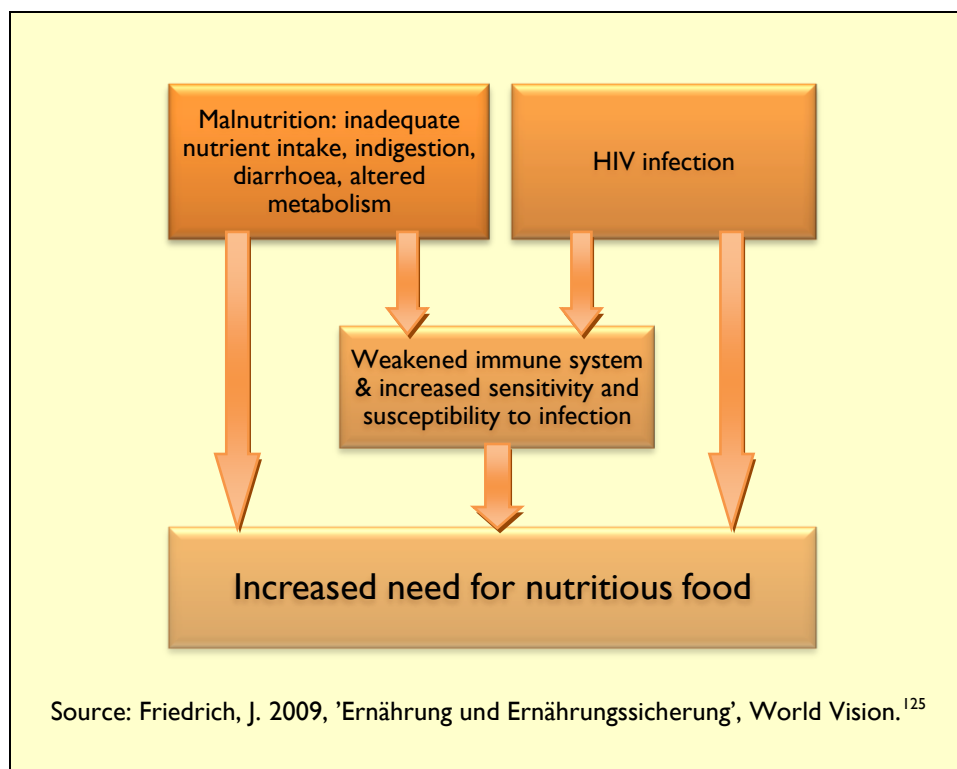
¹²¹ Note: also consider the window period of up to three months during which a newly infected person may not yet have produced enough HIV antibodies to be detected through testing.

¹²² WV 2005, p. 231.

5.4.3. HIV and Nutrition in Early Childhood

There is an important link between HIV infection and nutrition deficits in children under five. HIV infection, malnutrition and common childhood illnesses all weaken the immune system, thus leading to a need of increased nutrient intake (see Figure 5, p...). In other words, sufficient good quality nutrition (including both macro- and micronutrients) will contribute to a child's well-being on several levels. Children born to a mother who is HIV positive are more likely to be underweight compared to a mother who is not infected by the virus. Moreover, these children will also often be disadvantaged in their early development stages and frequently suffer from growth retardation, malnutrition and susceptibility to diseases (e.g. pneumonia and diarrhoea).¹²³ It is moreover obvious that those children that are already infected with HIV will need special attention regarding the types of food they are given as well as in terms of food preparation.¹²⁴

Figure 5: HIV, Malnutrition and Illness



¹²³ WV 2005, pp. 228-232 (specifically related to HIV and AIDS) / pp. 223-252 and pp. 205-212 (nutrition in general); see also co-infections in WV 2009c, pp. 10-11.

¹²⁴ WV 2005, p. 229. The paper also provides tips to aid nutritional intake of children with HIV (pp. 229/355).

¹²⁵ See also The World Bank 2006, *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action*, pp. 77-82.

5.4.4. World Vision Policy on Infant Feeding and HIV¹²⁶

“World Vision recognizes the challenges and limited field experience regarding infant and young child feeding in the context of HIV infection. Where HIV status of the mother is unknown or she is known to be HIV negative, World Vision encourages and supports the mother to exclusively breastfeed her infant for the first 6 months of life and continued breastfeeding for two years or beyond, with timely and correct use of adequate complementary foods.”

“WV encourages mothers who are HIV positive to make informed decisions about infant feeding option. The decision should be based on a woman’s individual circumstances but should take greater consideration of the health services available and the counselling and support she is likely to receive. World Vision supports the current WHO recommendation on HIV and Infant feeding In all circumstances, decision about infant feeding option for women who are HIV positive will be made in consultation with senior technical health and nutrition staff.”

The issue of health and food security in early childhood also relates to the high risk of HIV transmission through breastfeeding. Generally, World Vision promotes exclusive breastfeeding (see 7-11 H/N strategy). However, WV also recommends that an HIV positive mother may decide:

- ...either to *exclusively breastfeed* her child (with no other foods given)
- ...or to *exclusively use replacement feeding* (food substitutes for breast milk).

In order to understand possible risks to make informed choices, mothers must be given support, for example, through home visitors who will explain different feeding options to the mothers and thereby help reducing the risk of MTCT and malnutrition of the infant.¹²⁷ Apart from the risk of an infant getting infected with HIV, we also need to bear in mind that an HIV positive mother may be less able to care for her child due to increased physical weakness and thus worsen the child’s exposure to malnutrition.¹²⁸

Further Information on HIV and AIDS

LINKAGES 2004, *Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding...*

UNHRC 2009, *Guidance on Infant feeding and HIV in the context of refugees and displaced populations*

WHO 2008, *Learning from Large-Scale Community-Based Programmes to Improve Breastfeeding Practices.*

WHO 2009, *HIV and infant feeding Revised Principles and Recommendations Rapid Advice...*

WV 2003, *ADP Toolkit for HIV/AIDS Programming...*

¹²⁶ WV 2007b, *World Vision International Policy governing the procurement and use of Milk Products in field programs...* p. 6.

¹²⁷ WV 2005 pp. 228-235. The paper also provides further details on monitoring the nutritional status of pregnant women and breastfeeding mothers infected with HIV (pp. 230-231/354)

¹²⁸ Ibid.

6. Nutrition and Early Childhood Development

6.1. Facts and Figures

About 50 percent of all under-five deaths are associated with malnutrition (cf. Figure 1 p. x). Malnutrition weakens a child's immune system, thus making the child more vulnerable to infections as well as less able to fight those.¹²⁹ In comparison, a malnourished child is twice as likely to die from pneumonia, diarrhoea or malaria as a well-nourished child.¹³⁰ The first two years of a child's life are particularly crucial. It is not only the period with the highest risk of child mortality, but it also marks the time where malnutrition commonly starts, with long-lasting consequences.¹³¹ It is therefore crucial to examine the issue of food security - that is, the importance of adequate quantity and quality nutrition - in early childhood in more depth.

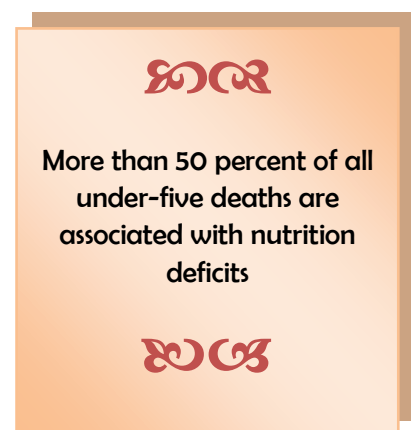
6.2. World Vision's Nutritional Framework¹³²

Generally, adequate household food security is achieved through provision of quality food for infants and young children, nutrient-dense food for families as well as sufficient quality food for families in crises.¹³³ In order to improve the nutrition of children under five, women of child-bearing age and vulnerable groups, World Vision has generated a framework with regard to three key development outcomes:

- 1) Adequate household food security
- 2) Adequate maternal and child care practices
- 3) Adequate health services and healthy environment

6.2.1. Adequate Household Food Security

Food security is “the condition in which everyone has secure access to sufficient and reliable food sources”.¹³⁴ World Vision has four fundamental approaches to enhance the food security of poor households. Those strategies are aiming to improve the:



¹²⁹ MacDonald, C. 2007, 'Malnutrition, an Underlying Cause of Child Mortality', *Global Future*, no. 1, p. 8; Bryce et al. 2005, p. 1150. [Note: estimates might vary depending on source]

¹³⁰ WV 2008a, p. 5.

¹³¹ WVC n.d., *Nutrition and Health*.

¹³² WV n.d., *Global Nutrition Framework – Draft Document: Improve nutrition of children U5, women of child-bearing age and vulnerable groups*.

¹³³ WV N-CoE 2008, *World Vision's Asia Pacific Region Nutrition Strategy*.

¹³⁴ WVC n.d., *What is Food Security?*, p. 1.

- Sustainable *availability*,
 - Secure *accessibility*,
 - *Utilization* [i.e. health conditions necessary to utilize nutrients + equitable distribution and hygienic preparation], and
 - Long-term *stabilization* (i.e. adequate nutrition throughout the year)
- ...of adequate, nutritious and culturally appropriate food supplies.

6.2.1.1. *Stunting, Wasting and Undernutrition*

Definitions¹³⁵

Stunting

A child whose height-for-age is less than -2 SD* from the mean is considered stunted. *Stunting* results from chronic undernutrition, which retards linear growth.

Wasting

A child whose weight-for-height is less than -2 SD* from the mean is considered wasted. *Wasting* results from inadequate nutrition over a shorter period of time.

Underweight

A child whose weight-for-age is less than -2 SD* from the mean is considered underweight. *Underweight* encompasses both stunting and wasting.

* The standard deviation is a measure of 'spread', that is the dispersion of the mass about the central value (mean). It measures how much the individual values of a distribution deviate from the mean of the distribution. 'Less than -2 SD (Standard Deviation)' means that the chances of the child's height-for-age / weight-for-height / weight-for-age being normal are less than 3 percent.

Stunting (low height-for-age) is an important measure of undernutrition in children under five years of age. Worldwide, an estimated 178 million children under five are suffering from stunting. Linear growth restriction is highly prevalent in developing countries (10-80% of children under five), with the result that these children are more vulnerable to illness and (chronic) disease as well as increased risk of dying; stunting contributes to 14% of all deaths in children under 5. Furthermore, young stunted children experience impaired cognitive development which has negative outcomes on later school achievements (see chapter 2).

¹³⁵ Caulfield, L. E. et al. 2006, 'Stunting, Wasting, and Micronutrient Deficiency Disorders', in D. T. Jamison et al., *Disease Control Priorities in Developing Countries* (2nd edition), p. 551.

Stunting is caused by a mother's poor diet during pregnancy as well as inadequate feeding practices within the first two years of a child's life. Lack of essential micronutrients is a major problem in identifying stunting in young children because the signs of chronic undernutrition are not always obvious from mere observation. This can have dire outcomes, because with two years of age stunting is largely irreversible. It is therefore crucial to focus World Vision's prevention strategies on the life stages from conception to 24 months (see 7-11 H/N core interventions) as this is going to have the greatest impact with respect to children's future development.¹³⁶ World Vision programme interventions aiming directly to improve children's and pregnant/breastfeeding women's nutrient intake should include both the provision with macro- as well as micronutrients.

6.2.1.2. *Macronutrients*

Macronutrients include carbohydrates, protein and fat, which are essential nutrition components of the human diet. Lack of sufficient macronutrient provision, which leads to inadequate intake of energy (kilojoules/calories) and protein, is a serious issue among young children in developing countries. "Even mildly underweight¹³⁷ children are twice as likely to die from infectious disease, while moderately or severely underweight children have a five- to eight-fold increase in mortality risk."¹³⁸ Generally, underweight describes the physical status of a newborn weighing less than 2,500 grams at birth and it is a causal factor in 60-80% of neonatal deaths.¹³⁹ Around 16 percent of all children in the developing world are born underweight, that is more than 19 million infants annually.¹⁴⁰ Low birth weight is most often associated with poor maternal health and nutrition.

6.2.1.3. *Micronutrients*¹⁴¹

Micronutrients are essential minerals and vitamins that are necessary for all human bodily functions. Micronutrient deficiencies are often described as "hidden hunger"¹⁴², because related symptoms may only become visible at later development stages. Some micronutrient deficiencies may already be noticed quite early. For example, vitamin A deficiency can lead to a weakened immune system and visual impairment, and iodine deficiency can cause early mental retardation/cretinism.¹⁴³

¹³⁶ WV 2009c, p. 13; Grantham-McGregor et al. 2007, pp. 62-63.

¹³⁷ 'Mildly underweight' means that a child's weight-to-age is at least -1 SD away from the mean.

¹³⁸ MacDonald, C. 2007, 'Malnutrition, an Underlying Cause of Child Mortality', *Global Future*, no. 1, p. 8.

¹³⁹ UNICEF ~2007, 'MDG: Eradicate extreme poverty and hunger: Low birth weight', Progress for Children, viewed 9 February 2010, http://www.unicef.org/progressforchildren/2007n6/index_41508.htm; UNICEF 2009, *The State of the World's Children: Maternal and Newborn Health*, pp. 15-16

¹⁴⁰ UNICEF ~2007, 'MDG: Eradicate extreme poverty and hunger: Low birth weight', Progress for Children, viewed 9 February 2010, http://www.unicef.org/progressforchildren/2007n6/index_41508.htm

¹⁴¹ See also Caulfield, L. E. et al. 2006, pp. 553-554; WV 2009a, p. 61.

¹⁴² See also Singh 2004, 'Role of Micronutrients for Physical Growth and Mental Development', *Indian Journal of Pediatrics*, vol. 71, no. 1, p. 59.

¹⁴³ Black, R. E. et al. 2008, 'Maternal and child undernutrition: global and regional exposures and health consequences', *The Lancet*, vol. 371, no. 9608, pp. 243-260.

There are several reasons that account for the importance of a micronutrient-rich diet. First and foremost, women and young children are those groups that are most vulnerable to micronutrient deficiencies. A lack of micronutrient intake also inhibits other health and nutrition programmes to succeed, which explains why World Vision promotes interventions that are embedded in integrated programming models (IPM).¹⁴⁴ But, the negative effects of micronutrient deficiency also expand to the macro level. That is, early childhood malnutrition ultimately leads to a country’s decline in productivity through declining work forces and thereby interlinks health and economic sectors.¹⁴⁵

Table 6: Consequences of Micronutrient Deficiency¹⁴⁶

Vitamin A deficiency	Iron-deficiency Anaemia	Iodine deficiency	Zinc deficiency
Increased susceptibility to disease	Impaired intellectual capacity	Low learning capacity and mental retardation	Increased risk of diarrhoea, pneumonia and malaria ¹⁴⁷
Night blindness and eventual total blindness	Low work capacity	Impaired growth	...
...	Premature death (especially for adolescent girls and women)	Goiter	...

Vitamin A Deficiency

“Vitamin A deficiency (VAD) results from inadequate intakes of vitamin A because of low intakes of animal foods; inadequate intakes of non-animal sources of carotenoids that are converted to vitamin A; and inadequate intakes of fat, which facilitates the absorption of carotenoids. Dietary sources of preformed vitamin A include liver, milk, and egg yolks. Dark green leafy vegetables such as spinach, as well as yellow and orange noncitrus fruits (mangoes, apricots, papayas) and vegetables (pumpkins, squash, carrots), are common sources of carotenoids (vitamin A precursors), which are generally less bioavailable than preformed vitamin A but tend to be more affordable.”¹⁴⁸

VAD is a common cause of preventable blindness and each year, 250,000 to 500,000 children under five will lose their sight as a result of VAD. Besides, a child who becomes blind from VAD has only a 50 percent chance of surviving the year. For those children who survive, blindness severely reduces their social and cognitive competencies which subsequently diminish children’s later economic

¹⁴⁴ WVC n.d., *What is Food Security?*, p. 2.
¹⁴⁵ See Hoddinott et al. 2008, ‘Effect of a nutrition intervention during early childhood on economic productivity in Guatemalan adults’, *The Lancet*, vol. 371, no. 9610, pp. 411-416.; see also The World Bank 2006, *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action*, pp. 52-61.
¹⁴⁶ WV 2006, *Improving Nutrition of Women and Children: The MICA Program - A Micronutrient And Health Program for Africa*, p. 9.
¹⁴⁷ Black et al. 2008, p. 249.
¹⁴⁸ Caulfield, L. E. et al. 2006, p. 553.

potential. VAD is also a risk factor for anaemia, increased severity of infectious diseases (e.g. diarrhoea, measles, and malaria) and child mortality, mainly because of its detrimental effects on the immune system.¹⁴⁹ Inadequate vitamin A is associated with 1.1 million child deaths each year.¹⁵⁰

Iron Deficiency

Iron is mainly found in haemoglobin which is essential for the binding and transport of oxygen and the regulation and differentiation of cell growth. Iron deficiency is the primary cause of anaemia in pregnant women and children under two years of age.¹⁵¹ The adverse effects of anaemia are largely irreversible after the age of two. Worldwide, almost one-half of all children under 5 years of age suffer from anaemia. “Globally, it is estimated that 50 percent of anaemia is due to inadequate dietary iron intake, physiologic demands of rapid growth, and iron losses due to parasitic infections.” Iron-deficiency anaemia in children under two years causes poor cognitive development and consequently school performance and work capacity in later years. Adverse effects in infants may include “altered behaviour and cognition, such as increased fearfulness/wariness, irritability, and unhappiness; lower ‘IQ’ scores; altered motor development, such as decreased exploration of environment, decreased willingness to leave a caregiver’s side; increased fatigue and stunting.”¹⁵²

Iodine Deficiency

“Iodine is necessary for the thyroid hormones that regulate growth, development, and metabolism and is essential to prevent goitre and cretinism. Inadequate intake can result in impaired intellectual development and physical growth.”¹⁵³ Maternal iodine deficiency impairs motor and mental development of the foetus (e.g. congenital anomalies and hearing impairment) and can also lead to foetal growth restriction, miscarriage and stillbirth.¹⁵⁴ “Iodine deficiency is the single most preventable cause of brain damage and mental impairment in young children.”¹⁵⁵

Zinc Deficiency

“Zinc is ubiquitous within the body and is vital to protein synthesis, cellular growth, and cellular differentiation. [Severe zinc deficiency can cause] growth retardation, impaired immune function, skin disorders, hypogonadism, anorexia and cognitive dysfunction. Mild to moderate deficiency increases susceptibility to infection. Zinc can prevent and palliate diarrhoea and pneumonia and may also

¹⁴⁹ Ibid.

¹⁵⁰ WV 2009a, p. 61.

¹⁵¹ Caulfield, L. E. et al. 2006, p. 553.

¹⁵² WV 2009c, p. 14.

¹⁵³ Caulfield, L. E. et al. 2006, p. 554.

¹⁵⁴ Ibid.; Black et al., 2008, p. 250.

¹⁵⁵ WV 2009a, p. 61.

reduce malaria morbidity in young children. [...]. Only animal flesh, particularly oysters and shellfish, is a good source of zinc, and fibre and phytates inhibit absorption. Thus, as with iron deficiency, populations consuming a primarily plant-based diet are susceptible. Deficiency can also result from losses during diarrheal illness.”¹⁵⁶ “Deficiencies in zinc, which helps strengthen the immune system, raise the risk of death from pneumonia, diarrhoea and malaria by 13-21%.”¹⁵⁷ Annually, an estimated number of 800,000 children under five die due to the latter diseases in connection with zinc deficiency.¹⁵⁸

Further readings on micronutrients

Black, R. E. 2003, ‘Zinc Deficiency, Infectious Disease and Mortality in the Developing World’, *American Society for Nutritional Sciences*, pp. 1485S-1489S.

Micronutrient Forum 2009, *Scaling Up Micronutrient Programs: What Works And What Needs More Work? - The 2008 Innocenti Process*.

6.2.1.4. Measuring Nutrition Deficits

Definitions¹⁵⁹

Acute malnutrition: Recent and severe weight loss as a result of acute food shortage and/or illness. Measured by weight for height or MUAC

Chronic malnutrition: Inadequate diet persistently, over a longer period. Child is stunted (height for age) and/or underweight (weight for age)

Global Acute Malnutrition (GAM): Weight for height < -2SD, or weight for height <80% or MUAC <125mm

Severe Acute Malnutrition (SAM): Weight for height <-3SD, or weight for height <70%, or MUAC <110mm and/or bilateral oedema

¹⁵⁶ Caulfield, L. E. et al. 2006, p. 554.

¹⁵⁷ WV 2009a, p. 61.

¹⁵⁸ Caulfield, L. E. et al. 2006, p. 554.

¹⁵⁹ SCF USA n.d., *Acute Malnutrition Summary Sheet*, Save the Children, pp. 1-2.

Table 6: Acute Malnutrition: Indices for children between 6 and 59 months of age

	Global Acute malnutrition (GAM)	
	Moderate Malnutrition (MAM)	Severe Malnutrition (SAM)
Weight for height or length (stunting)	Between -2 and -3 SD or 70th to 79th percentile	Less than -3 SD or below the 70th percentile
Mid-upper Arm Circumference	Less than 12.5 cm	Less than 11 cm
Nutritional Oedema	N/A	Bilateral

Source: SCF USA n.d., *Acute Malnutrition Summary Sheet*, Save the Children, pp. 1-2. [cf. WHO standards]

World Vision’s Nutrition Transformational Development Indicators (TDIs) provide a first guideline for WV staff to identify issues in relation to early childhood food security:¹⁶⁰

Summary indicators

- Children aged 6-59 months who are stunted (height for age Z-score ≤ 2 standard deviations)ⁱ
- Children aged 6-59 months who are underweight (weight for age Z-score ≤ 2 standard deviations)ⁱⁱ
- Children aged 6-59 months who are wasted (weight for height Z-score ≤ 2 standard deviations)ⁱⁱ

Context specific indicators

- Infants 6-59 months who receive vitamin A supplementation (pre-school vitamin A programs)
- Households with adequately iodized salt ⁱⁱⁱ
- Proportion of children receiving early initiation of breastfeeding (within one hour of birth)
- Infants 0-6 months old who are exclusively breastfed (i.e. not receiving any other fluids or foods, with the exception of oral rehydration solution, drops, and syrups (vitamins, minerals, medicines))
- Children 12-24 months old who are breastfed
- Children 6-12 months old who receive appropriate complementary solid, semi-solid or soft foods
- Children 6-24 months old who receive food from 4 food groups (minimum dietary diversity)
- children 6-24 months old who receive solid, semi-solid or soft foods at least an appropriate minimum (minimum meal frequency) ^{iv}
- Mean number of meals served in the household for consumption by children

¹⁶⁰ WV 2009e, table 1, p. 1-3.

- Women with children 0-24 months who consumed iron-fortified food or iron/multivitamin supplements regularly during their most recent pregnancy ^v
- Children 6-24 months old who receive an iron-rich food or iron-fortified food that is specially designed for infants and young children ^v
- Parents or caregivers of children 6-24 months who add a micronutrient product to the child's complementary food ^{vi}
- Children aged 1-18 years who consume a meal with fish or meat protein at least three times a week^{vii}
- Parents or caregivers who check the quality and quantity of food eaten by / who feed or assist their children aged 12-59 months
- Proportion of households with year round access to sufficient food (through own production, purchase or other source) to meet the daily food needs of their children ^{viii}
- Proportion of households with access to food reserves in times of need (food crisis) through informal/family network, government provision or others sources ^{viii}
- Proportion of households moving from food aid to providing for themselves without assistance ^{ix}
- Proportion of 'at risk' children who, before, during and after a disasters, remain well nourished

National level indicators

- Prevalence of underweight children under five years of age (below minus two standard deviations (moderate and severe) / below minus three standard deviations (severe), from the median weight for age of the WHO standard)
- Low birth weight incidence (below 2,5000 grams)
- Preschool aged children (children 6-59 months) with Vitamin A deficiency (serum retinol<70 Mml/L)
- Pregnant women with moderate to severe anemia (Hemocue Hb < 11g/dL)
- Children under 5 with moderate to severe anemia (Hemocue Hb < 11g/dL)
- Children aged 6-35 months with moderate to severe anemia (Hemocue Hb < 11g/dL)

ⁱⁱ This indicators may be seasonally variable and can be measured more frequently if required

ⁱⁱⁱ Physical verification where possible

^{iv} Number of times during the day: 2x for breastfed children 6-8 months; 3x for breastfed children 9-24 months.

^v Types of common iron rich or iron fortified foods available, for appropriate positive responses, to be defined locally (e.g. dark green leafy vegetables, red meat, liver, eggs, sea food and nuts)

^{vi} Types of common micronutrient products for appropriate positive responses, to be defined locally

^{vii} Where appropriate, this can be used as a proxy indicator for household wealth as well as an indicator for nutrition

^{viii} The season in which this indicator is measured may affect recall.

^{ix} The indicator may be seasonally variable

- The Government has a documented and implemented food security policy to ensure access to food in case of a food crisis

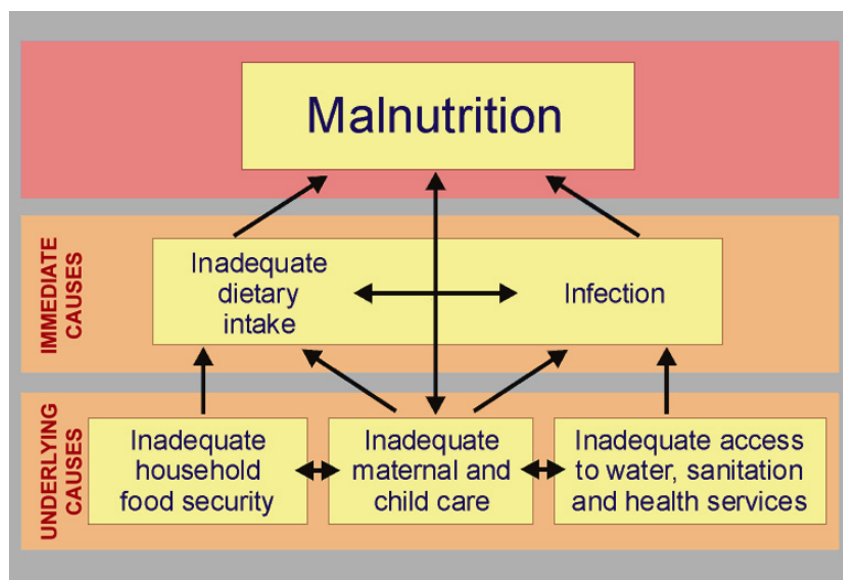
“Each year, about 20 million children under five become thin and wasted or severely malnourished and, as a result as many as 1 million die.”¹⁶¹ Understanding the immediate cause of early childhood food insecurity, namely insufficient provision of particular nutrients, is the baseline for direct interventions to improve young children’s nutrition (i.e. preventive and curative treatment with food supplements and information sharing on adequate feeding practices).

6.2.1.6. Direct and Indirect Causes of Malnutrition

The issue of malnutrition is closely interlinked with issues of health and child care practices. Figure 6 shows that malnutrition is caused by:

- 1) Two direct (immediate) factors: inadequate nutrient intake & sickness
- 2) Three indirect (underlying) factors: inadequate a) household food security, b) maternal and child care, c) access to water, sanitation and health services

Figure 6: Conceptual Framework of Malnutrition



Source: Friedrich, J. 2009, 'Ernährung und Ernährungssicherung', World Vision.

¹⁶¹ WHO n.d., ... viewed 27 October 2009, http://www.who.int/nutrition/topics/statement_commbased_malnutrition/en

This concept explains that a mere increase in food supply does not tackle the root causes of child malnutrition. Although food is obviously important, the majority of severe acute malnutrition among young children is caused by poor sanitary facilities and diseases that lead to diarrhoea.¹⁶² The broader underlying structural causes of malnutrition are linked to socio-cultural, economic and political issues. Poverty and social inequalities (unequal distribution of wealth), livelihood insecurity (lack of social protection by the government) and macro-economic constraints (higher food prices) are all important determinants for malnutrition in early childhood.¹⁶³

UNESCO (n.d.) states that “[stunting] is associated with low socio-economic status [and standard of living], low educational level of parents [(esp. women)], poor access [to food,] water supply and sanitation and high burden of infectious diseases. Height-for-age is considered the best indicator of chronic under-nutrition reflecting the cumulative effects of socio-economic, environmental, health and nutritional conditions”.¹⁶⁴ In addition, GTZ (2009) also says that “stunting is strongly correlated with parental education and economic status: those who are poor and minimally educated are more likely to ‘pass on’ poverty to the next generation. In addition, stunting is often associated with minority caste and ethnic groups, pointing to an impact of discrimination.”¹⁶⁵ Even though adequate complementary feeding is the direct means to prevent early childhood stunting, it is also a difficult matter. On the one hand, this is because “complementary foods for children 6 to 24 months need to be contextually appropriate, both in terms of using locally available foods and optimizing positive cultural beliefs and behaviours, while minimizing or changing negative behaviours.”¹⁶⁶ On the other hand, stunting is not only a matter of inadequate nutrient intake. It is however closely interlinked with the broader issues of poverty and therefore provides a useful indicator for poor development in general that needs to be assessed. It follows from this that WV staff has to make sure to not only treat the symptoms of early childhood malnutrition, but to also focus on the indirect causes.

Further readings

Ruel, M. T., Menon, P., Habicht, J.-P., Loechl, C., Bergeron, G., Pelto, G., Arimond, M., Maluccio, J. Michaud, L. & Hankebo, B. 2008, - ‘Age-based preventive targeting of food assistance and behaviour change and communication for reduction of childhood undernutrition in Haiti: a cluster randomized trial’, *The Lancet*, vol. 371, no. 9612, pp. 539-541.

UNICEF 2009, *Tracking Progress on Child and Maternal Nutrition: A Survival and Development Priority. District, Kenya*
Wu, T.-C. & Chen, P.-H. 2009, ‘Health Consequences of Nutrition in Childhood and Early Infancy’, *Pediatrics & Neonatology*, vol. 50, no. 4, pp. 135-142.

WV n.d., *Global Health Centre Sector Theme: Nutrition*, World Vision.

WV 2005, *Guide to Mobilising and Strengthening Community-led Care for Orphans and Vulnerable Children*, World Vision, p. 145 ff. (psychosocial support) / 163 ff. (counselling) / 175 ff. / 185 ff.

WV 2005, *Guide to Mobilising and Strengthening Community-led Care for Orphans and Vulnerable Children*, p. 205ff. / p. 213ff.

¹⁶² The World Bank 2006, *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action*, p. 11. Three myths about nutrition

¹⁶³ UNESCO 2010, *Education for All (EFA) Global Monitoring Report 2010: Reaching the Marginalized*, pp. 44-45.

¹⁶⁴ UNESCO n.d., *Prevalence of stunting among children under five years of age*, p. 1.

¹⁶⁵ GTZ 2009, *Getting the basics right: Contribution of Early Childhood Development to equality, equity and efficiency in education*, Deutsche Gesellschaft für Technische Zusammenarbeit, Eschborn, Germany, p. 10.

¹⁶⁶ WV 2009c, p. 14.

WV 2007, *Addressing Malnutrition Through Community-Based Therapeutic Care: Update on World Vision CTC Capacity Building & Programming*.

WV DeRT 2002, 'Well-being of families and children – part I: a guide to the indicators on nutrition, immunization, and education', *Transformational Development Indicators (TDI) Field Guide*, World Vision, vol. 2, pp. 7-15.

WV India 2008, *Maternal/Child Health and Nutrition: A Learning Manual*.

WV Mongolia ULAANBAATAR 2005, 'Effectiveness of Home-Based Fortification of Complementary Foods with Sprinkles in an Integrated Nutrition Program to Address Rickets and Anemia'

6.2.2. Adequate Maternal and Child Care Practices

Adequate maternal and child care practices involve care of young children, care of mothers, response to child illness and hygiene.¹⁶⁷

6.2.2.1. Child Feeding Practices

- Breastfeeding and complementary feeding practices
- (Semi-)solid or soft foods and supplements (e.g. iron, folate, iodine, zinc, vitamin A)
- Quality and quantity of food given to children under five years of age => customary practices of eating meals within the family setting, including intra-household food distribution
- Context-specificity: traditional belief systems regarding mothers' and young children's diets (in general and during sickness); traditional meals, e.g. certain staple foods

6.2.2.2. Exclusive Breastfeeding

World Vision's International Policy on milk products in field programmes states that:

"World Vision will support, protect and promote exclusive breastfeeding of infants for the first six months of their lives and continued breastfeeding for two years or beyond, with timely and correct use of adequate complementary foods in communities in which it has activities."¹⁶⁸

Generally, a mother should exclusively breastfeed for the first six months of her child's life. Giving the child any other food or fluids (e.g. water) during this time can make the infant sick and further lead to reduced milk production of the mother. After 6 months, a child should receive other complementary foods, though mothers should continue breastfeeding until the child is 2 years or

¹⁶⁷ WV N-CoE 2008.

¹⁶⁸ WV 2007b, p. 4.

older.¹⁶⁹ Breast milk (especially colostrum) contains antibodies, enzymes and hormones that all have health benefits and are important for the development of infants. Moreover, breastfeeding suppresses ovulation, that is women who are still breastfeeding are less likely to become pregnant than those who are not which further encourages birth spacing.¹⁷⁰ In fact, “exclusive breastfeeding for six months, with partial breastfeeding continuing to 12 months, could prevent 1.3 million (13 percent) deaths each year in children under five.”¹⁷¹ Despite this evidence, 62 percent of infants under six months of age are not exclusively breastfed.¹⁷²

Questions

- ◆ Promoting exclusive breastfeeding is another example of World Vision’s BCC approach to influence individuals’ behaviours on the micro-level.¹⁷³
 - What are the broader culturally determined factors that lead to insufficient breast feeding?
E.g. gender roles: women’s time poverty prevents them from providing sufficient and adequate care for their babies; norms and values: cultural belief systems may cause women to refuse feeding children colostrum which is believed to be harmful for the young child.¹⁷⁴

Further readings on breastfeeding

Hoddinott, P. et al. 2008, ‘Breast feeding’, *BMJ*, vol. 336, pp. 88-887.

LINKAGES 2004, *Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding...*

Taha, T. E. Kumwenda, N. I. Hoover, D. R. Kafulafula, G. Fiscus, S. A. Nkhoma, C. Chen, S. & Broadhead, R. L. 2006, ‘The impact of breastfeeding on the health of HIV-positive mothers and their children in sub-Saharan Africa’, *Bulletin of the WHO*, vol. 84, no. 7, pp. 546-554. [see end note references!]

6.2.2.3. *Feeding Practices for Children Six Months and Older*

As mentioned above, children six months and older should be given complementary food in addition to breast milk. However, growth impairment commonly starts at about six months of age when children transition to foods that are often inadequate in quantity and quality. During this time children also experience increased exposure to the environment making them more susceptible to illness.¹⁷⁵

Complementary feeding is the process of introducing other foods and liquids into the child’s diet when breast milk alone is no longer sufficient to meet nutritional requirements.¹⁷⁶ *Complementary food*

¹⁶⁹ AED 2004, *Course on Integrated Prevention of Mother-to-Child Transmission of HIV and Support For Infant Feeding - for Community Motivators*, p. 27.

¹⁷⁰ Hoddinott et al. 2008, p. 881.

¹⁷¹ Ibid.

¹⁷² PATH 2006, *Diarrheal Disease: Solutions to Defeat a Global Killer*.

¹⁷³ WV 2009c, p. 21.

¹⁷⁴ Hampshire, K. Et al. n.d., *The social context of childcare practices and child malnutrition in Niger’s recent food crisis*.

¹⁷⁵ Caulfield, L. E. et al. 2006, p. 551.

¹⁷⁶ Caulfield, L. E. et al. 2006.

includes any manufactured or locally prepared food suitable as a complement to breast milk or infant formula when the latter are no longer sufficient to satisfy the infant's nutritional requirements (previously referred to as weaning food or breast milk substitute).¹⁷⁷

In this context, WV's policy states that:

“Wherever possible World Vision will encourage and support local production of appropriate complementary foods, with the use of locally available nutritious food resources, with the aim of self-reliance and respect for local culture and eating habits.”¹⁷⁸

Brown et al. (1998) identify four main causes of inadequate nutrition intake in infants and young children in relation to complementary feeding practices:¹⁷⁹

- Complementary foods are introduced too early or too late¹⁸⁰
- Foods are served too infrequently or in insufficient amounts, or their consistency or energy density is inappropriate
- The micronutrient content of foods is inadequate to meet the child's needs, or other factors in the diet impair the absorption of foods
- Microbial contamination may occur

Caulfield, L. E. et al. (2006) also provide a list of guiding principles for complementary feeding practices. These principles relate to timing and frequency of breastfeeding and complementary food provision, quality and quantity of complementary foods as well as issues regarding hygiene and food handling.¹⁸¹

Questions

→ What are the underlying problems that prevent children in a particular context from receiving adequate complementary food?

→ How can evidence-based 'scientific' knowledge best be integrated with traditional child feeding practices? If these are not compatible and/or traditional practices are in fact harmful for a child, how can WV and MoH health experts 'convince' people to change their behaviours and attitudes?

¹⁷⁷ AED 2004, *Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding - Health Providers Course*, p. 163

¹⁷⁸ WV 2007b, p. 3.

¹⁷⁹ Brown et al. 1998 ... [quoted in Caulfield, L. E. et al. 2006, p. 555; original source not accessible]

¹⁸⁰ See also AED 2004, *Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding - Community Motivators Course*, p. 101. Consequences of too early or too late introduction of complementary food.

¹⁸¹ Caulfield, L. E. et al. 2006, p. 557.

6.2.3. Adequate Health Services and Healthy Environment

Adequate health services and healthy environments involve community-based maternal & child healthcare, access to essential (facility-based) primary healthcare and a healthy physical environment.¹⁸² *Community-based Management of Acute Malnutrition (CMAM)* is a good example of service delivery that focuses on people's urgent survival needs, while at the same time maintaining a focus on the prevention and reduction of illness and death.¹⁸³

Project Model: Community-based Management of Acute Malnutrition (CMAM)¹⁸⁴

CMAM is a decentralized community-based approach promoting the home-based treatment of severe acute malnutrition (SAM) in children under five and pregnant and lactating mothers that are affected by acute malnutrition using ready-to-use therapeutic food (RUTF). CMAM is a focused intensive approach (not a standard model for all ADPs) that should only be applied for context-specific situations where populations show high levels in wasting (>10 percent) in children under five¹⁸⁵, where the number of SAM children is high and where other programs addressing the underlying problems of malnutrition already exist.

“[SAM] is defined by a very low weight for height (below -3 z scores¹⁸⁶ of the median WHO growth standards), by visible severe wasting, or by the presence of nutritional oedema. In children aged 6–59 months, an arm circumference less than 110 mm is also indicative of severe acute malnutrition.”¹⁸⁷

¹⁸² WV N-CoE 2008.

¹⁸³ WV 2009i, *Part One: Introduction to the 7-11 Field Guide*, pp. 7-8.

¹⁸⁴ WV N-CoE 2009, *Community-based Management of Acute Malnutrition Project Model – DRAFT*; see also WV 2009d, p. 62.

¹⁸⁵ In communities with aggravating factors, including: general food ration below 2100 kcal/person/day, crude death rate greater than 1/10,000/day and or/ epidemic of measles or whooping cough; WV N-CoE 2009, p. iii.

¹⁸⁶ A 'z score' is the number of standard deviations below or above the reference mean or median value.

¹⁸⁷ WHO, WFP, SCN & UNICEF 2007, *Community-based Management of Severe Acute Malnutrition*.

Table 7: CMAM Project Model Contribution to the Child Well-being Outcomes

Outcome	Enjoy good health	Educated for life
Intermediate outcome	<i>Children, parents and care givers know how to keep themselves healthy</i>	<i>Adolescents are ready for economic opportunity</i>
Specific contribution	Influence behaviours that affect child, parents and care givers health	Improves educability Reduce physical disability such as blindness due to Vitamin A deficiency
Intermediate outcome	<i>Children are well nourished</i>	
Specific contribution	Rehabilitates severely undernourished children Increases children's access to adequate nutrition Establishes community capacity to address SAM Addresses nutritional status of pregnant women, improving birth results	[Reducing irreversible mental retardation due to iodine deficiency; reducing poor mental, motor, social-emotional and neurophysiologic functioning due to iron (+zinc) deficiency ¹⁸⁸]
Intermediate outcome	<i>Children protected from infection, disease and injury</i>	
Specific contribution	Provides essential child health services Creates access to child immunization and essential medicines Addresses vulnerabilities to illness caused by malnutrition	[Reducing children's susceptibility to infections (e.g. through unfavourable weather conditions) and thus their absence from school due to illness]
Intermediate outcome	<i>Children and their givers access essential health care services</i>	
Specific contribution	Increases access to health services Reduces cost of addressing child illness Increases mothers' contact with service providers and counselling services Initiates specific advocacy for National investment	

CMAM Key Principles¹⁸⁹

- Maximum coverage
- Timeliness
- Appropriate
- Care for as long as it is needed

¹⁸⁸ Walker et al. 2007, p. 147.

¹⁸⁹ WV N-CoE 2009, p. 6.

CMAM Key Components¹⁹⁰

- Supplementary Feeding Program (SFP)
- Outpatient Therapeutic Program (OTP)
- Stabilization Centre (SC)/Inpatient care

Ready-to-Use Therapeutic Food (RUTF)¹⁹¹

RUTF is an energy dense mineral/vitamin enriched food which includes several major benefits:

- Very dense so only small amounts are needed
- Does not need to be cooked or prepared
- Paste form includes low water content meaning it is microbiologically safe and will keep for several months in simple packaging

Middle Upper Arm Circumference (MUAC)¹⁹²

Screening and admission to CMAM programmes is based on measurement using either color-coded and/or numeric Middle Upper Arm Circumference (MUAC) tapes or presence of pitting oedema.

- Children screened using MUAC as “red” or <115 mm or with pitting oedema are referred to the OTP and/or SC, depending on their level of oedema and medical status, and
- Children screened using MUAC as “yellow” of between 115mm and 125mm are referred to the SFP program.
- Pregnant and Lactating mothers are admitted into the SFP if their MUAC is < 210mm and they are either visibly pregnant or the baby is under six months of age.

Some of the benefits of using MUAC include:

- Simpler and cheaper - can be used by community volunteers
- Less prone to measurement mistakes
- Greater sensitivity - A better indicator of mortality risk associated with malnutrition and therefore a better measurement by which to identify children most in need of treatment
- Reduced confusion - One measure for both screening and admission reduces confusion over multiple indicators (e.g. weight for height, weight for age etc.) and associated lack of programme coverage caused by children being screened and referred using one criteria and then turned away once measured for admission using another criteria.

¹⁹⁰ Ibid., pp. 6-8.; see also SCF n.d., *Acute-Malnutrition-Summary-Sheet*.

¹⁹¹ WV N-CoE 2009, p. 8; See also WHO & UNICEF 2009; WHO, WFP, SCN & UNICEF 2007.

¹⁹² WV N-CoE 2009, p. 9.

Further readings on CMAM

WV 2008, *Community Management of Acute Malnutrition (CMAM) Set UP Mission, Gwanda, District & Feasibility Assessment Mission Robert Sinyoka (ADP Area), Zimbabwe ...*

WV 2008, *Community Mobilisation Technical Support Visit World Vision/MoHCW CMAM Programme Gwanda District, Bulawayo, Zimbabwe*

WV 2008, *Community-based Therapeutic Care Assessment, Design & Set Up, Lokori Division, Tokana WV 2009, Community-based Management of Acute Malnutrition: Project Model – Draft.*

2009, *What is CMAM? A Framework to Maximize Coverage, Quality & Impact*

WVC n.d., *Nutrition and Health*, p. 4.

7. Maternal Health as Prerequisite for Child Well-being

7.1. Facts and Figures

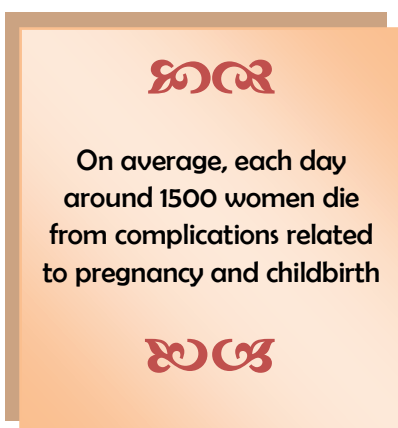
The United Nations Millennium Development Goal (MDG) 5 specifically relates to improvements in maternal health with the following targets:¹⁹³

Target 1: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

- ↳ Indicators:
- Maternal mortality ratio
 - Proportion of births attended by skilled health personnel

Target 2: Achieve, by 2015, universal access to reproductive health

- ↳ Indicators:
- Contraceptive prevalence rate
 - Adolescent birth rate
 - Antenatal care coverage (at least one visit and at least four visits)
 - Unmet need for family planning

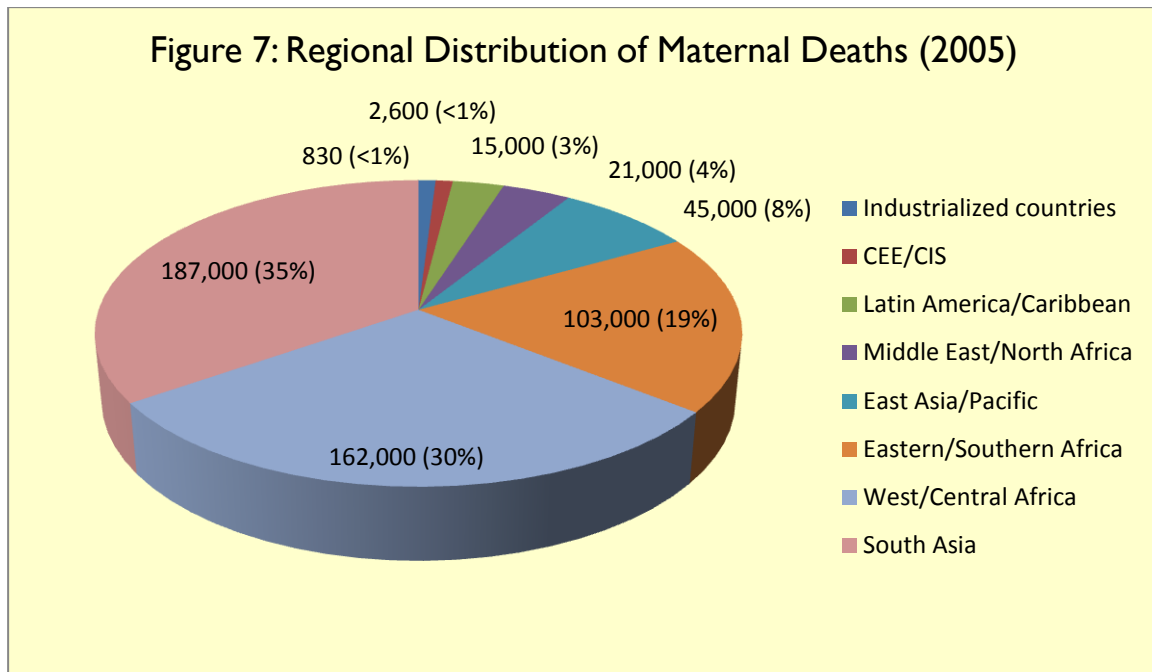


Despite these goals, each year 500,000 women die worldwide due to complications related to pregnancy and childbirth (that is around 1500 women each day), with more than 99 percent of these deaths occurring in developing countries (most of them in Africa and Asia), (see Figure 7, p. 64). A WHO (2006) systematic review identified seven main causes of maternal death in developing countries including: haemorrhage, hypertensive disorders, sepsis/infections, abortion, obstructed labour, anaemia and HIV/AIDS.¹⁹⁴ The risk for a woman to die from

¹⁹³ UN 2009, *The Millennium Development Goals Report*, United Nations, New York, USA, pp. 26-27.

¹⁹⁴ Khan, K. S., Wojdyla, D., Say, L., Gülmezoglu, A. M. & Van Look, P. F. A., 2006, 'WHO analysis of causes of maternal death: a systematic review', *The Lancet*, vol. 367, no. 9516, pp. 1066-1074. Incidence rate of causes in descending order. There is no reliable data available for HIV and AIDS from Asia, Latin America and the Caribbean, though its prevalence is high in Africa. Maternal deaths due to ectopic pregnancy and embolism are

complications during pregnancy or childbirth over the course of her life is 1 in 76 in the developing world, compared with 1 in 8,000 in industrialized countries. ¹⁹⁵ Estimates show that 74% of all maternal deaths could actually be prevented through low-cost interventions; an equivalent of 370,000 women who could be saved each year. However, the reduction in maternal deaths between 1990 and 2005 has been less than about one tenth of what is needed to achieve MDG 5. ¹⁹⁶



Source: World Health Organization, United Nations Children’s Fund, United Nations Population Fund and the World Bank, *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and the World Bank*, WHO, Geneva, 2007, p. 35 [viewed in UNICEF 2009, *The State of the World’s Children: Maternal and Newborn Health*, p. 6].

Maternal health is a crucial subject matter in focusing on early childhood. This is because “at least 20% of disease in children under the age of five is related to poor maternal health and nutrition, while children left motherless are ten times more likely than other children to die within two years of their mother’s death.”¹⁹⁷ In other words, a mother’s health and nutrition status largely determines her baby’s physical well-being. It is therefore crucial not to focus on children as individuals separate from their mothers, especially in the early developmental stages between -9 to 24 months. ¹⁹⁸

Proximate causes of women’s poor health status are rooted in much more complex structural issues, including “early marriage, poor nutrition, lack of access to contraception, low social, economic and

low in developing countries, with higher numbers occurring in developed countries; See also UNICEF 2009, *The State of the World’s Children: Maternal and Newborn Health*, p. 14.

¹⁹⁵ UNICEF 2008, *Progress for Children: A Report Card on Maternal Mortality*, p. 4.; UNICEF 2009, *Key Figures SOWC 2009: General Maternal Mortality Data*, p. 1.

¹⁹⁶ WV 2008, ‘Last chance for the world to live up to its promises? - Why decisive action is needed now on child health and the MDGs’, *Policy Briefing*, UN high-level event on the MDGs, pp. 6-7.

¹⁹⁷ WV 2008a, pp. 6-7.

¹⁹⁸ WV 2009c, p. 5.

legal status of women and lack of education for girls.”¹⁹⁹ Despite the many risk factors for pregnant women in developing countries, there are many constraints preventing them from receiving adequate medical health care. Most commonly these constraints are characterized by ill-equipped and poor quality health systems, poor care-seeking behaviours among pregnant women, limited access to health services (due to economic constraints or poor transport facilities), lack of community emergency infrastructure, traditional and culturally-defined perceptions of sickness and health, lack of awareness regarding the importance of accessing skilled birth attendance and lack of decision-making power among women to decide where to give birth.²⁰⁰

7.2. Maternal Health Risks

The three major risk factors to maternal health are related to: 1) childbirth 2) maternal anaemia and 3) mother’s susceptibility to infectious diseases.²⁰¹

7.2.1. *Childbirth*

Every minute, one woman dies from pregnancy/childbirth-related complications. Worldwide, over 80% of maternal deaths are caused by haemorrhage (severe bleeding), pregnancy-induced hypertension, infection, prolonged/obstructed labour and complications from unsafe abortions. Major issues regarding childbirth include scarce availability of and access to health systems, poor care-seeking behaviours among pregnant women as well as a lack of community emergency infrastructure. Many women therefore deliver their babies at home without skilled birth attendants with the result that those mothers who survive often suffer from pregnancy-related complications such as infections, injuries, diseases and disabilities.²⁰² Access to skilled birth attendance is also crucial as infant mortality rates are highest within the first 24 hours after birth. On a global scale about three quarters of all neonatal deaths occur just within the first week after birth.²⁰³

Context-specific reasons for women choosing not to use health services may include: “tradition and cultural perceptions (i.e. perceiving the health facility as “a place to die”), economic constraints, poor quality of services to include poor staff attitude, lack of understanding regarding the importance of accessing skilled birth attendance especially for birthing complications and lack of decision-making power among women to decide where to give birth.” Other risk factors relate to people’s ignorance

¹⁹⁹ Ibid.

²⁰⁰ WVI 2009c, p. 6.

²⁰¹ WV 2009c, pp. 5-11.

²⁰² WV 2009c, p. 5/69.

²⁰³ Lawn et al. 2005, p. 893.

of pregnancy and childbirth danger signs as well as their lack of skills to react accordingly, delayed care seeking and no access to distant service facilities²⁰⁴

One possible approach to tackle these issues provides the Home Based Life Saving Skills (HBLSS) model targeting families and caretakers. HBLSS is “a family-focused and community mobilization programme [with the] objective to reduce deaths among mothers and newborns by increasing access to basic lifesaving care within the home and community and by decreasing delays in reaching referral facilities where life-threatening problems can be managed.” Pregnant women and birth attendants (including family members, friends and TBAs) receive training to recognize the signs of child-birthing complications and to respond appropriately.²⁰⁵

Another crucial intervention to reduce infant, child and maternal mortality is healthy timing and spacing of births or limiting subsequent pregnancies. Estimates show that birth spacing of 3 to 5 years can reduce infant and child death rates by more than 50%. Likewise, birth spacing also reduces risks of early childhood stunting and wasting. Timing refers to the delay of first pregnancy. “Infants born to adolescent girls are twice as likely to die compared to infants born to older women. 90 percent of infants whose mothers’ die in childbirth will likewise die before their second birthday. [In addition] “Maternal mortality is the leading cause of death for girls aged 15 to 19.” Unmarried young girls are particularly at risk of suffering multiple health and social consequences.²⁰⁶

7.2.2. Maternal Anaemia

Iron deficiency is the most common micronutrient deficiency affecting women. It can lead to pre-term delivery, low birth weight babies and post-partum haemorrhage. Low birth weight also increases the risk of neonatal deaths. Infants who survive are likely to experience ill health as well as impaired physical and cognitive growth. Generally, children born to iron-deficient mothers have reduced iron stores and are thus more vulnerable to suffer from irreparable life-long development deficits. Iron-deficiency anaemia also increases the risk of maternal mortality with an estimate of around 115,000 maternal deaths each year. Mothers who survive often suffer from fatigue and decreased cognitive ability.²⁰⁷

Preventive and curative interventions for maternal anaemia include:²⁰⁸

- Eating adequate iron-rich foods, foods that enhance iron absorption and fortified foods (e.g. liver, animal foods, fortified staples)
- Iron/folate supplementation

²⁰⁴ WV 2009c, p. 6.

²⁰⁵ WV 2009d, p. 69-70.

²⁰⁶ WV 2009c, p. 41-42.

²⁰⁷ WV 2009c, p. 40.

²⁰⁸ WV 2009c, pp. 7-8.

- De-worming in areas of high worm-loads
- Anti-malarial prophylaxis during pregnancy in malaria-endemic areas
- Sleeping under LLINs in malaria endemic areas

7.2.3. Mother's Susceptibility to Infectious Diseases

“Infectious Diseases (ID) account for approximately 25% of maternal deaths, while illness from ID reaches 40% in developing countries.” World Vision has identified some of the major infectious diseases including: malaria, tetanus, tuberculosis, soil-transmitted helminthes (STH) and schistosomias as well as co-infections (TB/HIV, HIV/ Malaria, HIV/TB/Malaria and other neglected tropical diseases). Consequences and interventions (prevention, early detection and access to early management) regarding these IDs are outlined in World Vision's 7-11 Strategy for Health and Nutrition (Part Two).²⁰⁹

Further readings on maternal health

Oxfam (2009), *Your Money or Your Life: Will leaders act now to save lives and make health care free in poor countries?*, Oxfam International.

8. Case Studies

8.1. MICAH

The **MIC**ronutrient **And Health** (MICAH) Program was carried out between 1996 and 2005 by World Vision Canada (WVC) and National Offices in five African countries: Ethiopia, Ghana, Malawi, Sénégal and Tanzania. The programme's goal was “to improve the micronutrient and health status of mothers and children through the most cost effective and sustainable interventions.”²¹⁰ Integrated strategies and direct interventions (e.g. exclusive breastfeeding, capacity building of community health workers in nutrition and health, establishment of household gardens and revolving funds, latrine construction and education of local populations) led to improvements in Vitamin A, Iron and Iodine intake.²¹¹ Detailed strategies and measurements²¹² as well as programme achievements for women and children under five²¹³ are outlined in the WV (2006) paper *Improving Nutrition of Women and Children The MICAH Program - A Micronutrient And Health Program for Africa*.

²⁰⁹ WV 2009c, pp. 8-11.

²¹⁰ WV 2006, *Improving Nutrition of Women and Children The MICAH Program - A Micronutrient And Health Program for Africa*, p. 12.; see also WV n.d., *The MICAH Guide: Chapter 1 - Developing a MICAH Project Proposal*, p. 4.

²¹¹ WV 2006.

²¹² Ibid, pp. 12-23.

²¹³ Ibid, pp. 6-7. See also results (by country / by micronutrient / contribution to the MDGs) pp. 24-51.

Further information on MICAHA

WVC n.d., *Design and Implementation of Nutrition Surveys (Excerpt From the Micah Guide, a Publication of World Vision Canada)*

WVC n.d., *Indicators to Monitor Impact of Nutrition Programmes (Excerpt From the Micah Guide, a Publication of World Vision Canada)*

WV 2001, *MICAHA Program End of Project Evaluation Survey: Guidelines for Final Technical Report*

WVC n.d., *Nutrition and Health*, pp. 4-5.

WV n.d. *The MICAHA Guide: Chapter 1 - Developing a MICAHA Project Proposal*

8.2. ENHANCE

Expanding Nutrition and Health Achievements through Necessary Commodities and Education

“ENHANCE was developed to improve the survival and growth of children under the age of 5 in ADPs.” The specific goal was thereby to improve (‘enhance’) the quality of diet, access to essential health services, healthier environments, household food and nutrition security.²¹⁴ The scope and focus areas of the programme included:²¹⁵

- Breastfeeding and nutritious first foods for young children (adequate provision with Vitamin A, Iron and Iodine)
- Monitoring individual children’s growth
- Common childhood illnesses (malaria, diarrhoea, pneumonia, measles and worm infections)
- Educating families on growing, preparing and eating nutrient-rich foods
- Training of WV staff and government / community partners

Information to two World Vision case studies in Malawi and Cambodia are analysed in the following papers:

WV 2008, *Life in All its Fullness for Children of Malawi: Malawi ENHANCE Project Phase 2*

WV 2008, *Life in All its Fullness for Children of Cambodia: Cambodia ENHANCE Project Phase 2*

Further readings on ENANCE

WVC n.d., *Nutrition and Health*, p. 3.

CORE 2003, *Positive Deviance /Hearth a Resource Guide for Sustainably Malnourished Children.*

Sternin, M., Sternin, J. & Mars, D. 1998, *Designing a Community-Based Nutrition Program: Using the Hearth Model and the Positive Deviance Approach - A Field Guide*, Save the Children.

²¹⁴ WV 2008d, *Enhancing the Lives of Children under Five: Phase 2 ENHANCE*, p. 1.

²¹⁵ Ibid, p. 2.

Recommendations for Action

1) Recommendations for policy makers

- ◆ Bring early childhood health and nutrition into the political discourse!
- ◆ Invest in basic services and safety nets for mothers and young children.

2) Recommendations for ADP staff

- ◆ Identify the *underlying* determinants of child malnutrition and ill health: poverty, hierarchical power structures on the community and household level etc.
- ◆ Improve people's awareness on the local level regarding the importance of early childhood and maternal health/nutrition (e.g. see WV's 7-11 H/N Strategy).
- ◆ Approach women, because their decision-making power in early child health and nutrition is a crucial determinant for young children's well-being.
- ◆ Consider traditional norms and values that might interfere with development interventions, e.g. traditional child feeding practices that could harm an infant's health.
- ◆ Consider a range of multiple determinants that can influence children's physical well-being
 - 1) People's ways of life (standard of living, behaviour etc.)
 - 2) Children's environment (community support, a safe social setting etc.)
 - 3) Children's age (different caring and nutritional needs etc.)
- ◆ Provide adequate nutrition, safe drinking water, sanitation and hygiene for U5s to prevent infectious diseases *before* any treatment becomes necessary.
- ◆ Facilitate capacity building and knowledge exchange: promote community-based solutions through active involvement of beneficiaries in programme design and implementation processes, e.g. through community groups (such as CCCs) and training of CHWs/TBAs.
- ◆ Use multiple-level interventions to tackle early childhood sickness and disease; i.e. consider the individual, community and environmental level.

- ◆ Use integrated programming models for programme delivery, e.g. combine nutritional schemes, disease prevention and treatment.
- ◆ Identify the most vulnerable groups among infants and young children (e.g. newborns, children with disabilities, orphans, girls, ethnic minorities etc.) within any given context.
- ◆ Promote equal opportunities for everyone regarding the availability and accessibility of services.
Ask:
 - 4) How can MCHN services be delivered most effectively (e.g. through public services or home-based care)?
 - 5) Who does WV staff need to approach on the household level (i.e. who is predominantly responsible for early child care within the family setting)?
 - 6) Who decides about whether a child receives particular health care and nutritional services, or not?

9. Bibliography

AED 2004, *Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding - Health Providers Course*, pp. 173-177.

AED 2004, *Integrated Prevention of Mother-to-Child Transmission of HIV and Support for Infant Feeding - Community Motivators Course*, pp. 100-110.

Anand, S. & Bärnighausen, T. 2007, 'Health workers and vaccination coverage in developing countries: an econometric analysis', *The Lancet*, vol. 369, no. 9569, pp. 1277-1285.

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WV 2009d, *Part Three: Implementing the 7-11 Strategy*.

WV 2009e, *Compendium of Indicators - version 1.6: Girls and boys are cared for, protected and participating*.

WV 2009f, *Part One: Introduction to the 7-11 Field Guide*.

WV 2009g, 'Quick Guide Global Health and Nutrition Strategy', *Global Health and Nutrition*.

WV 2009h, 'Start-UP Strategy: 7-11', *Global Health and Nutrition*

WV 2009i, *An overview of the HIV and AIDS Hope Initiative*.

WV 2009j, *World Vision's Contribution to Child Well-Being: Child Well-being Outcomes and Indicators...*

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WV n.d., *TDI 2.0 Transformational Development Indicators for Child Well-being*.

WV n.d., *HIV & AIDS M & E Indicators for PMIS*.

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WV 2010, *Factors affecting PMTCT service delivery*.

WV India 2008, *Maternal/Child Health and Nutrition: A Learning Manual*.

WV N-CoE 2008, *World Vision's Asia Pacific Region Nutrition Strategy*.

WV N-CoE 2009, *Community-based Management of Acute Malnutrition Project Model - DRAFT*

You, D. Wardlaw, T., Salama, P. & Jones, G. 2009, 'Levels and trends in under-5 mortality, 1990-2008', *The Lancet*, vol. 375, no. 9709, pp. 100-103.

Additional Web Links

<http://www.coregroup.org> - The CORE Group

<http://www.globalhealth.org> - Global Health Council

<http://www.globalhealthlearning.org> - USAID Global Health eLearning Center

<http://www.child-survival.org> - U.S. Coalition for Child Survival

http://www.asksource.info/res_library/ecd.htm - International Information Support Center Early Childhood Development

<http://www.who.int/pmnch/en/> - Partnership for Maternal, Child & Newborn Health

http://www.who.int/immunization_monitoring/resources/en/ - Materials and methods on surveillance, monitoring and assessment [Information on various diseases]

<http://www.unitedcalltoaction.org/references.asp> - Vitamin and Mineral Deficiencies [References and micronutrient indicators by country as PDF]

Chapter 2: Child Well-being Outcome (2)

- “Children are Educated for Life”

Second Pillar: Education and Early Childhood Development

1. The Need for Early Childhood Education

In chapter 1 we identified physical well-being as an essential indicator for children’s early development. We will now be looking at early childhood education from two different perspectives: First, as an important determinant for children’s ongoing cognitive growth processes, mental and intellectual well-being; Second, as being itself heavily dependent on other CWBOs, in particular with regard to health, nutrition and early social stimulation. Thus, this chapter builds in many ways on the previous one and provides further links to the following topics discussed in this paper. With regard to World Vision’s ambition to develop early childhood education programmes the fundamental questions of this chapter are:

- ◆ What are the *long-term* effects of early childhood education on children’s cognitive development and later academic success in developing countries?
- ◆ What are the *prerequisites* for a young child to realize his or her full potential in cognitive development processes in early life stages?
- ◆ What are the *barriers* preventing children under five from receiving adequate care and education?
- ◆ What are the most effective *interventions* within World Vision programming to improve young children’s access to early childhood care and education?

2. Defining Early Childhood Education

The concept of early childhood education is most often interlinked with other ideas of ‘care’ and ‘development’. This is because education in early childhood (which itself subdivides into several components) cannot be separated from the latter two concepts. Definitions can thus vary and we will seek to incorporate all relevant aspects into our discussion to build a general framework from

which more specific schemes can be deduced. Generally, good-quality early childhood education is necessary for a range of different dimensions in young children's development.

Early childhood education has been defined in many different ways in the literature. For reasons of better comprehending specific ideas, we will draw from those definitions most commonly referred to by relevant sources as well as relating those to World Vision concepts and methodologies.

Early childhood care and education (ECCE)

Programmes that, in addition to providing children with care, offer a structured and purposeful set of learning activities either in a formal institution (pre-primary) or as part of a non-formal child development programme. ECCE programmes are normally designed for children aged 3 and above and include organized learning activities that occupy on average the equivalent of at least 2 hours per day and 100 days per year.²¹⁶

Pre-primary education (ISCED Level 0)

Refers to programmes at the initial stage of organized instruction, which are primarily designed to introduce very young children, usually from age 3 or so, to a school-type environment, to provide a bridge between home and school. Such programmes are variously referred to as infant education, nursery education, pre-school education, kindergarten, or early childhood education. They are the more formal component of early childhood care and education (see ECCE).^{217,218}

According to UNESCO's ECCE concept, *care* comprises "health, hygiene and nutrition within a nurturing and safe environment that supports children's cognitive and socio-emotional well-being". *Education* in early childhood involves more than just pre-schooling, as it encapsulates "learning through early stimulation, guidance and a range of developmental activities and opportunities".²¹⁹ In this chapter we will see that World Vision integrates all of these dimensions into its approach to early childhood education. WV defines *education* with regard to both formal and non-formal systems that facilitate the development of literacy, numeracy and essential life skills. Furthermore, WV

²¹⁶ UNESCO 2007, *Education for All (EFA) Global Monitoring Report 2007: Strong Foundations - Early Childhood Care and Education*, UNESCO, Paris, France, pp. 348/351.

²¹⁷ Ibid.

²¹⁸ See also GTZ 2009, *Getting the basics right Contribution of Early Childhood Development to quality, equity and efficiency in education*, Eschborn, Germany, pp. 11-14. Discussion on transition years, primary school efficiency and different forms of ECD interventions including home-based and centre-based learning programmes.

²¹⁹ UNESCO 2007, p. 15.

acknowledges that education already starts during early childhood to prepare children not only to succeed in formal education, but also to prepare them for life in general.²²⁰

World Vision also recognizes that early childhood education is most effective when it is integrated into the broader field of early childhood development (ECD). WV's holistic approach on child development sees education (including the acquirement of cognitive as well as non-cognitive skills) as being closely connected other positively 'mind-shaping' CWBOs (e.g. good nutrition, stimulating care etc.). Strictly speaking, the term ECCE may therefore be understood as component of early childhood care and development (ECCD), which is commonly used within WV work. For that reason we will be using the terms *early childhood care and education* (ECCE) and *early childhood care and development* (ECCD) interchangeably, however we will predominantly refer to the latter. ECCD combines several areas that are part of and influence children's development, including "infant stimulation, health and nutrition, early childhood education, community development, women's development, psychology, sociology and other fields of study."²²¹ This, of course, makes sense because the whole concept of *care* is an integrated and essential part of children's intellectual well-being, in fact, it is a prerequisite. In short, early childhood education always includes and only comes in combination with other development factors. As we will continue our analysis here as well as in the following chapters this will eventually become clearer.

3. Scientific Background

3.1. Facts and Figures

Pre-primary education (mostly for children aged 3 and above) has been steadily increasing. Worldwide, the gross enrolment ratio (GER) increased by over one quarter from 33 to 41 percent between 1999 and 2007. The highest increases took place in Sub-Saharan Africa (53 percent change) and South and West Asia (71 percent change). However, Sub-Saharan Africa in particular still has the lowest overall GER (about 15 percent) among all global regions, with only one in seven children enrolled in pre-primary education.²²² On the other hand, we will also discuss in later sections why high rates of pre-primary enrolment alone may neither be indicative for better quality of learning nor for more equal opportunities in early childhood education. For example, in 2007, the pupil-teacher ratio average in Sub-Saharan Africa was still twice as high (28 pupils per teacher) as in North America and Western Europe (14 pupils per teacher), (see Table 1, p. x).

²²⁰ WV 2009, *World Vision Public Policy Policies on Education*, p. 1.

²²¹ WVI 2002, *Education Taskforce for Transformational Development, Early Childhood Education Sub-Group ... Early Childhood Care for Development (ECCD)*, p. 3.

²²² UNESCO 2010.

Table I: Pre-primary Education: Pupil/Teacher Ratio & Gross Enrolment Ratio

	Pupil/Teacher Ratio Average in Pre-primary Education ²²³ (pupils per teacher)		Gross Enrolment Ratio (GER) in Pre-primary Education ²²⁴ (in %)	
	1999	2007	1999	2007
Developing Countries	27	26	27	36
Developed Countries	18	15	73	80
Sub-Saharan Africa	29	28	10	15
Arab States	21	18	15	19
Central Asia	10	11	19	28
South and West Asia	36	40	21	36
N/America and Western Europe	17	14	75	82

Source: UNESCO 2010, *Education for All (EFA) Global Monitoring Report 2010: Reaching the Marginalized*, UNESCO, Paris, France.

3.2. Early Brain Functions and Mental Growth Processes

The first few years of children's lives are crucial in determining their later cognitive development and school performance.²²⁵ The physical growth processes that are taking place particularly within the final prenatal months and first 2-3 years of a child's life significantly affect his or her skills and achievements. This marks the period when a child's brain develops the fastest (by age four, the brain is 90 percent of its adult size). Right from the time of birth, neural pathways develop through learning as they are stimulated through a child's experiences of and interactions with his or her social environment.^{226, 227} There are several determinants influencing children's early cognitive development

²²³ UNESCO 2010, Table 10A, p. 394.

²²⁴ UNESCO 2010, Table 2.1, p. 51.

²²⁵ Grantham-McGregor, S. et al. 2007, 'Developmental potential in the first 5 years for children in developing countries', *The Lancet*, vol. 369, no. 9555, pp. 60-61.

²²⁶ Sinclair, A. 2007, '0-5: How Small Children Make a Big Difference', *Provocation Series*, vol. 3, no. 1.; GTZ 2009, *Getting the basics right: Contribution of Early Childhood Development to equality, equity and efficiency in education*, Deutsche Gesellschaft für Technische Zusammenarbeit, Eschborn, Germany.

processes, most evidently this relates to physical well-being and early stimulation provided by primary caregivers. We will be examining both subject matters, with regard to universal principles as well as context-specific circumstances, within this chapter.

Further readings on early brain development

Thompson, R. A. & Nelson, C. A. 2001, 'Developmental Science and the Media: Early Brain Development', *American Psychologist*, vol. 50, no. 1, pp. 5-15.

Johnson, M. H. 2001, 'Functional Brain Development in Humans', *Nature Reviews*, vol. 2, pp. 475-483.

Johnson, M. H. 2000, 'Functional Brain Development in Infants: Elements of an Interactive Specialization Framework', *Child Development*, vol. 71, no. 1, pp. 75-81.

3.3. Early Cognitive Development: Barriers and Consequences of Neglect

An estimated number of 200 million children under five years of age in developing countries do not reach their full potential in cognitive development due to a wide range of risk factors including poverty, poor health and nutrition as well as deficient social stimulation.²²⁸ Lacking capacities for the development of young children's 'intellectual well-being' has negative consequences for the experiences of the individual child as well as for the broader community and national-level sustainable economic growth in terms of decreasing productivity.

There has been much attention given towards improving primary education in developing countries. The UN Millennium Development Goal (MDG) 2 sets to 'ensure that all boys and girls complete a



full course of primary schooling by the year 2015'.²²⁹ This objective is an essential element in the overall ambition of many international NGOs, including World Vision, to eradicate child poverty. However, it is important to consider that an increase in net primary school enrolment (national indicator) is neither equivalent with higher rates of school completion, nor with a better quality of educational services (context-specific indicator). Thus, we need to ask not only about quantitative outputs (i.e. the number of boys and girls that completed primary school in a given year), but also about

quality outcomes that could in fact indicate shortcomings in children's intellectual and social competencies (e.g. late enrolments, high drop-out rates, grade repetition, physical punishments, lack of teacher training, poor school facilities and so forth).

²²⁷ See also Thompson, R. A. & Nelson, C. A. 2001, 'Developmental Science and the Media: Early Brain Development', *American Psychologist*, vol. 50, no. 1, pp. 5-15.; Johnson, M. H. 2001, 'Functional Brain Development in Humans', *Nature Reviews*, vol. 2, pp. 475-483.

²²⁸ Grantham-McGregor et al. 2007, p. 60.

²²⁹ UN 2009, *The Millennium Development Goals Report*, United Nations, New York, USA

Early childhood education (in institutional as well as home-based care) can have a very constructive effect in providing children with the prerequisites for, and thus with the opportunity of a ‘good start’ into, formal education.²³⁰ Some of the major issues that primary schools are often facing include high gaps in teacher-pupil ratios (see Table I, p. x) with subsequent overcrowded classrooms, lack of learning materials, inadequate school facilities as well as inexperienced and unmotivated teachers. These issues are major contributors to high rates in primary school drop-outs (most of which occur within the first two years of school) as well as grade repetition, which tremendously increases a country’s national costs for primary education services.²³¹ Thus, although crucial, just making it into primary school is no guarantee for a child’s subsequent achievements in life. Apart from quality primary education itself (which is not subject of our discussion, but has broadly been analyzed in the literature elsewhere), children also have to already bring with them a strong foundation, which includes not only good health and nutrition, but also personal qualities such as persistence, self-regulation and motivation. On the family and community level this also strongly relates to learning support for young children. ECCD programmes may also consider the relevance of educating older siblings who often act as major caregivers and can help younger siblings making the transition into primary school level and socialize them into school activities.²³² ECCD can further help reducing the risk of dropping out of school, grade repetition and generally prolonged school attendance²³³ that otherwise translates into high national level costs of repairing educational losses in later stages of the lifecycle.²³⁴

UNESCO (2007) “[Early childhood development] programmes can enhance physical well-being and motor development, social and emotional development, language development and basic cognitive skills”²³⁵. Early brain development is heavily influenced by the quality of a child’s environment. Lack of adequate health care and nutrition, poor stimulation and social interaction as well as maternal stress can have irreversible adverse effects on children’s cognitive skills and emotional well-being (see also sections 6. And 7.).²³⁶ Early childhood development programmes will need to take into account all of these measures in order to be successful.

²³⁰ GTZ 2009, p. 11. In the developing world, it takes an average of 1.4 years for children to complete one grade year.

²³¹ Sub-Saharan Africa spends about 33 percent of public expenditures on education on grade repetition [expenditures on education = primary school only?], (GTZ 2009, p. 11). See also UNESCO 2010, Internal efficiency: repetition in primary education (Table 6, pp. 348-355) & Internal efficiency: primary education dropout and completion (Table 7, pp. 356-363)

²³² WVUS 2005, *Technical resources sector standards: version 1.0 – draft*.

²³³ In the developing world, it takes an average of 1.4 years for children to complete one grade year [in primary school?], (GTZ 2009, p. 11).

²³⁴ GTZ 2009, pp. 11-14.

²³⁵ UNESCO 2007, p. 111ff.

²³⁶ Walker, S. P. et al. 2007, ‘Child development: risk factors for adverse outcomes in developing countries’, *The Lancet*, vol. 369, pp. 145-157; Grantham McGregor et al. 2007.

Further readings on the link between ECCD and primary school

GTZ 2009, *Getting the basics right: Contribution of Early Childhood Development to equality, equity and efficiency in education*, Deutsche Gesellschaft für Technische Zusammenarbeit, Eschborn, Germany, pp. 6-7.

UNESCO 2005, 'Education for All - Global Monitoring Report 2005: The Quality Imperative', UNESCO, Paris, France, pp. 56-58.

UNESCO 2007, 'Education for All - Global Monitoring Report: *Strong Foundations - Early Childhood Care and Education*', UNESCO, Paris, France, p. 111.

Further readings on risk factors for early childhood development

Engle, P. L. et al. 2007, 'Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world', *The Lancet*, vol. 369, no. 9557, p. 236.

Walker, S. P. et al. 2007, 'Child development: risk factors for adverse outcomes in developing countries', *The Lancet*, vol. 369, pp. 145-157.

3.4. Basic Strategies of Intervention

Strategies to avoid the lost developmental potential of children under five have already been researched and implemented. Early Childhood Development (ECD) programme assessments in developing countries have demonstrated a range of different factors that are associated with programme effectiveness. For example, providing services directly to children has been proven to be more effective than interventions based on information delivery that is only transferred to parents. However, opportunities for building and practicing skills with parents increase effectiveness of programmes. Disadvantaged children benefit more than advantaged children and younger children more than older children. Other dimensions determining successful interventions include the quality, structure and processes as well as frequency and integration of programmes. Scientific evidence suggests that the most effective early childhood education programmes are those that:²³⁷

- Apply an integrated approach, including health, nutrition, educational and social dimensions
- Build upon multi-level collaboration between governmental agencies and civil society
- Focus on the most disadvantaged children.
- Work closely with young children for a longer period of time and support them in self-learning processes and exploration of their environment
- Involve parents and families in partnership with teachers and caregivers
- Bring together traditional child-rearing practices and cultural beliefs with other evidence-based approaches
- Provide staff with on-the-job training to acquire theoretical knowledge and practical experience to monitor children's development

All of these strategies closely correspond with World Vision's holistic and integrated approach to promoting early childhood development as we will see in the following sections.

²³⁷ Engle, P. L. et al. 2007, 'Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world', *The Lancet*, vol. 369, no.... pp. 231/234.

4. World Vision Background

4.1. Rights-based Approach

The right of children to gain an education is fundamentally anchored in the UN Convention on the Rights of the Child (CRC), (see box below)²³⁸. Although the CRC does not refer to early childhood education per se (it more specifically points out primary, secondary and higher education), the convention comprises a number of paragraphs that directly relate to children's intellectual well-being, including their understanding of and role within the broader context of their society. This stands in accordance with World Vision's holistic view on community development. In this context, WV actively promotes quality education that is "rights-based, non-discriminatory, inclusive, community-based, child-centred and empowers children to know their own rights."²³⁹

CRC Article 28

States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:

Make educational and vocational information and guidance available and accessible to all children

CRC Article 29

[The] education of the child shall be directed to:

The development of the child's personality, talents and mental and physical abilities to their fullest potential

The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own

The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin

The development of respect for the natural environment

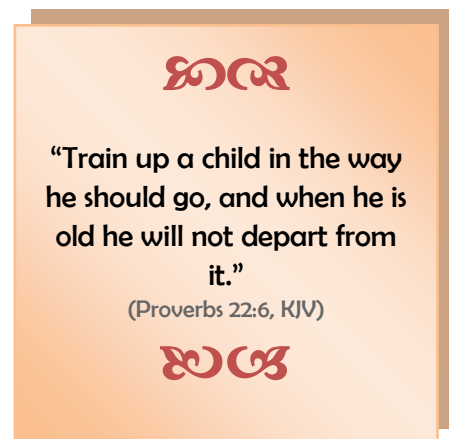
²³⁸ UN 1989, *UN Convention on the Rights of the Child*.

²³⁹ WV 2009, *World Vision Public Policy Policies on Education*, p. 2.

4.2. World Vision’s Christian Commitment (CC)

Johnson and Boyatzis (2005) explain that from an early age on children already have the cognitive capacities to understand dual concepts, including the physical and mental, the natural and supernatural. These early capacities need to be culturally nurtured to build the cognitive-cultural foundations of spiritual development. Chapter three specifically focuses on this topic more in depth. What is important in relation to early childhood education is that nurture is crucial for the development of children’s spiritual development within any context and belief system. That is to say, “spiritual practices are considered to be founded on uniquely human cognitive capacities that emerge early in development and depend on cultural support”²⁴⁰.

Supporting early cognitive development helps children to understand the world beyond their own self which helps them to orient, frame and connect themselves with the environment and people living within. Early childhood care and education thus provides the first steps in children’s lives to gain an understanding of their responsibility to care for others and their environment (see chapter 3). In this connection, early education also promotes participative capacities through cognitive meaning-making practices (e.g. dialogue and narratives) that teach children the social values of their culture, including certain emotions such as sympathy and compassion.²⁴¹ The essential value of early childhood education lies therefore not merely in the transmission of theoretical knowledge, but much more in developing the meaning of human interrelationships and responsibility. In this regard, parents play an important role in setting an example and to guide their children to the best of their abilities.



4.3. World Vision’s Public Policies and Holistic Approach

World Vision’s *Public Policies on Education* comprises a summary of recommendations and also provides guidelines to WV staff. An overview of World Vision’s education strategy is reflected in its *Do, Assure, Don’t Do* (DADD) framework (see Table 2, p. 88). World Vision’s strategy for developing children’s intellectual well-being exists in accordance with the Education for All (EFA) goals.²⁴² The

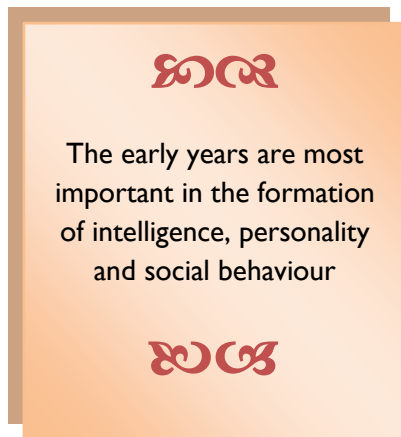
²⁴⁰ Johnson, C. N. & Boyatzis, C. J. 2005, ‘Cognitive-Cultural Foundations of Spiritual Development’, in E. Roehlkepartain, P. King, L. Wagener & P. Benson, *The Handbook of Spiritual Development in Childhood and Adolescence*, p. 211.

²⁴¹ Johnson, C. N. & Boyatzis, C. J. 2005.

²⁴² UNESCO 2007, *Education for All (EFA) Global Monitoring Report 2007: Strong Foundations – Early Childhood Care and Education*, UNESCO, Paris, France; WV 2009, *World Vision Public Policy Policies on Education*.

organisation supports all of the EFA goals agreed upon in the *Dakar Framework for Action* in 2000, including: expanding and improving early childhood care and education.²⁴³

World Vision recognizes that “the early years are most important in the formation of intelligence, personality and social behaviour.”²⁴⁴ Early childhood care and education thus builds the first and most



crucial foundation to ‘educate children for life’ and strongly supports the first formative years of children’s development and prepares them for later successes in formal education. Furthermore, a lack of early stimulation can cause lifelong learning difficulties in conjunction with antisocial behaviours and increased social isolation.²⁴⁵ Thus, early quality educational support can have long-lasting positive outcomes for children’s overall well-being as well as for a community’s social structure.

World Vision provides ECCD programmes in priority areas for children from age 0 to 5 and above. WV also offers teacher training, technical assistance and curricula/materials to governments supported schools and encourages governments to increase their attention and funding for early childhood education in public policy.²⁴⁶

Early childhood education also incorporates World Vision’s key ambition to empower communities through integrating adults into programmes and building human capacity in generating knowledge about the importance of children’s early intellectual well-being. WV thereby specifically focuses on making ECCE programmes accessible for disadvantaged, marginalised, poor and illiterate populations towards achieving equal opportunities for all, right from the beginning.²⁴⁷

²⁴³ Ibid, p. 1; UNESCO 2000, *The Dakar Framework for Action Education for All: Meeting our Collective Commitments*, Adopted by the World Education Forum (26-28 April 2000), Dakar, Senegal.

²⁴⁴ WVI 2002, *Education Taskforce for Transformational Development: Early Childhood Education Sub-Group*, p. 3.

²⁴⁵ Ibid, pp. 80/83.

²⁴⁶ WVI 2002, *Education Taskforce for Transformational Development: Early Childhood Education Sub-Group*

²⁴⁷ WV 2002, pp. 6/24.

Table 2: World Vision’s Do, Assure, Don’t Do Framework recommended for Education

CORE FOCUS of WV in this sector	DO	<p>Values-based Life Skills and citizenship training</p> <p>Education in Emergencies</p> <p>Adult learning and community empowerment</p> <p>Community based Early Child Care and Development</p>
	ASSURE	<p>Strengthening basic numeracy and literacy of children and adults within sector or thematic community projects</p> <p>Adaptation and production of Learning Resources with communities</p> <p>Community based initiatives to improve and monitor educational access, facilities and quality</p>
Other complementary areas of work, if the Core Focus is being addressed	ADDITIONS to Core Focus	<p>Partnering with providers of pre-vocational, vocational, apprenticeships, technical training and higher education scholarships</p> <p>Supplementary teacher training and curricula materials that support our core foci</p> <p>Leverage external resources to improve education infrastructure</p>
	EXCEPTIONS	<p>Support construction of basic school infrastructure in emergency contexts or failed states</p>
Phase Down /Transition	DON'T DO	<p>Exclusive educational supplies for sponsored children</p> <p>Build or improve schools where communities and governments can take on this responsibility</p> <p>Run schools</p> <p>Take on the responsibility for the design and implementation of national curriculum</p> <p>Lead educational reform</p>

Source: World Vision 2007, Revised Draft Do-Don't Do Framework recommended for Education.

The Abecedarian Study - A Theoretical Basis

The Abecedarian Study is one of the major frameworks on which World Vision ECCD resources are based (Stephenson 2010, pers. comm.). The child-focused study suggests that treatment in early infancy will have a positive effect on later cognitive development processes and academic performance. Early intervention leads to higher cognitive functioning, thus children are more ready when they enter primary school, leading to a greater likelihood of continuing school attendance and success.

Methodology

Participants were 111 infants from 109 low-income families (98 percent African-American). 57 children were randomly assigned to an Experimental Preschool group and 54 to a Control Group. The experimental treatment varied in intensity (i.e. duration): educational treatment from infancy through 3 years in public school (up to age 8), preschool treatment only (infancy to age 5), primary school treatment only (age 5-8 years) and untreated (control group).²⁴⁸

The Abecedarian early childhood programme was composed of “consistent, high quality early educational intervention. [That is], a systematic early childhood (infant) curriculum individualized for each child and designed to promote cognitive, language, perceptual-motor, and social development, [as well as] a curriculum [which] focused more on language development and pre-literacy skills [for children attending preschool, in addition to] low child-staff ratios, on-site paediatric care and low staff turnover”.²⁴⁹

Findings relevant for WV early childhood research

The Abecedarian programme provides an essential proof of the lasting benefits of early education for children from economically disadvantaged families, thus linking it to WV’s overall aim to reduce child poverty.

Some data suggests that treatment for less than four years may not be effective in leading to long term development processes (the Abecedarian project provided treatment for five years before

²⁴⁸ Campbell, F. A. & Ramey, C. T. 1994, ‘Effects of Early Intervention on Intellectual and Academic Achievement: A Follow-Up Study of Children from Low-Income Families’, *Child Development*, vol. 65, no. 2, pp. 684/686.

²⁴⁹ Campbell, F. A., Pungello, E. P., Miller-Johnson, S., Burchinal, M. & Ramey, C. T. 2001, ‘The Development of Cognitive and Academic Abilities: growth Curves from an Early Childhood Educational Experiment’, *Developmental Psychology*, vol. 37, no. 2, pp. 233/240. See also Sparling & Lewis, 1979; Ramey, McGinness, Cross, Collier, & Barrie-Blackley, 1982; Sparling & Lewis, 1984.

kindergarten, 8 hours a day). This may indicate questions about the feasibility of ECCD programmes in terms of costs as well as the willingness of parents/caregivers and the wider community for a long-term commitment to participate.

Educational interventions have to be complemented with the fulfilment of other CWBOs, e.g. adequate housing, affordable medical care, public transportation, good family relationships and support, which parallels WV's integrated approach on ECCD.

Positive outcomes in early childhood need to be upheld in later development stages, which means that efforts to improve children's overall well-being have to be holistic and extend towards transferring knowledge into the family setting (e.g. through adult education programmes, child-to-child approach) and supporting subsequent education for children in primary and secondary school levels.

4.4. Beneficiaries

There are many benefits of World Vision's ECCD approach for participants on several levels, including the individual child, the family, the community as well as the broader national level. Young children acquire intellectual knowledge as well as social skills, including improved abilities to think and reason, improved language skills, better skills at relating to others by means of improved solidarity and participation, as well as gaining a better self image. In particular, poor and vulnerable groups (e.g. children with disabilities, AIDS orphans or those living with HIV or AIDS, young girls whose parents do not see the benefit in ECCD or children in remote rural areas) will benefit from these programmes as they gain access and are more integrated into their communities.²⁵⁰ Children are also often provided with nutritious food and health care which further enhances their chances of survival and protection from illness. This does not only have immediate advantages for children in their early years, but also contributes for them being much better prepared for primary school. They learn easier and faster, perform higher and are less likely to drop out of school. In addition to these factors, early childhood education can also contribute to increasing primary school enrolment and subsequently lead to a country's more active labour force.

Caregivers of children participating in ECCD programmes also benefit as they are able to seek employment outside the home. In particular, women who are constraint by time poverty and therefore unable to sufficiently care for their children may greatly benefit from any form of additional support. That is, early childhood care and development services can ease mothers' double burden of

²⁵⁰ WV 2002.

work and child care which can, in turn, lead to higher household incomes as well as maternal health benefits. What children learn at school can have an influence on their family members at home (e.g. children learn to be more disciplined about health matters and remind their parents to wash their hands after using the toilet). This also takes into account older (but often still very young) siblings responsible for caring for infants and young children who cannot be cared for properly by their parents working outside the home. Furthermore, bearing in mind that these programmes ought to be designed as an integrated concept, parents and caregivers may also learn about general and child-specific subject matters including essential life issues to do with early stimulation, literacy for women (that may also enable them to engage in income-producing activities), nutrition, health practices and managing illness, home-based protection from accidents and injury prevention, as well as personal and household hygiene.²⁵¹

4.5. World Vision's ECCD Programming Principles²⁵²

World Vision's programming principles in ECCD reflect WV's ecological view on children's well-being which is embedded in dynamic interrelationships between the child and his or her socio-cultural environment. ECCD programmes therefore aim to look at *all* dimensions of children's well-being and consider a range of different programming practices that take into account not only the child as the direct target, but also parents (especially mothers) and the community setting.

The latest global Education for All (EFA) monitoring report describes early childhood care and education (ECCE) to be the 'bedrock' of EFA.²⁵³ This statement corresponds with World Vision's programming principles that encapsulate a whole set of multidimensional layers which contribute to children's well-being from the very beginning of their lives. In short, pre-school education and psychosocial development ought to be combined with other elements including child health and nutrition programmes, maternal care and parent involvement, hygienic practices and sanitary facilities, child safety regulations as well as community participation.²⁵⁴

4.5.1. Contextual Principles [WV 2002, pp. 5]

World Vision needs to respond to local needs while also considering the larger context. WV's overall action framework for partnership and collaboration needs to operate between different stakeholders including governments, NGOs, the private sector and community members. Sustainable development for ECCD programming requires World Vision to build and maintain links to other

²⁵¹ WV 2002.

²⁵² Ibid.

²⁵³ UNESCO 2010, p. 5.

²⁵⁴ UNESCO 2010; WVI 2002, *Early Childhood Education Sub-Group*, pp. 4-7.

institutions that are developing programmes for small children. In particular, it may be useful to link ECCD projects to complementary services, to share the responsibility for financing programmes and to connect national support service delivery with local knowledge and capacities. WV staff needs to ask: What are the factors influencing the life of young children in a programme area? These factors may include:

- Government organization (economic structure & political climate)
- Size of the programme area and people's settlement patterns
- Cultural homogeneity or differences within the programme area
- Community organization, family structure and tradition
- People's standards of living (incl. poverty, livelihood and employment)
- Educational levels of the community and certain groups (e.g. mothers)
- Different gender roles
- Incidence of disability, HIV infection and other communicable diseases
- Risk of natural disasters

Further readings on ECCD 'in context'

Hurenkamp, M. 1998, 'Culture or context: what makes approaches appropriate?', *Early Childhood Matters*, no. 90, pp. 6-14.

Smale, J. 1998, 'Culturally or contextually appropriate?', *Early Childhood Matters*, no. 90, pp. 3-5.

UNESCO 2007, *Education for All (EFA) Global Monitoring Report 2007: Strong Foundations - Early Childhood Care and Education*, UNESCO, Paris, France, pp. 107-108.

4.5.2. *Social Principles* [WV 2002, pp. 6-7]

World Vision has established four main social principles for ECCD programming to ensure the good quality of early childhood education. Good quality programmes are characterized by high child protection standards and optimal resource utilisation. World Vision staff is responsible to design projects that:

- Attend first and foremost to children at the greatest risk
- Begin with what exists and build from there
- Develop programs and activities with and for the family
- Increase effectiveness of ECCD programs with community participation

It is important for ECCD programming to stay closely connected to local level structures. The most disadvantaged children also benefit the most from programmes, however they are the ones that are

often left out.²⁵⁵ WV needs to develop strategies to reach those children in order to provide equal opportunities for all. We also need to carefully consider approaches for financing ECCD as vulnerable children can be denied access to ECCD programmes because their parents cannot afford the cost. In this context, building and strengthening the capacity of networks, rather than creating new institutions and programmes, should be prioritised. Linkages with existing programmes and resources, including community structures relating to young children, local NGOs as well as churches can be advantageous. Churches are often important partners in offering parent education, spiritual nurture and in operation of child centres. Strategies need to be designed in ways that children and their parents can both participate in programmes. That means programmes need to support (*not replace*) the family and include mothers as well as fathers.²⁵⁶

Further readings on quality education

UNESCO 2005, *Education for All (EFA) Global Monitoring Report 2010: The Quality Imperative*, UNESCO, Paris, France.

4.5.3. *Technical Principles* [WV 2002, p. 7]

There are many different ways of ECCD programming strategies.^{257,258} In fact, “there is no right way to develop a programme”. Again, each context requires a new *particular* framework and design. Generally, World Vision staff should consider some possible concepts and basic requirements. That is, ECCD programmes:

- Need to be flexible and have to seek diverse strategies
- Can be home-based and focus on education for parents
- Can be centre-based, including education facilities such as crèches, home day care, formal and non-formal preschools, kindergartens, child-care centres and Sunday schools
- Can seek to develop skills relating to care of young children
- Can seek to influence policies relating to care of young children through advocacy efforts

²⁵⁵ WV 2009, *World Vision Public Policy Policies on Education*.

²⁵⁶ Although mothers are usually a child’s key attachment figure, involving fathers into ECCD programmes can have significant positive outcomes for the well-being of young children as well as for intra-household relationships.

²⁵⁷ WV 2002, p. 7.

²⁵⁸ GTZ 2009, pp. 21-23. GTZ suggests four categories of ECD strategy interventions: Formal pre-school reception year classes, often attached to primary schools; Centre-based approaches, such as kindergartens, play groups, day care or nurseries, either stand-alone or combined with existing services; Small-scale, home-based arrangements located in households; Home-visiting approaches, such as mobile services, distance education (i.e. community radio), ‘camps’ or ‘fairs’ on a systematic basis.

“A quality programme can operate in a variety of settings, in homes, in thatch-roofed huts, in primary schools, in converted buildings and even under trees.” The question whether ECCD programmes should be home-based or centre-based depends on the given situation in the local setting.²⁵⁹

4.5.3.1. *Centre-based Programmes*

Centre-based services need to be accessible and within reach of the communities routine everyday activities. Most importantly, the facility has to be a place where children feel comfortable and safe to learn. An attractive environment with a secured outdoor space to play, hygienic sanitary facilities and access to clean water are essential.²⁶⁰ Research has shown that early child care provided by day-care centres for children 0-3 years of age can have positive effects on children’s intellectual input as well as social experiences. Social support should certainly first and foremost be provided by the home environment. However, especially within the context of developing countries where parents are often limited in their possibilities to sufficiently stimulate their children’s social development, day care centres may be a useful alternative.²⁶¹ GTZ (2009) remarks that “even very basic programmes with minimal staffing or facilities may be much better than the alternative of leaving young children spending their days in unsafe environments – locked up at home alone, roaming the streets, or in the workplace – and that their existence can lead to a gradual increase in demand for better programmes as perceptions of quality evolve”.²⁶² Evaluations from different centre-based programmes reported considerable effects of these services on children’s cognitive development. In particular, children acquired many non-cognitive skills, such as sociability, self-confidence, willingness to talk to adults, and motivation. In addition, the studies also showed improvements in the number of children entering school, age of entry, retention and performance.²⁶³

4.5.3.2. *Home-based Programmes*

One of the main problems with centre-based services is that the poorest young children often live in very remote areas and thus cannot reach these facilities. It is important that World Vision programmes support services that can be accessed by all members of a community. If it only reaches a few better-off people, children from these families will be better prepared for school than more disadvantaged groups and as a result the inequality gap widens. But, ECCD can also be provided through parenting and parent-child programmes. Depending on the context, home-based ECCD programmes staffed by trained volunteers and run by parents may be a better option than more

²⁵⁹ Engle et al. (2007) provide brief summaries of several ECD project case studies.

²⁶⁰ WV 2002, p. 26.

²⁶¹ O’Brian Caughy et al. 1994

²⁶² GTZ 2009, p. 23.

²⁶³ Engle et al. 2007.

costly pre-primary school institutions.²⁶⁴ Working with parents is generally important because they are the child's first teachers providing them with ongoing learning experiences. Home-based ECCD programmes may include interventions such as parent education, parent support groups and home visiting.²⁶⁵

Several studies on parenting programmes using home visiting have shown that these had positive effects on both child development as well as parenting practices. However, it appears to be crucial that information sharing with parents is supplemented by active participation. For example, increased knowledge of child development and child rearing only had positive effects on children's development when the families applied practise or skill-based activities through play and other activities with the child.²⁶⁶ Public media (e.g. radio) may also provide a useful tool to deliver information on good childrearing and the actual needs of young children and their families.²⁶⁷

4.5.4. *Assessment and Design*

Early child care practices can vary greatly across countries. The Home Observation for Measurement of the Environment (HOME) Inventory is thereby a common tool to measure the family environment. It assesses the quality and quantity of support and stimulation provided for children within their families and communities. Parent-child interactions being measured include: warmth and responsiveness, harshness and discipline as well as stimulation and teaching. Designing effective ECCD programmes needs considering the different ways of interaction between adults and young children.²⁶⁸

Generally, ECCD programme design requires decisions upon combining certain components²⁶⁹, including:

Goods: food and nutritional supplements, immunisations, vitamins and minerals and other health supplies, materials and toys etc.

Services: access to health services providing health checks, weighing of children, home visits, parent education, full day care for children etc.

Activities: focus can be on families, the community, regional, national, or even international levels. Activities might include playgroups for children, caregiver training, parent meetings, community

²⁶⁴ WV 2002.

²⁶⁵ WV 2002; WVUS 2005.

²⁶⁶ Engle et al. 2007.

²⁶⁷ WVUS 2005.

²⁶⁸ UNESCO 2007, p. 154.

²⁶⁹ WV 2002, pp. 25-26.

planning meetings, development of radio and other media programs, national curriculum development efforts and national policy planning.

Curriculum: The curriculum needs to be open and flexible to the changing needs of the community. All activities should be in a framework or curriculum that serves as a guide to the kinds of activities offered and how they are offered. The curriculum should ensure that the programme is developmentally sound and provides scope for child play, interaction and sharing.

Delivery system: a place for activities to be held, equipment and materials for the running of the project, staffing, training and institutional supports. Teacher training means ensuring teachers understand the development stages of young children. Equipment has to be affordable and appropriate to promote learning and discovery. Facilities need to be safe, and provide a physical environment that allows for a quality program.

Questions

- ◆ Acknowledging that there is no standard, ready-made concept of / curriculum for early childhood education:
 - How can the WV partnership most effectively develop guidelines to inform staff on creating early childhood education frameworks?
- ◆ Considering that the entry age for primary school differs from country to country:
 - What issues does WV have to take into account in relation to the age of enrolment and years spend in pre-primary education?

5. Early Childhood Education and World Vision's CWBOs

5.1. Indicators for "Intellectual Well-being"²⁷⁰

A specific focus on early childhood requires some disaggregation of specific indicators with regard to World Vision's CWBOs. WV is thereby drawing from several sources to integrate them into WV's TDI 2.0 compendium (Stephenson 2009, pers. comm.). The following indicators are a summary of the present TDIs that may be applicable to children under the age of five.

²⁷⁰ WV 2009, *Compendium of Indicators - version 1.6: Girls and boys are educated for life*, table. 2, pp. 1-7. This is a summary of the CWBOs main indicators. The full compendium provides more detailed information.

5.1.1. *Children's Reading, Writing and Numeracy Skills*

- Reading skills is the current main TD indicator (this is because school enrolment alone is regarded to be insufficient for measuring the quality of children's education)²⁷¹
 - Is this indicator applicable for children under five? Should we instead focus on age-appropriate programmes to support children's abilities to communicate ideas through dialogue, play, drawing etc.?
- Literacy rate of 15-24 year-olds, women and men
 - This may also be an indirect indicator for early childhood development and child well-being, because higher educational levels among adolescence and young adults is likely to have a positive influence on parents' child rearing practices.

5.1.2. *Children's Judgments, Self-protection, Emotion Management and Communication of Ideas*

- Children's communication of thoughts and feelings
- Children's problem analysis and problem solving capacities
- Sexual abuse
- HIV and AIDS (knowledge about self-protection; attitudes towards HIV positive persons)
- Knowledge transfer between child-peers / child-parents or child-caregivers
- 12-18 year olds
 - Lack of early childhood stimulation translates into deficits in later development stages
- Youth pregnancies
 - Early pregnancies can have a negative effect on children's early development and well-being due to young parents' lack of inexperience in addition to health risks for mother and child. Early childhood education also increases the possibility of children remaining in school for a longer period of time, thus making it less likely for girls to become pregnant.

5.1.3. *Adolescents' Readiness for Economic Opportunities*

- Youth (15-18 year olds) who have a learning opportunity that leads to a productive life (i.e. young people not in school, but either attending a skills or vocational training course, or earning/producing a livelihood with opportunities ahead (not menial work or underemployed))
 - This indicator may be relevant for measuring young children's well-being when looking at youth pregnancies (i.e. young parents' ability to care for their children) as well as in future perspective, regarding financial income, good practical skills and knowledge base to provide for family and contributing to household earnings

²⁷¹ WV 2009, FY10 Education ADP Summary Planning Guidance; GTZ 2009, p. 11.

5.1.4. Children's Basic Education²⁷²

- School enrolment, attendance and completion => Pre-school attendance refers to the number of children aged 36-59 months who are attending pre-school²⁷³
- Access to schooling for children from vulnerable / marginalised groups => inclusion policies
- Access to schooling without official documentation (e.g. birth certificates)
- Access to schooling for OVCs/MVCs (e.g. orphans-non-orphans ratio)
- Gender ratio
- School fees [+ costs for uniforms, learning materials etc.?]
- Pupil-classroom, pupil-teacher and pupil-desk ratios
- Supply, salaries and training of teachers
- School materials (for learning and for play)
- School facilities (buildings and furniture, play areas, safe clean water, latrines or toilets)
- Travel distance to learning institution
- Child protection policies as part of school regulations
- Children's absence from school due to lack of safety
- Parent Teacher Associations (PTAs), (i.e. parents' involvement into school matters / teachers' responsiveness to parents' concerns)
- Gender-balanced school management committees (school policies and budget monitoring)
- Parent-child support regarding school matters
- Curriculum and teaching methods
- Life skills and child rights education

We may note that tools for early stimulation in reading, writing and numeracy skills have become a commodity on the public market in the Western World. In fact, early school achievement is particularly valued in North America, Europe and parts of Asia, emphasizing early stimulation since the late twentieth century.²⁷⁴ Moreover, values attached to cognitive and non-cognitive skills vary greatly between different cultural contexts. We thus have to be careful in determining the standards for certain indicatory measures. As World Vision is developing frameworks of indicators for early education for children under the age of five, we pay particular attention to children's early capacities

²⁷² According to the International Standard Classification of Education (ISCED), "basic education comprises primary education (first stage of basic education) and lower secondary education (second stage)", (UNESCO 2008, p. 390). However, due to WV wide range of *basic education* indicators that are transferable to pre-primary education as well as its reference to pre-school attendance, we will include this terminology into our discussion, while acknowledging that not all indicators may be applicable in any context.

²⁷³ Note: achievements at primary school can also be indicatory for quality pre-schooling that makes children (see sections 2.3., 5.2., 6.)

²⁷⁴ Andresen 2010, pers. comm.; UNESCO 2007, p. 154

to develop certain life skills (see section 6.3. below). This is because social and emotional competencies are the first that young children adopt.

6. Cognitive and Foundational Life Skills Development

6.1. Early Literacy and Numeracy Skills

The UNESCO EFA Global Monitoring Report 2005 states that “the spread of basic cognitive skills such as literacy and numeracy is key to individual and societal development”, but it is also “bound to be country-specific, given the history of each written language and the individual and collective uses of literacy that will arise” (p. 126).²⁷⁵ Promoting reading, writing and numeracy skills in early childhood is an important subject that needs to be further investigated in more detail.

Questions

- What are the indicators for pre-primary school reading, writing and numeracy skills?
→ What is the empirical evidence for the benefits of promoting children’s early reading, writing and numeracy skills? Are there alternatives to primary school measurements of reading, writing and numeracy skills, e.g. communicating ideas and feelings through other media than writing (e.g. drawing) or ways of using numbers other than by applying basic arithmetic math operations (e.g. counting objects)? How can this objective be realized within WV programming?

Some sources to look at may include:

- The New Breakthrough to Literacy (NBTL) methodology (used by WV)²⁷⁶
- The Primary Reading Programme (PRP) methodology
- Cognitive achievements as an important indicator for schooling success²⁷⁷

6.2. Language

The issue of language and whether it is more advantageous for children to learn at school in their mother tongue or in a country’s official language is highly debated among experts with supporting arguments on both sides. According to Micael Olsson, Senior Education Advisor at World Vision International, language is an important aspect to consider within early childhood education programming. Children, particularly those from an ethnic minority or migrant background, may be disadvantaged with regard to their first language. As these children start primary school they may face major problems with regard to comprehending certain subject matters. Olsson states:

²⁷⁵ UNESCO 2005, *Education for All (EFA) Global Monitoring Report 2005: The Quality Imperative*, UNESCO, Paris, France.

²⁷⁶ Referred to by Olsson, M. 2006.

²⁷⁷ E.g. Behrman 1996, p. 25ff

Lack of appropriate literacy readiness training can have serious consequences, particularly for ethnic minority and migrant populations where children hear local languages in the home rather than the national language. Failure to deal early on with two conflicting sound systems can inhibit literacy achievement for life. The good news is that strategies like the *Breakthrough to Literacy* methodology (now broadly used in southern Africa) are turning this ostensive barrier into an asset. WV Mexico, with 291 indigenous languages, has recognised this need and is developing its own Spanish-as-a-second-language strategy to help children with the transition from mother tongue to Spanish. Working alongside appropriate partners, World Vision could become known for its efforts to tackle literacy issues among excluded groups right from the beginning with literacy-oriented early childhood education programmes.²⁷⁸

Hurenkamp (1998) states that “language is one of the fundamental vehicles for transmitting and sustaining culture [and most often] linked to the relationship between minority and majority culture”.²⁷⁹ Marginalisation through language is an important issue with regard to both World Vision’s primary focus on vulnerable groups as well as its relevance to children’s first acquisition of essential cognitive skills.²⁸⁰ There is much debate on whether young children benefit more from being taught in their mother tongue or the national mainstream language of a country.

According to UNESCO (2007), ECCD programmes that are based on children’s first languages are more effective than those taught in official languages. However, the latter remains to be the predominant norm around the world. The UNESCO 2005 Monitoring Report on quality education further states that “children in areas not yet covered by primary-school systems probably need smaller class sizes than the average because they are often first-generation learners from underprivileged social groups and are more likely to belong to a minority whose language is not used as a medium of instruction”.²⁸¹ Thus, UNESCO (2007) promotes mother tongue instruction in pre-primary and primary education based on scientific findings suggesting that: “children who learn in their mother tongue for the first six to eight years (an approach known as the additive bilingual model) perform better in terms of test scores and self-esteem than those who receive instruction exclusively in the official language (subtractive model) or those who make the transition too soon (before age 6 to 8) from the home language to the official language (transition model). It is easier to become a competent reader and communicator in the mother tongue. Once a child can read and write one language, the skills are transferable to other languages.”²⁸²

²⁷⁸ Olsson, M. 2006, ‘Can “Education for All” Help Inform World Vision’s Minimum Standards for Education?’, *World Vision TDNews*, vol. 4, no. 4, pp. 2-3.

²⁷⁹ Hurenkamp, M. 1998, ‘Culture or context: what makes approaches appropriate?’, *Early Childhood Matters*, no. 90, p. 13. See the author’s full reference to Vedder, P. & Bouwer, E. et al. 1996, *Multicultural Child Care*, Multilingual Matters Ltd, Philadelphia, USA.

²⁸⁰ Hyde & Kabiru 2003, p. 65. Children say their first meaningful words at age 7 to 12 months and start speaking and understand words and ideas at age 1 to 2 years.

²⁸¹ UNESCO 2005, p. 114.

²⁸² UNESCO 2007, p. 159.

Others argue that since young children are very receptive for acquiring new languages, early childhood programmes can be an opportunity for children to develop confidence and self-belief by using their mother tongue while at the same time acquiring a second language that will further help them to cope with mainstream everyday life. Furthermore, bilingual learning environments where local languages are used tend to be more comfortable for children than monolingual settings. This may also be advantageous for promoting understanding among children of different ethnic groups with different languages attending school together. In addition, research from several developing countries has shown that bilingual settings also encourages parents more to communicate with teachers and participate in their children's learning processes.²⁸³ All this would be a call for to introduce local languages into the pre-primary school curriculum by integrating domestic minority and official languages.

6.3. Defining Life Skills Development

Education in early childhood also involves responding to children's psychosocial needs and social experiences. There has been profound evidence that high quality early intervention programmes have had positive outcomes on children's acquisitions of non-cognitive skills, such as "sociability, self-confidence, willingness to talk to adults and motivation."²⁸⁴ The Inter-Agency Working Group on Children's Participation defines life skills as: "Social and emotional skills, for example problem solving, conflict resolution, self awareness, assertiveness and interpersonal communication."²⁸⁵ The WHO (2003) further speaks of life skills as "abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life" (p. 3). Generally, life skills may be best understood as encompassing a range of psychosocial competencies and interpersonal skills that are closely connected to community-level knowledge, norms and values.²⁸⁶

In order to promote early life skills it is crucial to create safe environments for children that focus on development of sensory awareness and physical coordination. Most importantly, the space should provide children with opportunities to play, explore and learn as well as to interact with other children and adults in ways that encourages them to develop self-help skills and responsibility.²⁸⁷ As it is difficult to measure the mental and motor development of children in these programmes, it may be useful to identify indicators measuring whether a growth-promoting environment (regarding children's physical, mental and social development) has been established.²⁸⁸

²⁸³ UNESCO 2005, p. 111.

²⁸⁴ Engle et al. 2007, p. 232.

²⁸⁵ IAWGCP 2008, *Children as Active Citizens: A Policy Guide and Programme Guide*.

²⁸⁶ WHO, 2003, p. 3; UNESCO 2007, p. 57.

²⁸⁷ WVUS 2005; WV 2002, p. 26.

²⁸⁸ WV 2002, p. 25.

Table 3 (see p. 102) provides an overview of recommendations of what World Vision’s focus needs to be in early childhood care and development programmes. It should also link ‘CWB-Outcomes’ with ‘CWB-Input’, that is pre-school curricula and methodologies for supervising infants at ECDs.

Table 3: WV Life Skills Action Learning - Prenatal to age 6

	Critical thinking	Managing Emotions	Assertive communication	Building affirmative and mutual relationships	Assume responsibility for the collective good
Prenatal to 3 years Foundational skills	Perceptions Gross and fine motor coordination Rhythm	Identity Confidence	Developing corporal exp. Developing oral expression	[Responding to caregivers instructions / peers’ actions – refer to studies on early childhood?]	[Early childhood studies on participation?]
4-6 years Foundational & Essential Skills	Sensory Integration	Self-recognition Self-confidence Recognize feelings	Corporal and oral expression Figurative expression Developing self-expression	Recognize and understand others’ feelings	Participatory skills

Source: WV n.d., *Children in Ministry - Child Development and Rights - Education/Hope Initiative: WV Life Skills Action Learning - Prenatal to 18 years old.*

We may conclude that early childhood ‘skills’ can only be understood in a more comprehensive context. Accordingly, World Vision’s basic programming practices to promote children’s educational and psychosocial development need to include a broader set of interventions including:

- Responsiveness to developmental milestones and cues
- Attention, affection and participation
- Encouragement of autonomy, exploration and learning
- Prevention of and protection from child abuse and violence²⁸⁹

In conclusion, the following is a set of early childhood skills and competencies that WV is generally looking to promote through ECCD. Indicators are still in development.²⁹⁰

²⁸⁹ WV 2002, p. 5.

Table 4: Education Technical Recommendations for Pre-school Children

CWB - Outcomes	Indicator	Description
Children read	Basic print concepts	Letter knowledge, print/page direction, first phonology processing
Children use numerical skills	Children are able to count objects	Children discriminate similar shapes and sizes of drawn objects
Children make good judgments	Children master psychomotor and sensorial integration skills	Right brain and left brain functions integrate
Children manage their emotions	Children express their feelings	Children become aware of their self-existence
Children communicate ideas	Children use corporal and oral expression skills	Children intentionally communicate using body/voice
Children enjoy positive relationships with peers, family, and community	Children recognize the feeling of others	Self-recognition triggers recognition of others' feelings
Children value and care for others and for their environment	Children join in cooperative play	Children are comfortable with group activity

Source: WV n.d. *Education Technical Recommendations on Indicators*. [Outcomes 8 and 9 refer to adolescents' readiness for economic opportunity as well as children accessing and completing a basic education]

World Vision frameworks promoting children's cognitive, social and emotional abilities are the solid basis to start from in building successful ECCD programmes. However, it is vital that these objectives are backed up by and run parallel with programming practices supporting children's good health and adequate nutrition. The following section deals with those issues links education with aspects of maternal and child health, nutrition and feeding practices.

²⁹⁰ Stephenson (pers. comm. 2009)

7. The Crucial Link between Health, Nutrition and Education

We already discussed World Vision's commitment to reduce the high number of preventable deaths among children under five in chapter one of this paper. At this point we have to bring back attention to what World Vision has described to be a 'silent emergency' in early child health and nutrition.²⁹¹ The UNESCO 2010 *Education for All (EFA)* Report corresponds to these issues and directly links the global health debate to subject matters in early childhood education, as outlined in its section 'Malnutrition and ill health - a 'silent emergency' in education'.²⁹²

Article 24 of the UN Convention on the Rights of the Child states that:

*"All segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents"*²⁹³

This account broadly affirms that education and health are closely interrelated matters. Food security is a crucial issue and as we have already seen in our discussion on micronutrient deficiencies, malnutrition can severely undermine young children's cognitive development and intellectual well-being. This also shows that matters concerning education go far beyond the question of mere availability and accessibility of school facilities in terms of knowledge transfer. Transferred information also needs to be absorbed and translated into some productive outcome, which can only be achieved through a 'healthy mind'. Despite this vital interconnection, one third of all children in developing countries (about 175 million children) entering primary school each year have experienced malnutrition, with long-lasting damaging effects on their cognitive development.²⁹⁴ These damages are preventable. In particular, they are most effectively avoided through timely interventions that combine early childhood education with targeted health and nutrition programmes (cf. World Vision 7-11 Health and Nutrition Strategy²⁹⁵).²⁹⁶ Thus, ECCD programmes cannot only assist already disadvantaged children getting an easier start into primary school. But, integrated nutritional schemes can generally help children to reach the same cognitive levels as their peers from more advantaged family backgrounds.²⁹⁷

²⁹¹ WVI 2009, *Child Health Now: Together We Can End Preventable Deaths*.

²⁹² UNESCO 2010, pp. 42-43.

²⁹³ UN 1989, *UN Convention on the Rights of the Child*.

²⁹⁴ UNESCO 2010, p. 5.

²⁹⁵ WVI 2009, *Part One: Introduction to the 7-11 Field Guide*.

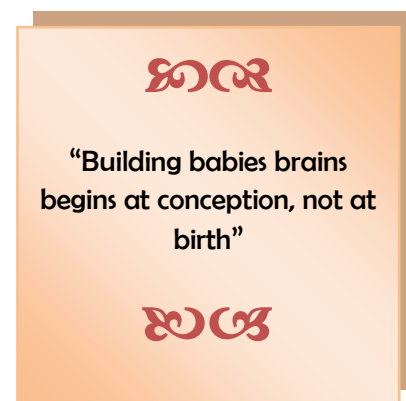
²⁹⁶ See also Walker et al. 2000.

²⁹⁷ Walker et al. 2000.

7.1. Risk Factors for Poor Cognitive Development

Physical well-being precedes cognitive skills. Poor maternal and early childhood health and nutrition (such as protein-energy malnutrition as well as iron-deficiency anaemia) can have long-lasting and irreversible consequences for children's cognitive development.²⁹⁸ Low birth weight, stunting (generally occurring before the age of 2 years) and micronutrient deficiencies are all associated with children's ill health.

Pre-natal development processes can already have an influence on children's educational prospects in later life. In other words, "Building babies brains begins at conception, not at birth".²⁹⁹ Restricted growth and neural pathway formation (interconnections that build the foetus' nervous system) during pregnancy can hinder children from reaching their full developmental potential in later development stages. Mothers' health and nutritional status are therefore the first determinants for children's intellectual well-being. However, birth asphyxia still causes around 1 million children a year to suffer from learning difficulties and other disabilities. Furthermore, around 38 million children a year are at risk of mental impairment due to maternal iodine deficiency.³⁰⁰ Maternal stress can influence children's development already before they are born, resulting not only in increased behavioural and emotional problems, but also in impaired cognitive and language development which significantly impairs children's later performance at school. Maternal stress and depression are major problems in developing countries, caused by general effects of poverty, difficult circumstances of life, lack of support networks as well as traumatic experiences. As a result, children are often deprived of parental assistance leading to substantial disadvantages in cognitive development processes.³⁰¹ Research from developed countries has shown that screening during pregnancy, counselling or cognitive behavioural therapy can help decreasing maternal stress. However, generally it is to say that sensitive postnatal care, including early attachment with caregivers, is crucial for a child's functional brain development.³⁰² In addition, there have also been studies suggesting that exclusive breastfeeding can improve children's motor development.³⁰³



²⁹⁸ See also Behrman 1996.

²⁹⁹ Thompson, R. A. & Nelson, C. A. 2001, 'Developmental Science and the Media: Early Brain Development', *American Psychologist*, vol. 50, no. 1, p. 8.

³⁰⁰ UNESCO 2010, pp. 45-46.

³⁰¹ Engle et al. 2007, p. 236.

³⁰² Sinclair 2007, p. 18.

³⁰³ Dewey, K., Cohen, R., Brown, K. & Rivera, L. 2001, 'Effects of exclusive breastfeeding for four versus six months on maternal nutritional status and infant motor development: results of two randomized trials in Honduras', *Journal of Nutrition*, vol. 131, pp. 262-297.

Inadequate health and nutrition can have severe negative effects on various areas in a child's ongoing cognitive and social development processes. Particularly within the first three years of life children develop a range of foundational skills, such as language learning, perceptual skills and memory competencies.³⁰⁴ Consequently, undernutrition and micronutrient deficiencies in early childhood can seriously harm a child's cognitive, language and motor competencies.³⁰⁵ Furthermore, a child's nutrition also influences his or her psychological and socio-emotional development. Research studies have shown that inadequate food quality and quantity can lead to low educational aspirations and lack of motivation.³⁰⁶ Other studies revealed that stunted children were also less likely to attend school, to enrol late and also to have higher drop-out rates than non-stunted children. Moreover, poor parents of stunted children may choose to only send healthier siblings to education facilities. Malnourished children attending school may however have difficulties in managing to walk longer distances to the facilities. Within the school setting these children may further experience psychological stress due to discrimination and social stigma.³⁰⁷ These problems could be avoided through ECCD programme interventions.

Tackling these issues is most likely to be effective using an integrated approach to ECCD programming that will have multidimensional effects on children's educational benefits as well as physical well-being. World Vision research and sources from the broader literature suggest several ways of combining and delivering goods and services. Recommendations include school feeding and monitoring interventions, salt iodisation and iron supplementation, de-worming, psychological stimulation, life skills education for children and adults on nutrition, health and hygiene as well as training caregivers and parents about child care and feeding practices.³⁰⁸ These interventions also reflect World Vision's social principles on ECCD. Implementation processes should start with looking at children's individual needs and further reach out to support parents that are unable to adequately care for their children as well as to raise awareness within the wider community. Bringing children from diverse groups together at an early age can also help avoiding the development of antisocial behaviour and lead to positive peer relationships with positive outcomes for children's mental health.³⁰⁹

Further readings on the interconnection between education and health and nutrition

Alderman, H. et al. 2006, 'Long term consequences of early childhood malnutrition', *Oxford Economic Papers*, vol. 58, no. 3, pp. 450-474.

Alderman, H. et al. 2009, 'Preschool nutrition and subsequent schooling attainment: longitudinal evidence from

³⁰⁴ UNESCO 2010, pp. 42-43; see also Hyde & Kabiru 2003, pp. 65-66. Stages of development - what children do and what children need.

³⁰⁵ UNESCO 2007, pp. 110-111.

³⁰⁶ GTZ 2009, pp. 8-10

³⁰⁷ UNESCO 2007, p. 111.

³⁰⁸ WV 2002, pp. 4-5/12/ 26; UNESCO 2007, p. 110; Engle et al. 2007, pp. 230-232; GTZ 2009, p. 10.

³⁰⁹ Note that an integrated ECCD approach should also incorporate World Vision's CWBOs on spiritual nurture, child protection and participation (WV 2002, p. 12).

Tanzania', *Economic Development and Cultural Change*, vol. 57, no. 2, pp. 239-260.

UNICEF 2009, *The State of the World's Children: Maternal and Newborn Health*.

Walker, S. P., Chang, S. M., Powell, C. A. & Grantham-McGregor, S. M. 2004, 'Psychosocial Intervention Improves the Development of Term Low-Birth-Weight Infants', *The Journal of Nutrition*, pp. 1417-1423.

Walker et al. 2005, 'Effects of Early Childhood Psychological Stimulation and Nutritional Supplementation on Cognition and Education in Growth-Stunted Jamaican Children: Prospective Cohort Study', *The Lancet*, vol. 266, no. 9499, pp. 1804-1807.

7.2. HIV & AIDS and Early Childhood Education

World Vision advocates for young children affected by HIV and AIDS to have access to ECCD programmes. Major issues preventing children and their parents from accessing ECCD services are often the inability of families and institutions to afford the necessary resources for programmes as well as the social stigma attached to the disease.³¹⁰ In other cases, HIV-positive children or AIDS orphans may be neglected and abused by fostering guardians. As a result, these children are often malnourished, suffer from health problems, may become traumatized or start behaving antisocially.³¹¹ Research from high-income countries has shown that HIV infections can have quite negative effects on children's cognitive development processes. Consequences can include lower IQ and academic achievement, weaker language skills in the late pre-school and early school-age years as well as poorer visual-motor functioning in older children. However, research has also shown that antiretroviral therapy can actually reduce or reverse these effects and further improve children's socio-emotional development with regard to adaptive behaviours, including daily life skills.³¹²

The bottom line is that young children affected by HIV and AIDS require special educational and psychosocial support. ECCD programmes can be very effective in helping those children to reach their full potential and be provided the same opportunities as other children. Integrated ECCD programme interventions should aim at providing services such as access to free basic education, school feeding programs, psychological, spiritual and material support for young children, ARV treatment for HIV positive parents (which enables them to live longer and more comfortably to continue caring for their children) as well as PMTCT services.³¹³

Further readings on HIV and AIDS in relation to ECCD

Gregson, S., Waddell, H. & Chandiwana, S. 2001, 'School education and HIV control in sub-Saharan Africa: from discord to harmony', *Journal of International Development*, Vol. 13, no. 4, pp. 467-485.

Vandermoortele, J. & Delamonica, E. 2000, The 'Education Vaccine' against HIV/AIDS, *Current Issues in Comparative Education*, vol. 3, no. 1, pp. 7-8.

³¹⁰ WV 2002, p. 13.

³¹¹ Hyde & Kabiru 2003, p.38.

³¹² UNESCO 2007, 110.

³¹³ Hyde & Kabiru 2003, p.38.

8. Social and Environmental Factors Influencing Children's Cognitive Development

Inadequate health care and nutrition are not the only detrimental factors to young children's poor cognitive development and intellectual well-being. In fact, social and environmental influences are key determinants in early childhood development processes. This is because young children are very much dependent on others, particularly within the first few years of their lives.³¹⁴ Thus, parents or caregivers have a responsibility to support children in a responsive and sensitive way, to provide motor and sensory as well as language stimulation.³¹⁵ Poverty and low levels of parental education, in connection with inadequate health and nutritional status, can have severe consequences on children's early development and intellectual well-being. We will therefore be looking at two specific influences on children's cognitive and non-cognitive skills: adult education and socio-economic status as well as early stimulation within the home environment.

8.1. Adult Education and Socio-economic Status

Children from disadvantaged families are most in need of early education. Longitudinal studies have shown that there is a strong association between wealth at birth and later educational and cognitive attainment at the age of five.³¹⁶ A child's successful transition to primary school is thereby greatly determined by his or her learning support received at home, which is often linked to a family's socioeconomic background.³¹⁷ A case study from Ecuador looked at the relationship between early cognitive development, child health, socio-economic status and parenting. Findings showed that wealth and higher levels of parental education were 'protective' of children's cognitive development.³¹⁸ Low levels of parental education and socio-economic deprivation, as well as belonging to a minority ethnic group and speaking a minority language, all influence a child's later educational achievements.³¹⁹ Disparities in young children's language skills are most often linked to household income and can be so severe that children will never be able to reach the same level as their peers in subsequent school years.³²⁰ Children develop their language competencies first and foremost through interactions with parents in their early years. Parents' verbal communication skills, vocabulary use and reading are thereby important determinants of a child's later school

³¹⁴ Walker et al. (2007) have identified four high prevalence risk factors (affecting at least 20-25 percent of children) for child development in developing countries. Three of those (stunting, iodine deficiency and iron deficiency anaemia) are directly related to nutritional deficits. The fourth one, inadequate cognitive stimulation, is associated with psychosocial risks deriving from aspects of parenting.

³¹⁵ Hyde & Kabiru 2003, p. 65.

³¹⁶ Grantham-McGregor et al. 2007, p. 64.

³¹⁷ GTZ 2009 p. 12.

³¹⁸ Paxson & Schady 2005, p. 15.

³¹⁹ UNESCO 2007...

³²⁰ UNESCO 2010, p. 49.

performance.³²¹ Indeed, caretakers' verbal IQ (in addition to education and level of stimulation) in the home can have significant effects on children's IQ and cognition.³²²

8.2. Education for Women and Girls

There is a particular strong interconnection between women's education and children's cognitive development and well-being. In fact, women's empowerment through education is a very critical issue regarding children's physical as well as intellectual well-being. Worldwide, about two thirds (64 percent) of all illiterate adults are women (almost 500 million).³²³ Women are most often the primary caregivers responsible for children's upbringing. Women who participate in literacy programmes obtain better knowledge about early childhood health. They are therefore more likely to adopt preventive health practices (including immunization) and to seek medical care services for themselves and their children. ³²⁴ In terms of reproductive knowledge and behaviour, research also suggests that women with higher educational levels are much more likely to practice birth spacing as well as to have a skilled birth attendant present during delivery.³²⁵

One case study from Indonesia and Bangladesh found a correlation between mother's educational level and child stunting which, as we have seen, can have a dramatic impact on children's later cognitive achievements.³²⁶ Furthermore, in South/West Asia and Sub-Saharan Africa, the probability of an uneducated mother to give birth to a child without antenatal care is about 50 percent less likely than of a mother who received primary education. Mothers who went to secondary school are even about five to seven times more likely to seek a skilled birth attendant for assistance than an uneducated mother.³²⁷ Generally, infants and young children of less-educated women are more likely to experience health and nutrition problems, be exposed to poor sanitation and to not receive sufficient cognitive stimulation than off spring of more-educated women.³²⁸ Studies from 32 countries have also shown that about 50 percent of all illiterate women do not know the basic facts about HIV and AIDS. In comparison to illiterate women, literate women are three times more likely to know that a healthy-looking person can have HIV and they are also four times more likely to know the

³²¹ Nordtveit 2008, p. 415.

³²² Walker et al. 2000, p. 37.

³²³ UNESCO 2006, *Literacy for Life: 2006 Education for All (EFA) Global Monitoring Report*, p. 30

³²⁴ *Ibid.*, p. 22.

³²⁵ *Ibid.*, p. 47.

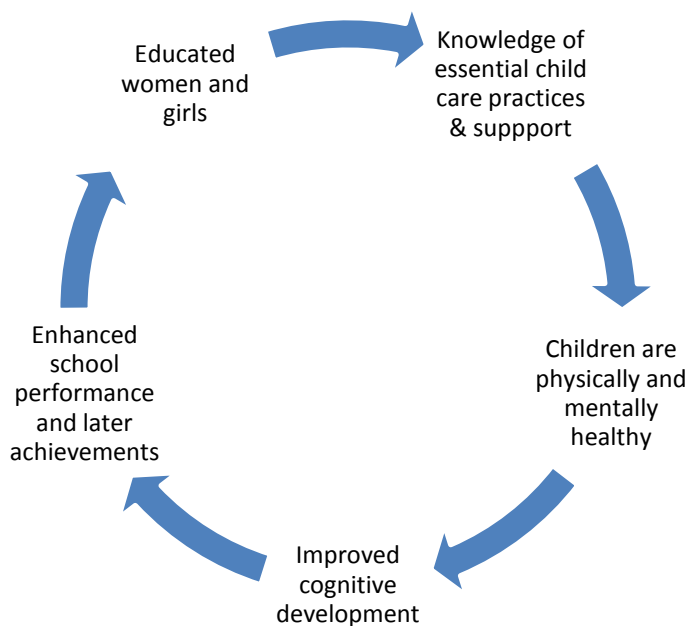
³²⁶ Semba, R. D. Et al. 2008, 'Effect of parental formal education on child stunting in Indonesia and Bangladesh: a cross-sectional study', vol. 371, pp. 322-328. Household surveys showed that children from a mother who had completed primary education had a 22 percent and 26 percent reduced risk of stunting in Bangladesh and in Indonesia respectively; See also Walker et al. (2000). The authors showed in their research that caretakers of non-stunted children had higher educational levels than of those growth-restricted children.

³²⁷ UNESCO 2010, p. 47 [own interpretation based on diagram]

³²⁸ Walker et al. 2007. See also p. 151 on causal studies on the effects of cognitive stimulation interventions.

main ways to avoid an HIV transmission.³²⁹ With regard to children's education, research has shown that educated parents (especially mothers) are more likely to send their children to school and to support them with their studies.³³⁰ In particular, literate mothers with high expectations and great interest in their children's schooling positively affect children's early development, educational achievements, fine motor skills and language competencies.³³¹ The interconnections between all of these factors are illustrated in figure 1.

Figure 1: The positive cycle of women's education



In particular for young girls, long school attendance reduces the possibility of having children at an inexperienced early age (early marriage and sexual activity), in addition to higher risks of HIV infection and transmission to the child.³³² Generally, the younger a woman is at the time of birth, the greater are the health risks for mother and child. Adolescent girls between 15 and 19 years of age account for one in seven maternal deaths related to pregnancy and childbirth. Research also shows that a child who is born to a

mother under 18 years of age has a 60 percent higher risk of dying; those children who survive often suffer from low birth weight, undernutrition and delayed cognitive development.³³³ Over and above this, the increased chances of an educated mother to earn money can lead to reduced financial problems and as a result to less maternal stress, which also has a positive effect on children's development.³³⁴

Nordtveit (2008) uses an integrated approach to poverty and literacy education, suggests three programme types that may be useful to consider when planning ECCD projects integrated with adult education:³³⁵

³²⁹ Vandermoortele, J. & Delamonica, E. 2000, The 'Education Vaccine' against HIV/AIDS, *Current Issues in Comparative Education*, vol. 3, no. 1, pp. 7-8.

³³⁰ UNESCO 2010, p. 47.

³³¹ GTZ 2009, p. 8.; Venetsanou & Kambas 2010, p. 322

³³² Gregson, S. et al. 2001, 'School education and HIV control in sub-Saharan Africa: from discord to harmony', *Journal of International Development*, Vol. 13, no. 4, p. 473.

³³³ UNESCO 2010, p. 47.

³³⁴ Venetsanou & Kambas 2010, p. 322.

³³⁵ Nordtveit 2008, pp. 413-417; See also UNESCO 2006.

- 1) *Non-formal literacy education and adult basic education* is a literacy-informed initiative aiming predominantly at non-literacy outcomes such as better health, rural development, self employment and women's empowerment.
- 2) *ECD programmes* are targeted towards children's basic needs (including nutrition, protection, health care, stimulation, affection and learning) are crucial determinants for their physical, cognitive, and mental development. *Parenting education* is aimed at adults learning to understand those needs and to respond appropriately. *Family literacy* promotes an educative interaction between parents and pre-school children. Family literacy programmes are aimed to promote two particular types of skills: emergent literacy and school readiness. The former are skills, knowledge and attitudes foundational for reading and writing processes. School readiness defines whether or not a child is able to fulfill the school's performance expectations.
- 3) *Health and nutrition programmes addressing safe motherhoods and early childhood* aims at partly decentralizing some services (such as counseling, information, detection, prevention, immunization, and nutrition-related work) to CHWs attached to ECD and literacy training. In particular, adolescent girls could greatly benefit from programmes addressing family planning, HIV and AIDS awareness and management as well as prenatal and postnatal care. short-term services (Basic health care and food provision for immediate problems), medium-term needs (nutrition supplements, income-generating activities, and literacy education) and long-term education strategies (training and learning respond to the underlying knowledge needs that affect behaviour and attitude changes, such as gender equality)

8.1. Early Stimulation and the Home Environment

GTZ (2009) argues that the home environment rather than socioeconomic status has the most effect on children's achievements.³³⁶ In fact, a poor home environment significantly contributes to children's poor developmental levels and school performance.³³⁷ "Inadequate emotional support and intellectual stimulation within the home environment may account for up to half of the deficiencies in mathematics, reading, and verbal skills among children who live in poverty."³³⁸ This is because only a stimulating physical environment can adequately provide for children's psycho-social needs and mental well being, which is as important as their physical health.³³⁹ Receiving a combination of both

³³⁶ GTZ 2009, p. 12

³³⁷ Walker et al. 2000.

³³⁸ GTZ 2009, p. 8.

³³⁹ Hurenkamp 1998, p. 10.

nutritional support as well as psychosocial stimulation is most likely to have more effective longer-term benefits on cognition in stunted children.³⁴⁰

A child's caregivers have a powerful influence on his or her psychological development in early life.³⁴¹ "Stimulation occurs through responsive and increasingly complex developmentally appropriate interactions (matched to the child's emerging abilities) between caregivers and children that enhance child development."³⁴² Increased cognitive stimulation or learning opportunities for young children will result in increased and long-lasting cognitive and social-emotional competencies. In particular, the quality of maternal care has a significant influence on children's long-term development with regard to stress reactivity, anxiety and memory function.³⁴³ Psychosocial stimulation and emotional support are crucial determinants for children's knowledge acquisition and thought processes. This relates back to our definition of early childhood development as a *social process* (see Part I, p. x). That is, young children's cognitive skills develop first and foremost in interaction with their significant others at the household level.³⁴⁴ Cognitive achievement is thus very much influenced by social dynamics on multiple levels, including the child's family and the community as a whole.³⁴⁵ "The techniques employed by caregivers to cultivate children's development differ across cultures, classes, gender and other dividing lines. Meanwhile, parental beliefs, attitudes and practices are very much influenced by social norms."³⁴⁶

Depending on individual contexts the roles of primary caregivers differ. These roles may be culturally determined, but they can also be the result of a lack of time, sickness or death of a family's key providers. For example, children may have to take care of their younger siblings while the parents are working outside the home, AIDS orphans are brought up by close relatives or foster families and in some cases all members of a community are equally responsible for looking after any young child freely walking around. The family size itself also plays a role, especially because many developing countries have high fertility rates.³⁴⁷ On the one hand, this could mean that each individual child is given less attention by their parents. On the other hand, older children may actually have a significant role in taking care of their younger siblings, in encouraging them and in serving as a role model for

³⁴⁰ Walker, S. P., Grantham-McGregor, S. M., Powell, C. A. & Chang, S. M. 2000, 'Effects of growth restriction in early childhood on growth, IQ, and cognition at age 11 and 12 years and the benefits of nutritional supplementation and psychological stimulation', *Journal of Pediatrics*, vol. 137, no. 1, pp. 36-41.

³⁴¹ GTZ 2009, p. 8.

³⁴² Engle et al. 2007, p. 230

³⁴³ Grantham-McGregor et al. 2007, p. 61.

³⁴⁴ UNESCO 2007, p. 155.

³⁴⁵ Behrman, T. R. 1996, 'The Impact of Health and Nutrition on Education', *The World Bank Research Observer*, vol. 11, no. 1, pp. 23-37.

³⁴⁶ GTZ 2009, p. 8.

³⁴⁷ UNICEF 2007, Maternal and Newborn Health, pp. 6/141. High fertility rates are particularly high in West and Central Africa with a total fertility rate of 5.5 children in 2007. The total fertility rate is the number of children a woman will bear on average during her life course

developing motor skills. In sum, the society and cultural context in which a child lives shapes his or her skills and competencies. In particular, a permissive, accepting family environment can have a very positive influence on children's intellectual and motor development.³⁴⁸ Walker et al. (2007) identified some of the predominant psychosocial risk factors for impaired cognitive development in children under five. They distinguish between parenting factors (i.e. cognitive stimulation or child learning opportunities, caregiver sensitivity and responsiveness) and contextual risk factors (i.e. maternal depression and exposure to violence).³⁴⁹ Early childhood is the time when children start learning through exploration and experimenting. During this process the relationship that children develop between themselves and their family and community is crucial.³⁵⁰ The negative outcomes of social neglect which includes failed secure infant attachments can result in children developing no empathy, no respect of rules as well as an inclination to disruptive and violent behaviour.³⁵¹ Research suggests that only 10-41 percent of parents in developing countries provide cognitively stimulating materials to their child and only 11-33 percent of parents actively involve their children in cognitively stimulating activities.³⁵² Generally, parental income and education have a major impact on child-rearing practices. This means that educated parents are by and large more stimulating and less punitive. The acceptance of using physical punishment differs depending on the cultural context. However, harsh physical discipline is generally regarded to have negative outcomes for small children.³⁵³

³⁴⁸ Venetsanou & Kambas 2010, p. 322

³⁴⁹ Walker et al. 2007.

³⁵⁰ UNESCO 2007, p. 14; see also Hyde & Kabiru 2003, pp. 65-66.

³⁵¹ Sinclair 2007, p. 25.

³⁵² Walker et al. 2007, p. 153, table 3.

³⁵³ UNESCO 2007, pp. 154-155.

Table 5: Factors Influencing Children’s Cognitive Development

	Observable/measurable factors	underlying factors
Individual level	Health and nutritional well-being Pre-school enrolment Age and gender	Innate ability Motivation Genetic endowment Capacity to concentrate
Family level	Parental education Parental income / occupation / socio-economic status	Household intellectual atmosphere / stimulation in the home Reading and play materials Parental time devoted to cognitive development of child / child-adult interaction Amount of food given to the child Presence or absence of siblings Extended family / informal support systems Standard of housing
Community level	Population size / density Pupil-teacher ratio Public health programmes	General intellectual atmosphere Effectiveness of pre-school management / integration of parents/children into curriculum design Water quality / safety and cleanliness of environment Conflicting vs. peaceful environment

Source: [adapted from Behrman 1996 + other literature => add information - see also SEARCH 40 Assets]

Question

- ◆ In order to achieve the greatest impact, WV staff needs to work in collaboration with children’s primary caregivers as well as those in power of decision making regarding child rearing practices. → Who is responsible for the upbringing of infants and young children (e.g. mothers, grandparents, older siblings, extended family / kinship clan, the whole community etc.)? Do caregivers’ attitudes, behaviours and childrearing practices encourage or impede children’s cognitive development (context-specific)?

- How can WV programming strengthen the capacities of caregivers without interfering in traditional cultural structures?
- How can parents/caregivers best support an infant or young child? E.g. through play, reading books to children, telling stories, singing songs etc.
- How should WV approach supporting child-headed households? I.e. in what ways should WV staff intervene so that all children benefit (i.e. cares and infants)
- ◆ “Each context places specific demands on the motor competencies and physical activities of infants and children.³⁵⁴ And, “there is no universal model of early childhood provision that can be followed globally.”³⁵⁵
- No standardised frameworks...?

Further readings

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9. Case Studies

9.1. Growing Strong Project: Models for Early Childhood Care and Development (WV Vietnam & Australia)

- Start 2002; 3 year project
- A Luoi District of Thua Thien Hue Province
- Goal: develop and improve the quality of, and access to, Early Childhood Care and Development (ECCD) for poor Vietnamese families
- Outcome: By the upgrading of infrastructure and teaching materials for kindergartens, the project radically changed the hours of operation of kindergartens from half-day long to all-day long, enabling many parents to go out and earn their living. => Thus, the provision of ECCD services has allowed parents to pursue various income-generating opportunities [a matter repeatedly appearing in the literature; esp. regarding women working in fields]
- Outcome: positive changes in children’s social behaviour and attitudes; generally children felt happier
- Home-based childcare networks

³⁵⁴ Venetsanou & Kambas 2010, p. 322.

³⁵⁵ UNESCO 2007, pp. 154-155

9.2. Assin Kindergarten Project (WV Ghana & Germany)

- Start March 2008 - completion October 2008
- Construction of the three Kindergartens three communities: Homaho, Wurakese and Armah Camp
- Sponsored by PM International through World Vision Germany
- Goal: to increase enrolment rate in kindergartens as well as to promote pre-school education as a pre-requisite for basic education
- Outcome: parents are prepared to send every child at school going age to enjoy the projects, the buildings are now good structures, children are protected from the rain, the teachers are available and can encouraged to teach the children, the KG enrolment increased, the parents are encouraged to send their children to the KG, people from the nearby communities are visiting the KGs regularly to see the structure people are always talking about
- A very conducive and an enabling environment for learning provided for their children. The parents are now assured of security of their children in school.
- Lessons learnt: in all the communities where projects were organized, the prevailing need was to have the nursery schools (kindergarten) attached to all the schools.
- Challenge: there is the need for more animation to make the community more proactive in support of community projects.
- The number of children per KG were 160 (480 children overall) aged between 4-7 years
- KG schedule is from 9.00 am-12.00 noon from Monday to Friday
- Children bring their own lunch from home
- Numeracy, writing, singing, dancing, rhymes, poems alphabets, counting, drama plays
- Toys help carrying out the syllabus on sorting, counting, numerals and numbers, groupings and colours
- Sustainability: children are the future; no primary school without pre-school facilities to train the children under 5 years
- Cross-cutting themes: environment, children with disabilities, peace building, gender
- Justification: future protection for the child's academic life
 - Children will enjoy a very conducive and enabling environment which fosters effective teaching and learning.
 - Children will enjoy a full academic calendar, because the children vacate prematurely in the raining season, since classes are held under trees and dilapidated structures.
 - Domestic accidents will relatively reduce since every child will be in school under a special care of teachers.
 - With the necessary and needed facilities the interest of the children will be sustain in the school to check truancy and drop-out from school.

- This will go a long way to improve examination results since children will get good foundation from the beginning.

Difference between pre-school and kindergarten in Ghana

In Ghana pre-School is made up of the crèche (toddlers), nursery (younger children age 2-3 years) and the Kindergarten for children between age 4-5 years. The crèche only exist in the cities. In towns pre-school is made up of nursery and KG .However in the rural settings like our CIP communities Pre-School is the kindergarten, where the children age 4 are in KG I and Children 5 years are in KG

9.3. Early Childhood Development (ECD) centres (WV Nepal)

- Managed by community committees and staffed by trained childcare facilitators and assistants
- Pre-school programmes involving mothers and children under five
- Linked with health care support and nutrition programmes
- Improving children's physical and mental development
- Teaching children to sing and dance, work and play in groups
- "At this age, for children to recognise alphabets and play is more than enough" [need to explain benefits of these abilities - Question: Why is early childhood 'education' important, i.e. is basic/primary school education not enough for children's what are the specific benefits of pre-schooling regarding later development processes? => e.g. learning the alphabets from wooden cubes enable children to learn better and faster at primary school]
- Children learn rhymes containing messages on good children's health and hygiene (children learn about hygienic behaviours - e.g. regular hand washing - through singing)
- Children become more disciplined
- Children have opportunities to play with other children with toys that they might not have at home
- With children at day-care centres for a few hours every day women's double burden, i.e. mothers can work on their farms without having to care for their little children at the same time + day-care provide a safe environment

10. Recommendations for Action

1) Recommendations for policy makers

- ◆ Bring early childhood education into the political discourse!
- ◆ Invest in early childhood teacher/caregiver training and formal educational institutions.
- ◆ Promote equal opportunities to access ECCD programmes; if projects only reach the more advantaged groups, the inequality gap between poor and better-off people widens.

2) Recommendations for ADP staff

- ◆ Be aware that early childhood education does not necessarily mean 'formal pre-schooling'. Instead, education for U5s is very much linked to general child care practices to foster broader development processes.
- ◆ Promote children's early stimulation - i.e. psychosocial support through primary caregivers - on the household level and in institutions to improve their later cognitive development.
- ◆ Work closely together with parents to promote children's early stimulation within the family; there is more research needed for mechanisms to support parents in this matter.
- ◆ Consider the quality of the home environment, educational status and support of parents/caregivers when planning early childhood education programmes.
- ◆ Adapt your programme design to the particular socio-cultural context of a community's setting:
 - 4) Consider different ideas and practices regarding early childhood education
 - 5) Use an integrated approach to early childhood care and development (ECCD) that responds to the needs of the individual child while involving families and the wider community in programme implementation
 - 6) Combine early childhood development programmes with health services and nutritional schemes
- ◆ Be aware of context-specific social issues and aim to reach the most disadvantaged children (e.g. orphans, girls, children affected by HIV and AIDS, ethnic minorities, non-registered children, children deprived of parental care, children living in remote rural areas etc.).

- ◆ Address gender stereotypes through acknowledgement and inclusion of female roles in early childhood education. In addition, promote active involvement of men into programmes, safe transport for children to centre-based institutions, training of female teachers and so forth.
- ◆ Bring together children from diverse backgrounds in order for them to learn mutual acceptance and to avoid later discrimination and social exclusion.
- ◆ Consider issues of verbal communication in educational settings (i.e. inclusion of official and/or minority languages).
- ◆ Consider issues of curriculum design:
 - 5) Acknowledge and integrate a society's context-specific norms and values
 - 6) Focus on early foundational and essential life skills development that supports children's sensory awareness, physical coordination, the learning of certain social competencies (e.g. taking on responsibilities) and interpersonal skills
 - 7) Find more research on defining early literacy and numeracy skills and determine whether they are constructive for U5s development; consider how those may be implemented in diverse social settings
 - 8) Ask: Are current CWBO 2 indicators applicable to *early* childhood education? And, how can we adapt present indicators to make them age-appropriate for U5s?
- ◆ Do more research on other themes, including education in emergency situations, children with disabilities and early childhood education staff training.

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Chapter 3: Child Well-being Outcome (3) - "Children Love God and Their Neighbours"

Third Pillar: Spiritual Nurture in Early Childhood

I. The Need for Holistic Development and Spiritual Maturity

Spirituality in early childhood is not an abstract concept. A child grows in spirit not in isolation from others, but always through human interactions within his or her community. In this chapter we will be discussing why spiritual nurture is essential for children's positive development within the different dimensions of everyday life. Spiritual development is relevant to any child, in any context and independent of a family's socio-cultural and religious background. Essential to this process is building strong relationships and learning to be responsible for oneself, other people and the environment. Spiritual nurture is not an optional 'add-on' to other well-being outcomes or general development processes. Instead, 'spiritual wellbeing' is essential for children's experience of a life in all its fullness and it is thereby closely interlinked with all other of WV's CWBOs. The aim of this chapter is to clarify the concepts of 'spiritual development' and 'spiritual nurture' in early childhood, to show what research has already been established by World Vision and to identify ways in which WV programming design and methodologies may be improved.

2. Scientific Background

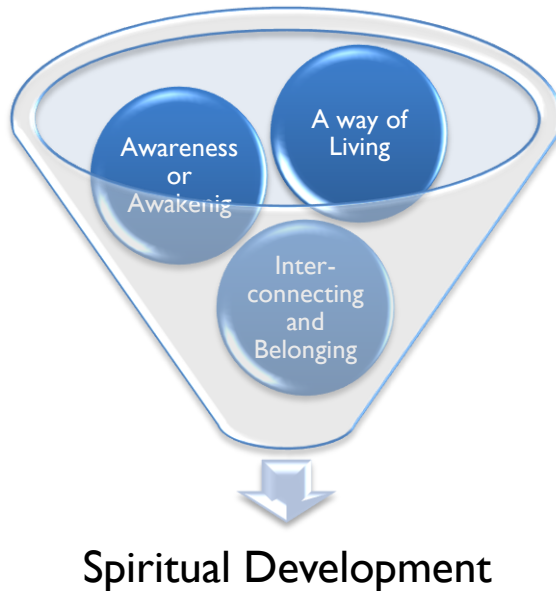
The terms *spirituality* and *spiritual development* have been perceived and defined in various ways by different scholars. Moreover, there seems to be a - more or less clear - distinction between *spirituality* and *religion* which needs to be considered. In particular, spirituality may be associated with a person's subjective experiences involving "personal transcendence, supra consciousness sensitivity and meaningfulness".³⁵⁶ Religion, on the other hand, is often associated with "[formal structures], religious institutions and prescribed theology and rituals".³⁵⁷

³⁵⁶ Zinnbauer et al. 1997, p. 551.

³⁵⁷ Ibid.

The Center for Spiritual Development in Childhood and Adolescents at the SEARCH Institute³⁵⁸ defines 'spiritual development' as follows: "Spiritual development is, in part, a constant, ongoing, dynamic, and sometimes difficult interplay between three core developmental processes (which are emphasized differently in different cultures and traditions)". The three processes are described below.

Figure 1: Basic concept of spiritual development formation



Awareness or awakening -

Being or becoming aware of or awakening to one's self, others, and the universe (which may be understood as including the sacred or divine) in ways that cultivate identity, meaning, and purpose.

Interconnecting and belonging

- Seeking, accepting, or experiencing significance in relationships to and interdependence with others, the

world, or one's sense of the transcendent (often including an understanding of God or a higher power); and linking to narratives, beliefs, and traditions that give meaning to human experience across time.

A way of living - Authentically expressing one's identity, passions, values, and creativity through relationships, activities, and/or practices that shape bonds with oneself, family, community, humanity, the world, and/or that which one believes to be transcendent or sacred.³⁵⁹

However, Eugene C. Roehlkepartain³⁶⁰ (2008) explains in his paper 'Seeking Common Ground in Understanding Spiritual Development: A Preliminary Theoretical Framework', that these three dimensions are not in themselves complete.³⁶¹ They are embedded in and interact with:

³⁵⁸ The SEARCH Institute is a non-profit non-sectarian research organisation with a history of collaboration with different church denominations and traditions.

³⁵⁹ SEARCH 2008, *What is Spiritual Development?*, Search Institute, viewed 18 December 2009, <http://www.search-institute.org/system/files/What+Is+Spirit+Dev.pdf>

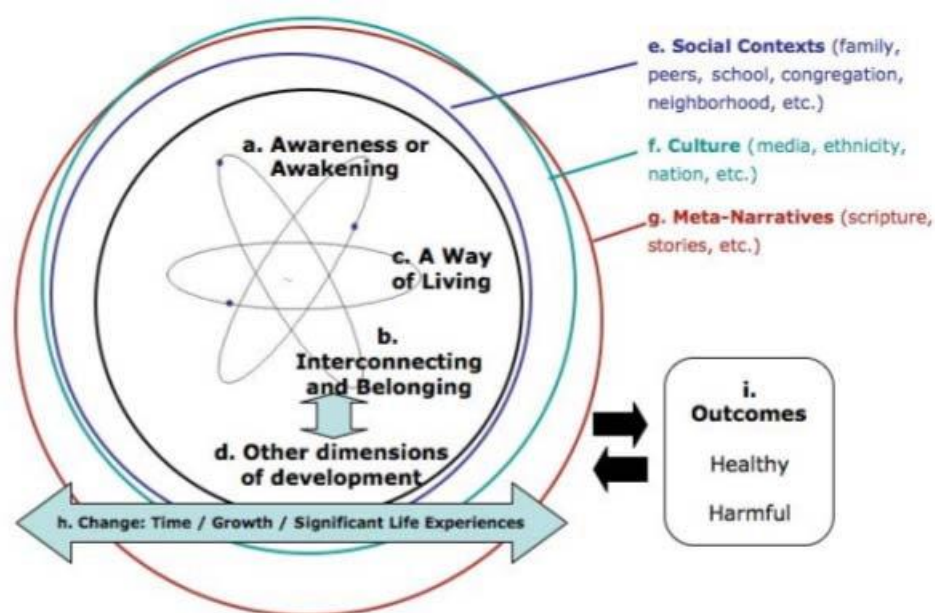
³⁶⁰ "Eugene C. Roehlkepartain is widely recognized as an expert in youth development in community contexts, with a particular specialty in the role of religious institutions and spiritual development in young people's healthy development. He has also worked extensively on the role of parents and families in positive development. The core of his work as co-director at Search Institute's Center for Spiritual Development in

- 1) Other aspects of development (physical, social, cognitive, emotional, moral, etc.)
- 2) Personal, family, and community beliefs, values, and practices
- 3) Culture (language, customs, norms, symbols) and socio-political realities
- 4) Meta-narratives, traditions, myths, and interpretive frameworks
- 5) Other significant life events, experiences, and changes

These processes may result in...

- 6) Cognitive, affective, physical, and social outcomes that become manifested in either healthy or unhealthy ways.

Figure 2: Holistic framework for spiritual development



Source: Roehlkepartain, E. C. 2008, *Seeking Common Ground in Understanding Spiritual Development: A Preliminary Theoretical Framework*, Progress Report, Search Institute, Minneapolis, USA, viewed 18 December 2009, <http://www.spiritualdevelopmentcenter.org/DefinitionUpdate>.

3. World Vision Background

World Vision has developed a recommended 'Policy on the Spiritual Nurture of Children' which sets principles to inform World Vision's involvement in spiritual nurture of children. These principles aim towards contributing to children's wellbeing through WV's commitment to support children's spiritual development within any given context. The policy is based on approved partnership policies including key documents such as the Policy on Witness to Jesus Christ, the Policy on Children's

Childhood and Adolescence involves a series of studies that will advance the theory, definition, and scientific foundations of spiritual development."

³⁶¹ Roehlkepartain, E. C. 2008, *Seeking Common Ground in Understanding Spiritual Development: A Preliminary Theoretical Framework*, Progress Report, Search Institute, Minneapolis, USA.

Well-Being, the Policy on Interfaith Relationships and the Child Protection Policy. Its principles are informed by previous and current research as well as a broad literature on spiritual development of children and faith formation. World Vision partners that were involved in the process of policy formation included staff from ADPs, National Offices (NOs), Support Offices (SOs), Christians Commitments (CCs) and Children in Ministry (CIM).³⁶²

World Vision's commitment to the spiritual wellbeing of children also draws close lines to the UN Convention on the Rights of the Child (CRC), (see box below).³⁶³

Article 14

States Parties shall respect the right of the child to freedom of thought, conscience and religion.

States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.

Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

Article 30

In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

In accordance with the UN CRC and Universal Declaration of Human Rights (UDHR)³⁶⁴, World Vision supports the affirmation of children's religious freedom. In relation to WV's Christian foundation and

³⁶² Cadaing et al. 2010, *Toward a Policy to Guide WV Contributions to the Spiritual Nurture of Children: Background Note on Spiritual Nurture of Children Policy*, World Vision; WV 2010, *Executive Summary: Issues and Partnership Process Policy on the Spiritual Nurture of Children*.

³⁶³ UN 1989, *UN Convention on the Rights of the Child*.

³⁶⁴ UN 1948, *Universal Declaration of Human Rights (UDHR)*, viewed 19 December 2009, <http://www.un.org/en/documents/udhr/index.shtml#a18>. Article 18 states that: "Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance."

ambition to support the positive development of children's wellbeing and it is important to clearly state WV's position to spiritual nurture:

*"We [World Vision] respond to God's profound love for children through our relationships and actions, with the desire that children experience fullness of life in any context. Spiritual nurturing is expressed in ways that encourage love for God and others, empower children and build resilience and hope. World Vision's role in children's spiritual nurture is primarily supportive and facilitative, expressed through partnerships as well as through the character and witness to Jesus Christ of our staff, partners and volunteers. World Vision does not proselytize, nor does it use its resources to promote other religions or provide spiritual nurture in other faiths."*³⁶⁵

In this context, World Vision operates on a very personal level and in direct collaboration with the programmes' beneficiaries (children, families and communities). Furthermore, WV is committed to serve *all* children (including the very young) regardless of their religion, race, ethnicity or gender. Our discussion requires that we first look at the concepts of spirituality and Christian faith formation with regard to early childhood development and child wellbeing.

3.1. Defining Spiritual Development³⁶⁶

World Vision's third CWBO has been defined as: "children love God and their neighbours".³⁶⁷ Assumingly, this outcome may be understood and interpreted in different ways depending on people's personal experiences and socio-cultural backgrounds. A child-focused approach requires gaining an understanding of how the notion of 'experiencing God' may be understood differently depending on children's own perspectives. In particular, we need to develop frameworks based on an understanding of how children develop a sense of self, relate to others and experience their immediate environments. Considering WV's multicultural realm of practice, we may use the term *spirituality* and related concepts to refer to children's perceptions and experiences of the 'inner self' and the 'self in context' (i.e. the family and community setting) as well as perceptions of things transcending the material world.

³⁶⁵ WV 2010a, *Toward a Policy to Guide WV Contributions to the Spiritual Nurture of Children*, p. 2.

³⁶⁶ WV n.d., *Partnership Policy Spiritual Nurture of Children - Draft 12.2*.

³⁶⁷ WV 2009a, *Compendium of Indicators - version 1.6: Girls and boys love God and their neighbours*, table 3, pp. 1-3.

World Vision defines *spiritual development* as:

“An inward and outward journey of discovery for children as they grow in awareness of a sense of meaning and purpose in life; connect, empathize with and are influenced by others, especially parents and peers; begin to explore their understanding of God, and live out their spiritual beliefs and commitments in daily life.”

Spiritual nurture is defined as:

“Spiritual nurture is the fostering of children’s spiritual development throughout their life cycle stages [starting from basic life skills, leading to moral, social, intellectual and spiritual maturity³⁶⁸].”

3.2. CWBO Indicators: Children’s Social and Spiritual Well-being

Spirituality means different things to different people. World Vision’s CWBO indicators therefore need to be contextualised, that is culturally appropriated depending on the individual context. The essential element however relates to WV’s integrated community-based approach and focuses on the interrelationships between a child, his or her family as well as the people outside the home setting.

3.2.1. *Children’s Awareness and Experience of God’s Love*

- Spiritual beliefs and practices (e.g. prayer and meditation)
- Strength-building and feeling of security through religion
- Children’s involvement in religious services
- Conflict resolution (reconciliation) and forgiveness
- Children’s subjective experience of God’s love

3.2.2. *Children’s Positive Relationships with Peers, Family and Community Members*

- Emotional support from parents or caregivers (e.g. affection and time to play)
- Children within their family and community group (e.g. different ways of treatment and support)
- Children among their peers (e.g. acceptance and judgement of others and oneself)
- Children’s opinions on boys’ and girls’ rights

³⁶⁸ WV 2009b, *Spiritual Nurture Policy - Draft 8.0*.

3.2.3. *Children's Value and Care for the Environment*

- Involvement in community environmental improvements
- Involvement in taking care of vulnerable members of their community
- Treating others with dignity and respect
- Speaking out or advocating for others and for oneself

3.2.4. *Children's Hopes and Visions for the Future*

- Dreams of what to become as an adult
- Strengths and talents
- Determination and self-belief
- Attitudes towards work (working hard in order to accomplish ones goals)
- Positive sense of oneself
- Hopes for the future
- Adult role models

It follows from these development indicators that the CWBO definition 'children love God and their neighbours' needs to be understood within a broader set of different dimensions. In other words, we have to be aware that "the culturing of spiritual development is more than the fostering of particular religious beliefs".³⁶⁹ It may actually be useful to think of some of these indicators as a certain set of 'assets' that children acquire through their interrelationships with other people.³⁷⁰ These assets already start developing during early childhood and comprise both fundamental principles of WV's Christian Commitment as well as universal values of social life in general.

The point is that spirituality is not equivalent with being religious. Although the CWBO indicators refer to children's beliefs and religion, they do not provide a fixed framework on how these should be practiced. Rather, what is important is that children's personal beliefs give them strength in their development processes and makes them feel safe and secure. Moreover, the ways in which children experience God's love is to be defined subjectively by the individual child him or herself. The socio-cultural and emotional components of these indicators refer to how children feel, relate to others, are treated and cared for, participate in community life, perceive themselves and how they view their future. Encouraging children's hopes for the future may also be described in a way that "a child finds the world interesting and enjoyable, and feels that he or she has a positive place in it."³⁷¹

³⁶⁹ Johnson & Boyatzis 2005, p. 218.

³⁷⁰ Cf. SEARCH 2005, 40 *Developmental Assets for Early Childhood (ages 3 to 5)*, Search Institute, Minneapolis, USA, viewed 25 February 2010, <http://www.search-institute.org/system/files/40AssetsEC.pdf>

³⁷¹ Ibid.

Furthermore, intrinsic Christian values are also transferrable to more universal morals, such as a sense of equality, social justice and ethical sensibility which children are able to understand and express already at an early age (e.g. the ability to distinguish between truth and lies as well as right and wrong behaviours). In this context, family and community support are vital for young children to develop positive values and social competencies which basically relates to their attitude towards others and their environment. Regarding children as resources for the common good implies that these child well-being outcomes are also positively transmitted to the community as a whole. In particular, children's caring behaviour and deeds, responsible actions as well as their personal testimonies will benefit all those people with whom they interact. However, these qualities precede the need to learn from adult role models. Teaching children self-control, social skills, engagement in learning and healthy lifestyles will subsequently lead to individuals empowered to accomplish their personal goals.³⁷²

Generally, developing *spiritual maturity* (even though this might be subjectively defined) can be understood as comprising both the ambition for children to develop a positive view of themselves as well as their interest in and care for their fellow human beings. In addition, it also becomes obvious how children's spiritual well-being is connected to all other child well-being outcomes (i.e. living a healthy lifestyle, early stimulation, care, protection and participation).³⁷³ In some ways we may even argue that spiritual well-being in early childhood is the base upon which many other development assets are built. On the other hand, other CWBOs are also essential for spiritual care and nurturing processes, in particular in relation to young children's psychosocial development. For example, considering child health indicators, GTZ (2009) states that: "the perspective children have on life, their aspirations for the future, and their own sense of wellbeing are strongly associated with nutrition. Psychosocial indicators of self-esteem, agency and a sense of respect are negatively associated with stunting in all the four countries studied, that is, after controlling for the effects of household material circumstances. Hungry children often feel shame."³⁷⁴ Overall, one major outcome of affirmative spiritual nurture is children's confidence and contentment with their 'inner selves'. This core asset has a potentially strong impact on children's positive attitudes and actions in the long term (see Table I below).

³⁷² WV 2009a; SEARCH 2005.

³⁷³ Ibid.

³⁷⁴ GTZ 2009, p. 10.

Table 1: Components of Children's Positive Identity³⁷⁵

Personal power	The child can make choices that give a sense of having some influence over things that happen in her or his life.
Self-esteem	The child likes her- or himself and has a growing sense of being valued by others.
Sense of purpose	The child anticipates new opportunities, experiences, and milestones in growing up.
Positive view of personal future	The child finds the world interesting and enjoyable, and feels that he or she has a positive place in it.

It is important to mention that there is some debate going on regarding the wording of the third pillar. Kurt Bangert, Director Research at the World Vision Institute, argues that while WV's CWBOs 1, 2 and 4 are services provided to children, CWBO 3 ('Children Love God and Their Neighbours') appears to be something that children are expected to render themselves. Bangert suggests that instead of using the current wording for WV's CWBO 3, we may consider to rephrase the outcome as 'Children Experience God's Love and Wholesome Relations'. This is because 'experiencing' God's love and care from others is a prerequisite for children to love God and other people. In this context, 'care' may also be better included under the third pillar rather than the fourth.

Questions

- How do we practically measure young children's self identity (i.e. self-esteem or feeling of belonging)?
- How can we analyse and evaluate young children's sense of meaning or purpose regarding their subjective experience of God's love and spiritual well-being?
- How can the objectives of positive spiritual nurture be achieved through both educational programmes as well as people's daily interactions? How is this to be realized in WV projects?
- How can WV support young children in their individual context-specific spiritual development, but at the same time not promote other religious beliefs?
- How can young children be involved in religious practices (e.g. through plays or singing in communal services or participation in Sunday school)?
- How can parents and other caregivers be involved in programmes, in particular when their views differ from WV values?

³⁷⁵ SEARCH 2005.

- Which indicators still need clarification in terms of early childhood development?
- Which indicators are not always applicable and what is missing in defining young children's spiritual well-being?

3.3. World Vision's Policy on the Spiritual Nurture of Children

Children are spiritual by nature; "how this is nurtured plays a huge role in how they develop as caring, ethical, creative, hopeful and empathetic human beings".³⁷⁶ In this context, Roehlkepartain et al. (2005) state that spiritual development is fundamental to "the pursuit of meaning, connectedness to others and the sacred, purpose and contributions, each and all which can be addressed by religion or other systems of ideas and belief".³⁷⁷ WV has worked with great effort to bring the 'natural' dimension of spirituality into the development discourse of spiritual 'nurture' in accordance with children's individual context. World Vision's *Partnership Policy on the Spiritual Nurture of Children* (SNPolicy) thereby provides an essential set of definitions, principles and practices to realize this objective.³⁷⁸ However, the first and foremost step to promote spiritual nurture in children under five is to ask the children themselves about how they experience their environment, including the support provided by their parents, caregivers and the community setting. That is, we need to listen to children's personal experiences and perspectives on spirituality.

In order to improve our knowledge and understanding of children's spiritual needs and experiences, WV has conducted a survey to receive children's feedback (through focus group discussions (FGD)) on the SNPolicy.³⁷⁹ Participants were children and youth aged 5-21 years, however the results may also be relevant for an early childhood focus.³⁸⁰ The most important findings reporting from children's voices with regard to the policy components included:

Children's positive feedback

- General agreement with WV's policy principles
- Children grow towards becoming responsible adults
- Importance of participation (with regard to age-appropriate involvement)
- Any child no matter his or her faith background is supposed to benefit from WV programmes
- Children of all different religions get involved together in activities
- Schools are important to transmit knowledge and understanding about beliefs and values

³⁷⁶ Stephenson 2009, pers. comm.

³⁷⁷ Roehlkepartain et al. 2005, 'Spiritual Development in Childhood and Adolescence: Moving to the Scientific Mainstream' in E. Roehlkepartain, P. King, L. Wagener & P. Benson, *The Handbook of Spiritual Development in Childhood and Adolescence*, Sage, California, USA.

³⁷⁸ WV n.d., *Partnership Policy Spiritual Nurture of Children (Draft 12.2)*, Integrated Ministry.

³⁷⁹ CWI 2009, *Children's Feedback on the Draft Policy on Spiritual Nurture of Children*, World Vision.

³⁸⁰ Ibid.

- Freedom to show one's faith through spiritual nurture activities and prayer
- "WV should have a plan for children who wanted to convert and they should inform the parents about this strategy"

Children's concerns

- Even though policies may be in place, some parents or caregivers may not be prepared to care for their children or even harm children through spiritual abuse.³⁸¹
- Sometimes children do not know what is 'in their best interest' and need the guidance from adults (very young children). Sometimes parents decide for the children without them having a choice to resist (e.g. religious fasting)
- What will WV do with children belonging to a church or tradition that does not believe in the organisation's shared values? How are these children taught WV's values?
- Although children participate in collective activities, parents of different religions (e.g. Christians and Muslims) may not come together.
- When parents engage in harmful spiritual practices, how can WV be informed about secret rituals without putting children or others involved into danger? How can WV approach parents and convince them to stop these practices?
- What will WV do if children want to convert but their parents disagree and/or choose another religion for them?

Questions that resulted from this survey referred to

- The need to develop frameworks and DADDs for guiding WV staff, volunteers and partners
- Engagement with and capacity building of parents (life skills) to provide spiritual nurture support for their children
- Developing mechanisms for children's active participation in policy development and programming
- Ensure child protection, monitoring and reporting
- Incorporating schools and churches
- Advocacy and awareness raising on the CRC
- Consultation with National Offices and ADPs in order to develop context specific programmes
- Inclusion of children and families across different faith traditions and belief systems

³⁸¹ *Spiritual abuse* is the misuse of power, authority or trust by any person in a position of spiritual power or authority (whether within an organisation, institution, church or family), through controlling, coercing, manipulating, or dominating a child's spiritual development (WV n.d., *Partnership Policy Spiritual Nurture of Children (Draft 12.2)*)

Questions

- How do we obtain valid and useful data regarding children's own subjective experiences of spiritual nurture in early childhood?
- What are WV's current measurements to evaluate spiritual support for young children?
- How may current indicators be refined in order to develop effective frameworks and guidelines that reflect and aim towards the best interest of the child?

4. WV Spiritual Development in Practice

4.1. Transformed Relationships

World Vision's *Transformational Development Indicators (TDIs) Field Guide* on transformed relationships through caring for others, emergence of hope and Christian impact provides a basis for measuring quality of life indicators within communities where WV operates. To look at the individual topics will be useful to gain a general overview on possible methodologies that can then be evaluated in terms of their relevance and applicability within early childhood research and development.³⁸² [The following sections have been predominantly quoted from the original text]

4.1.1. *Caring for Others*³⁸³

Definition: Care for each other means that men, women, boys and girls perceive that they care for others and others care for them within their community. The concept is defined regarding particular dimensions such as the use of community resources, gender relations, valuing and protection of children, wellbeing of vulnerable persons and conflict prevention and resolution.

Indicator: Community members care for each other.

³⁸² WV 2002b, 'Transformed Relationships: A Guide to the Indicators on Caring for Others, Emergence of Hope, and Christian Impact', *Transformational Development Indicators (TDI) Field Guide*, vol. 4, p. 2.

³⁸³ *Ibid*, pp. 7-25.

Key concepts

Children are valued and protected

High score indicator: Adults value children highly and excellent practical examples of this were given. Children's opinions are expressed and adults take these into account. Children are not at risk from harmful practices and/or violence. Adults and children have taken effective action against this. Children feel safe. Child work does not interfere with study and leisure opportunities.

Equal opportunities for boys and girls

High score indicator: Births of boy or girl babies are valued equally. Both boys and girls are given similar levels of food/nutrition at all times. Education is seen as important for girls as for boys and there are no differences. Most boys and girls feel safe from harm.

4.1.2. Emergence of Hope³⁸⁴

Definition: Emergence of hope means that men, women, boys and girls perceive and demonstrate hope in their future. Dimensions of this emergence of hope include peoples' perceptions of the past and the present, attitude towards the future, self-esteem, and spirituality

Indicator: Communities' emergence of hope in their future.

Role of spirituality: The first guide question in this topic aims to avoid introducing "spirituality" on purely conceptual terms by using common reference points from the girls/boys experiences.

FG with men & women on the role of spirituality

Key concepts:

- a) Perceived relevance and importance of spirituality to their lives.
- b) Extent to which their spirituality provides them strength during times of difficulty, and confidence for the future.

Questions:

- a) Can you describe what you understand by the term "spirituality"?
- b) How does it help you and the community in times of difficulties?
- c) How does your spirituality affect your perception of the future?

³⁸⁴ WV 2002b, pp. 26-47.

FG with boys and girls on the role of spirituality

Question:

a) Can you describe some spiritual or religious aspects of your and/or your families' lives? This question will need to be adapted according to context, for example: "...such as when you go with them to the mosque/temple/church/pagoda."

"It is recognized that this is narrower, religion-focused understanding of the spirituality of boys and girls, which may more broadly encompass their sense of mystery, values, and being. However, the following questions should lead to a broader discussion in line with the topic on how their spirituality affects the way they perceive their lives and futures."

Spiritual well-being - FG men & women / boys & girls

High score indicator: Their belief in a loving God gives them hope and strength during times of difficulties. Progress in life or development is viewed as part of the character of a loving God.

Other themes to be explored in relation to CWBO 3:

- Perceptions of the past / good memories
- Recovery from critical events / dealing with difficult times
- Control over the present
- Support from others
- Future vision
- Planning for the future
- Self-esteem

4.1.3. Christian Impact³⁸⁵

Definition: Christian capacity and intentionality means active staff spiritual nurture, strong church relations and appropriate witness to Christ.

Indicator: Christian capacity and intentionality of programme teams.

- TD indicators
- Measurements and analysis
- TDI instruments + scorecard - FGD guide - Christian program staff

³⁸⁵ WV 2002b, pp. 48-72.

- Steps in measuring, analyzing and reporting - caring for other / emergence of hope / Christian impact

Questions

→ How does WV realize 'spiritual development' of children under five within different cultural contexts (i.e. age- and culturally appropriate approaches, methodologies and tools used for the spiritual nurture of children aged 0-5 years)?

→ Where is the line between 'nurturing' and 'manipulating'/'controlling' children's spiritual development?

5. Recommendations for Action

1) Recommendations for policy makers

- ◆ Bring early childhood spiritual nurture into the political discourse!
- ◆ Work together with churches and spiritual leaders to develop concrete ideas of how to best integrate young children into religious activities.

2) Recommendations for ADP staff

- ◆ Carry out more in-depth research on spiritual nurture in U5s considering WV's child well-being outcomes. Create an understanding of U5s spiritual experiences and needs. Find answers to:
 - 4) How do we define and measure young children's subjective experiences of God's love / spiritual wellbeing?
 - 5) How do young children see themselves within the context of the environment in which they live - i.e. what are U5s concepts of their own identity as well as the meaning and purpose in their lives?
 - 6) How do children interpret their relationships with God and other people through narratives, beliefs and traditions?
- ◆ Be aware that *spiritual development* and *spiritual nurture* mean different things to different people. Start promoting WV values that may be more or less universal:
 - 3) Encourage children's love for others and positive human interrelationships (with family, peers and community members)

- 4) Empower children, build their resilience and increase their hopes through strengthening their positive self identities
- ◆ Develop frameworks that acknowledge local belief systems as well as support WV's commitment to facilitate young children's spiritual development in getting to know Christian values; WV's CWBO indicators may have to be contextualised, i.e. culturally appropriated depending on the individual socio-cultural context.
 - ◆ Use spiritual nurture in connection with other CWBOs; e.g. promote U5s developing assets such as determination and willpower, basic life skills and positive interactions with others, engagement in learning as well as healthy lifestyles.
 - ◆ Integrate early childhood spiritual nurture within other dimensions of development, e.g. health services or ECCD programmes.
 - ◆ Facilitate forums for open discussions regarding general ideas about early childhood care and spiritual nurture; this includes building rapport between WV staff and local communities as well as bringing together people from different faith backgrounds.
 - ◆ Integrate early childhood groups into already existing programmes and activities in local churches.

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Chapter 4: Child Well-being Outcome (4) - “Children are Cared for, Protected and Participating”

Fourth Pillar: Early Childhood Care, Protection and Participation

◆ Adequate Child Care and Protection

I. Scientific Background

We already discussed the issue of child care from different perspectives in the previous chapters. We talked about health *care* services, early childhood *care* and education as well as spiritual *care*. In fact, care needs to be considered in a much broader context “[considering] health, hygiene and nutrition within a nurturing and safe environment that supports children’s cognitive and socio-emotional well-being”.³⁸⁶ The terms ‘care’ and ‘protection’ are not interchangeable, but they are closely interlinked and are generally associated with children’s safety within a particular social environment. We have already seen that the physical, cognitive and mental wellbeing of infants and young children is very much dependent on the caregivers’ ability to understand and adequately respond to children’s basic needs.³⁸⁷ In this context, care and protection are closely related to both young children’s intimate relationship with their caregivers as well as issues regarding child poverty.

One fundamental problem in defining early child care and protection is that their meanings differ depending on context as well as on whether we apply a relativist or absolutist approach to develop frameworks and guidelines. More specifically, in relation to child safety “a relativistic approach is justified on the basis that what constitutes child abuse is socially and culturally determined, whereas an absolutist approach, which ignores the context in which abuse has occurred, might lead to inappropriate interventions that compound the harm a child has already suffered.”³⁸⁸ From this perspective we may also ask: what happens to a child in the absence of early childhood care and protection? Using a child rights-based and public-health approach, Reading et al. (2009) are looking at children’s status in society, in particular with regard to maltreatment within the private and public

³⁸⁶ UNESCO 2007, p. 15.

³⁸⁷ Nordtveit 2008, p. 415.

³⁸⁸ Engle et al. 2007, p. 334.

realms. They state that “maltreatment is [most often] defined in terms of physical, emotional, and sexual violence, or neglect perpetrated by individual adults, usually parents or those close to the child. [However] these approaches do not permit collective harm and exploitation, for instance that caused by institutions, harmful policies and laws, and avoidable war, conflict, failure of governance, or social disruption”.³⁸⁹ In this context, we would need a definition including both intentional harm on the individual level (abandonment of nurture, protection and care within families) as well as harm caused by broader structures (societal, economic and professional abandonment).

The Consultative Group on Early Childhood Care and Development (CGECCD) defines ‘care’ in terms of physical as well as psychological wellbeing and states that “[children] need attention to their health and nutrition, their evolving emotional and social abilities, as well as their minds. The term care was chosen, rather than education, to move policy makers and program providers away from thinking exclusively in terms of pre-schooling”.³⁹⁰ Thus, in examining early child care and protection we may actually see a coming together of the diverse CWB areas that need to be dealt with by means of a holistic all-encompassing approach.

Further readings

Onyango, P. & Lynch, M. A. 2006, ‘Implementing the right to child protection: a challenge for developing countries’, *The Lancet*, vol. 367, no. 9511, pp. 693-694.

2. World Vision Background

World Vision staff is committed and pays particular attention to support the most vulnerable children in this world (child-focused approach). The first few years of a child’s life require special care and protection, because children under five years of age are very much dependent on their caregivers as well as subject to a range of risk factors from which they cannot protect themselves. The first and foremost need that young children have is a loving and caring environment. World Vision’s advocacy to improve adequate child care and protection thereby corresponds with the standards defined in the UN Convention on the Rights of the Child (CRC).³⁹¹ The CRC clearly states that:

*“[The] child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.”*³⁹²

³⁸⁹ Reading, R. et al. 2009, p. 333.

³⁹⁰ CGECCD n.d., *About ECCD: What is ECCD?*, The Early Childhood Care and Consultative Group, viewed 7 January 2010, http://www.ecdgroup.com/what_is_ECCD.asp

³⁹¹ WV n.d., *Here We Stand: World Vision and Child Rights (2nd edition)*; see also WV UK 2008, *Children’s Rights: Understanding the UN Convention on the Rights of the Child*.

³⁹² UN 1989, *UN Convention on the Rights of the Child*.

2.1. Defining Child Care and Protection³⁹³

The World Vision International Child Protection Policy and Standards defines child protection as:

“All measures taken to prevent and respond to exploitation, neglect, abuse, and all other forms of violence affecting children”

Article 19 of the CRC distinguishes between different forms of harm towards children, namely:

“States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.”³⁹⁴

This definition contains three aspects that are important for developing frameworks to improve young children’s safety within their community and family settings. First, the responsibility of child care and protection is assigned to several key players including national governments, public institutions (e.g. ECD centres) and the home environment. Second, there are different types and degrees of harm from which children need to be protected. Third, ‘care’ and ‘protection’ belong together, with a child’s significant other having the primary responsibility of providing for his or her wellbeing.

Children living in very difficult circumstances, denying them adequate care and protection, are those children that are the focus of World Vision’s vulnerability approach. WV defines most vulnerable children as “children whose quality of life and ability to fulfil their potential is most affected by extreme deprivation and violations of their rights. These children often live in catastrophic situations and relationships characterized by violence, abuse, neglect, exploitation, exclusion and discrimination”.³⁹⁵ Four vulnerability factors are:

- Extreme deprivation
- Serious rights violations
- Abusive and exploitative relationships
- Vulnerability to catastrophe and disaster

³⁹³ WV 2009, *Guidance Note: Child Protection Incident Definitions and Response Protocols*.

³⁹⁴ UN 1989, *UN Convention on the Rights of the Child*. Article 19.

³⁹⁵ WV 2009, ‘What’s In a Name? A Discussion Paper on Child Protection Terms in World Vision World Vision International’, *Keeping Children Safe from Abuse, Exploitation and Neglect*, Version 1.0, p. 2.

As we can imagine, infants and young children that are exposed to one or more of these factors are particularly at risk of suffering from the resulting negative effects. Moreover, physical abuse appears to be closely correlated with child poverty. Linking early child care and protection to poverty however means that we need to look at different realms, including direct relationships and responsibilities of caregivers as well as the impact of outside forces.

2.2. Different Forms of Harm and Child Abuse

There are many forms of harm toward children. We will be looking at three in the following sections: loss of identity, physical and emotional abuse and children in war and armed conflict. Some of the material has not been drawn from sources specifically referring to children under five years of age. However, the information provided should generally be applicable to early childhood care and development matters.

2.2.1. *Loss of Identity*

A child's legal identity is commonly associated with his or her name, nationality and family ties.³⁹⁶ We already discussed the importance of children to develop a sense of self, to relate to others and to experience their role and responsibilities within their immediate environments (see chapter 3, p. x). Early childhood is a time when children develop an awareness of their own selves (i.e. personal identity) in interaction with others. Children's immediate environment - that is the community in which they participate - shapes their cultural identity (including norms and values, people's behaviours as well as traditional belief system).

Lachman and Poblete (2002) argue that a sense of identity and belonging is a fundamental asset of children living in many developing countries. This is particularly true for many African societies that are built upon strong cultural ties and value a child-centred family life. A community's social cohesion encourages children's self-esteem, promotes their social and emotional development and teaches them to show respect and empathy towards other community members. A positive identity (see also chapter 3, p. x; referring to personal power, self-esteem, a sense of purpose and a positive view of one's personal future) helps children to be emotionally more resilient, even in most difficult circumstances.³⁹⁷

Article 8 of the UN Convention on the Rights of the Child states that:³⁹⁸

³⁹⁶ UN 1989, *UN Convention on the Rights of the Child*; Early Childhood Rights Indicators Group 2009, *Manual for Early Childhood Rights Indicators*, UNICEF, Vancouver, Canada.

³⁹⁷ Lachman & Poblete 2002.

³⁹⁸ UN 1989.

States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to speedily re-establishing his or her identity.

Where infants have been purchased - either willingly, or through fraud or pressure - from their biological parents they are also at risk of losing their identity. This is also an area where birth registration is important in order to protect children by granting them a clear citizenship and identity.³⁹⁹ Where young children are removed from their original family setting and placed into foster care⁴⁰⁰ they are also likely to develop confusion about their identity. In cases where children have no contact at all to their former parents or close relatives they may in fact lose all of their family history, traditions and cultural background. Nevertheless, after kinship care, foster care is still considered an alternative model for WV's community-based care programming, because it provides children with a 'family-like' environment.⁴⁰¹

A research study conducted by World Vision in three Pacific islands countries - Vanuatu, Papua New Guinea and Solomon Islands - investigated the role of communities and families in relation to child rights and protection. WV focused on the support provided by communities and caregivers as well as children's resilience to difficulties. Regarding children's sense of identity, in these cultural contexts the concepts of religion and *kastom* are very important. Religion, for a child, is a source of identity that also provides social support. It may sometimes be difficult for a child to balance conflicting religious beliefs and practices with those of *kastom*. Children also come to identify themselves with the values of their own [Melanesian] culture, which encompasses an approach to life where the whole community works together. The *wantok* system (i.e. familial, language and cultural links) thereby forms a social safety net upon which children can rely in times of hardship. For example, in case of a parent falling sick or dying, a member of the community takes care of that person's children. In teaching children about *kastom* they learn about their own cultural identity, values and responsibilities. As children identify themselves with *kastom* the harmony of the group is maintained.

In order to establish how children view their own identity it is important to understand the context in which a child grows up. If a social structure is disrupted, children are likely to lose their cultural identity, in particular if they are separated from their key attachment figures of their original kinship group. The WV research study in the Pacific islands communities used several activities to establish children's understanding of their own identity. By means of drawing, people were able to put

³⁹⁹ WV Asia-Pacific 2009, *10 things you need to know about trafficking*, Bangkok, Thailand, pp. 28/31.

⁴⁰⁰ See WV programme model 'foster care' in Oswald & Forbes 2009, p. 33.

⁴⁰¹ Oswald & Forbes 2009, pp. 33-34.

themselves and others into 'a bigger picture', to see the interrelations between themselves and other members of the village and interpret (through self-expressions) their own identities with regard to roles, responsibilities and relationships.⁴⁰² This, or other forms of play, may be a useful task to assess young children's sense of identity and to understand how they create and experience their roles within the family and community setting. Another method to promote a child's sense of identity may include using a life story book including personal information about the child's life in pictures, personal objects and mementoes.⁴⁰³

Questions

- How might young migrant children experience their environments differently compared to children who have grown up within the same particular community? How can WV staff work together with migrant parents (who may also find it difficult to integrate themselves into their new environments) in order to strengthen a community's bonds as well as to enable parents to better support their children?
- Who do orphans identify with? What can be done to strengthen their sense of 'self'? How can they be supported to develop a healthy relationship to people in their environment? What are the most suitable programme models for orphans in order to 'find their place' within a community?
- How may an integration of different cultural elements into ECCD programmes be realised (e.g. ECCD staff and children speak minority languages, storytelling in relation to different cultural histories etc.)?
- How might HIV and AIDS be an influential factor in contributing to young children's undeveloped sense of identity? I.e. as social structures change due to the deaths of many adults, children may start experiencing their immediate environments differently. E.g. Children might be brought up by other caregivers (siblings, grandparents etc.) or placed into foster care and AIDS orphanages. HIV positive parents might not be able to adequately provide for their children and, consequently, young children may not regard their own parents as key attachment figures capable of caring for them.

2.2.2. *Physical, Sexual and Psychological Abuse*

Defining child abuse as a universal concept is not as easy as it might initially seem to be. This is because the vast diversity of socio-cultural environments leads to different understandings of when child punishment crosses the line to become a form of abuse. Defining abuse in a particular context thus requires taking into account the different underlying structures (e.g. traditional values and practices, religious beliefs, political organisations etc.) as well as certain other factors (e.g. the child's age, combination of circumstances, intensity of corporal punishment etc.). Since opinions about child

⁴⁰² WVI 2005, *Strongim pikinini, strongim leaf b'long family - enabling children to reach their full potential*.

⁴⁰³ UN 2009, *Promotion and Protection of all Human Rights, Civil, Political, Social and Cultural Rights, including the Right to Development: Guidelines for the Alternative Care of Children*, Human Rights Council - General Assembly (15 June 2009), p. 23.

abuse are also subjective, we have to keep in mind that what might be considered to be abusive behaviour from one person's point of view may not be seen that way by another. In other words, "what may seem to be abusive in one country may be acceptable in another".⁴⁰⁴ Child abuse and neglect comprise many different forms of ill treatment that can harm children's "health, survival, development or dignity in the context of a relationship of responsibility, trust or power."⁴⁰⁵ The WV child protection policy and Keeping Children Safe (KCS) Coalition have outlined the following types of abuse that can also affect the lives of young children under five years of age.⁴⁰⁶

Table 1: Different types of abuse

Type of Abuse	Description
Physical abuse	Hitting, burning or caning children to discipline, or punishing them by denying food/nutrition, abduction and kidnapping
Sexual abuse	Inappropriate touching to rape (contact) / expecting sexual favours, and noncontact sexual abuse, which is forcing a child to observe sexual acts, showing a child pornography
Emotional abuse	Humiliation, uncaring attitudes, unfairly criticism and absence of praise, ridiculing and discriminating, bullying, denying time to play, demoralising the child rather than focusing on behaviour changes, stigmatising children with disabilities, shouting at a child, treating child with contempt, ignoring a child, making a child stand on bench, fear of physical abuse and abandonment, absence of a primary attachment figure, restriction of movement, degrading, scape-goating, threatening and scaring, or other non-physical forms of hostile or rejecting treatment
Harmful cultural practices	Denying children their rights, including female genital mutilation, female infanticide and early marriage [↗]
Early marriage	Often leading to pregnancy at a young age (with related risks), being unable to finish schooling
Exploitative child labour	Involves giving a child tasks for which she or he is not developmentally ready, expecting children to do work that does not allow time for their education, rest and play, e.g. bonded or forced labour, persuading children to sell drugs, recruiting children into fighting forces, domestic workers, and trafficking
Spiritual abuse	Misuse of power, authority or trust by any person in a position of spiritual power or authority (whether within an organisation, institution, church or family), through controlling, coercing, manipulating, or dominating a child's spiritual development. ⁴⁰⁷
Other forms of abuse	Not sending girls to school, abandoning child for marriage, leaving a child unsupervised, ignoring a disabled child, sending children to beg

⁴⁰⁴ KCS n.d., *Definitions of abuse*, p. 1, A Toolkit for Child Protection: Trainer's Notes.

⁴⁰⁵ *Ibid.*, p. 2.

⁴⁰⁶ Myers, J., n.d. *Keeping Children Safe: Tools for Child Protection, Tool 3*, Keeping Children Safe Coalition, pp. 33-35/50.

⁴⁰⁷ WV n.d., *Partnership Policy Spiritual Nurture of Children: Draft: 1.2.2*

Sources: WV 2007, *Child Protection Policy: Creating a safer community for children*, p. 4; Myers, J., n.d., *Keeping Children Safe: Tools for Child Protection, Tool 3*, Keeping Children Safe Coalition, pp. 72/ 65)

Child abusers cannot be easily identified; they can be male or female members of any social, cultural, or economic group and of any age. Table 2 (p. x) gives examples of where child abuse might take place within or near community settings.

Table 2: Where does child abuse take place?

Where does abuse take place?	Description
Abuse in the family	Most abuse of children occurs within the home by other family members
Within the community	In most cases, children are abused by people known to them, and the abuse takes place in the local area
In institutions	In schools, day-care centres, refugee camps and correctional rehabilitation and children's homes, peer violence among children (bullying, physical attacks, name-calling, social exclusion)
By visitors to communities	By outsiders who take advantage of a child's vulnerability, for example, drug dealers, sex tourists, paedophiles, debt collectors, the military and recruiters for brothels

Source: WV 2007 *Child Protection Policy: Creating a safer community for children*, p. 4; Early Childhood Rights Indicators Group 2009, pp. 92-104.

Table 2 shows that violence toward young children takes place in many different spheres. Children who get abused at home or early childhood institutions are particularly at risk of experiencing not only physical pain, but also humiliation and rejection from people they would normally trust. This can have a tremendous impact on children's mental wellbeing and as a result these children may face learning difficulties as well as discouragement or even fear of going to care centres (and later primary school).⁴⁰⁸

In this context, strengthening families and monitoring early childhood institutions are important elements of protecting children from abuse. Interventions may include: ⁴⁰⁹

⁴⁰⁸ Lansdown 2004, 'Participation and young children', in Jim Smale & Teresa Moreno, *Young children's participation: rhetoric or growing reality?*, *Early Childhood Matters*, vol. 103, pp. 11.

⁴⁰⁹ Engle et al. 2007, p. 236; Hawkins, L. 2001, 'Because they are girls', In Gow, M., *A Safe World for Children*, World Vision, California, USA, p. 43.; Early childhood rights indicators group 2009, p. 93.

- Law reform on standards of early childhood care
- Monitoring and surveillance systems
- Information and training on parenting practices
- Community sensitisation to address harmful cultural practices
- Supportive and therapeutic services (including therapeutic day-care, rehabilitation and home visiting) for young children
- Promoting alternative forms of punishment and control
- Prosecuting parents, caregivers and professionals who abuse or use violent methods to discipline children

The KCS Coalition also provides exercises (e.g. questionnaires) that may be useful for researchers to assess what participants (adults as well as children) think child abuse is and in order to develop context-specific frameworks.⁴¹⁰ For example, it may be helpful for WV staff to ask questions such as:

- What kinds of abusive practices are observed locally that cause harm to children?
- What are local people's own attitudes towards child abuse and protection?
- Who causes the harm within particular social settings?
- Are there any common practices or traditions that could harm children? (e.g. female infanticide)
- Are there any laws that exist to protect children?

Questions

- ◆ Young children who are getting abused by a close attachment person might not have anyone else to turn to. They may feel ashamed, fear rejection and abandonment and seek the guilt by themselves.
 - What are the reasons for children not telling about their abuse?
 - What does stop adults from responding to child abuse within the home environment and the broader community?
- ◆ Young children with disabilities are particularly vulnerable to abuse because they may be less able to express themselves, are stigmatised and not taken seriously.
 - How can children with disabilities be better protected?
- ◆ Infanticide is correlated with underlying cultural structures in terms of gender inequality traditional values and customs.
 - How can WV address fundamental inequalities on the local level, without disrupting a society's cultural organisation in terms of traditional male and female roles?

⁴¹⁰ Myers n.d..

2.2.3. War and Armed Conflict

War and armed conflict is a structural extra-familial form of violence. However, the impact of armed conflict can extend to the household level where it places high stress on families and the wellbeing of young children.⁴¹¹ However, “war does not excuse child rights violations.” In fact, war already threatens the most basic rights expressed in the Convention on the Rights of the Child (CRC): “the right to survival, the right to food, the right to family, the right to cultural and religious identity and the right to education.”⁴¹² The consequences for children who have been exposed to war and conflict are severe. We need to understand that what children experience in reality is a “psychological warfare at grassroots community level”; the battlefields are children’s homes and close neighbourhoods.⁴¹³

War and armed conflict can cause extreme psychological stress on young children, including severe anxiety, depression, post-traumatic stress and emotional disorders. What is more is that at an early age, when children are actually most dependent on their caregivers, they witness their parents’ helplessness in conflict situations and thus might develop a picture that they are not able to take care for them. Parents’ inability to protect their children may lead to a child developing a sense of shame and aggression. These traumatic experiences in which children live in constant fear and with lack of support from a fragmented family system are also likely to have an impact on their cognitive development and later performance at school.⁴¹⁴

Interventions to protect young children in situations of armed conflict have to take place at various levels and also need to be sensitive to the particular cultural context. Psychological assistance and social reconstruction of supportive environments are supposedly the main areas that development programmes should focus on. Factors promoting children’s resilience include re-building self esteem and a positive sense of self, meaningful attachment relationships and positive role models, involvement of parents in children’s education, support from outside the family, developing social skills and so forth. Generally, working in groups may be a useful method in order for children to establish a sense of belonging and to overcome traumatic experiences.⁴¹⁵

One WV concept that focuses on re-establishing children’s psycho-social, spiritual and physical needs is the model of so-called ‘Child Friendly Spaces’ (CFS). A CFS is a protective area where children can meet other children, play and learn together and deal with their difficult situations. It is also a place

⁴¹¹ Lachman & Poblete, p. 589.

⁴¹² WV n.d., *Here we stand (2nd edition)*, pp. 3-6.

⁴¹³ Killian, B. 2002, ‘Is child protection possible in areas of war and conflict?’, *Child Abuse & Neglect*, vol. 26, p. 601.

⁴¹⁴ *Ibid.*, pp. 600-605.

⁴¹⁵ Killian, B. 2002, pp. 603-605. See also the author’s summary of key findings that promote resilience factors on page 604.

where parents get involved in activities and receive information on children's safety and care. Moreover, mothers may be provided with a clean private space to breastfeed their babies and meet with other mothers. This practical approach aims to build capacities to cope with and re-establish routine everyday life situations. CFS should be inclusive and can therefore be an opportunity for young children under five to get together with other vulnerable groups and older children from which they can learn. Furthermore, educational structures themselves may be expanded (e.g. through kindergartens) to promote children's early intellectual development.⁴¹⁶

Further Readings

Gow, M., Vandergrift, K. & Wanduragala, R. 2000, *The Right to Peace: Children and Armed Conflict*, Working Paper no. 2, World Vision International.

Pampell Conaway, C. & Fish, C. 2004, 'Children's Security', in *International Alert & Women Waging Peace, Inclusive Security, Sustainable Peace: A Toolkit for Advocacy and Action*, pp. 49-63.

WV n.d. *Child Friendly Spaces in Situations of Crises*.

WV n.d. *Children in Armed Conflict*.

2.3. CWBOs Indicators: Children are Cared for and Protected⁴¹⁷

Child protection is a crosscutting theme that needs to be considered in all areas of WV programming and within all sectors of child development. The Compendium of Indicators includes a very detailed list of what WV considers to be important in terms of providing children with adequate care and protection. The following is a summary of the main areas and measures covered in the framework of child well-being indicators.

2.3.1. *Children are Cared for in a Loving, Safe, Family and Community Environment with Safe Places to Play*

- Love, support, care and protection instead of violence, exploitation, neglect and discrimination
- Support mechanisms and child protection laws and policies
- Child labour
- Safe areas to live, learn and play
- Migration patterns
- Child trafficking
- Harmful traditional or customary practices

⁴¹⁶ WV 2006, *Child Friendly Spaces in Situations of Crisis*, World Vision; See also UN CRC 1989, article 38.; WV 2008, *World Vision International's Submission to the Committee on the Rights of the Child's Day of General Discussion: "The right of the child to education in emergency situations"*, p. 4.

⁴¹⁷ WVI 2009, *Compendium of Indicators - version 1.6: Girls and boys are cared for, protected and participating*, table 4, pp. 1-8.

- Behaviours and attitudes towards child punishments and discipline (physical and non-physical methods)
- Child protection laws and policies

2.3.2. *Parents or Caregivers Provide Well for Their Children*

- Access to and availability of basic necessities (without external assistance) - food, shelter, clothes, health care, education etc.
- Community-based, government social protection (safety-nets) or emergency support/response for households with most vulnerable children (MVCs)
- Household incomes (own production or off-farm employment)
- 'Coping strategies'
- Access to credits
- Access to basic needs in households with chronically ill caregivers and/or OVCs
- Support of orphans within kinship networks
- Slums
- Social protection and welfare laws

2.3.3. *Children are Celebrated and Registered at Birth*

Summary indicator

- Children aged 0-5 years with a birth certificate, reported by caregiver and verified by observation

Context-specific indicators

- Communities have a system in place to ensure the registration of every child at or shortly after birth, and fulfil his or her right to acquire a name and a nationality, in accordance with national laws and relevant international instruments
- Communities can describe how children are celebrated at birth by their families and communities
- The cost of birth registration documentation is affordable to parents or caregivers, and easy to obtain
- Parents or caregivers who report that their children are prevented from accessing government services like education, health care, welfare support, because of a lack of registration

National level indicators

- Number of children under 5 years of age whose births are reported registered

3. Birth Registration

Birth registration is the official recording of a child's birth by a government department, including the child's name, sex, date and place of birth as well as the parents' names, addresses and nationality status whenever possible. Birth registration is important for several reasons. First and foremost, it establishes formal proof of a child's existence, society membership and belonging to a family (the personal identity establishes lineage). This proof may be required for accessing special services, including education and health care facilities, protection against child labour as well as child marriage.⁴¹⁸

Article 7 of the UN Convention on the Rights of the Child states that:

“The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality, and, as far as possible, the right to know and be cared for by his or her parents.”⁴¹⁹

Despite all these facts, each year there are about 50 million unregistered births worldwide (between 30 and 40 percent).⁴²⁰ The reasons for parents to not register their child are diverse. First of all, registration systems may simply not be available, accessible (long-distance travel) or do not work properly. Furthermore, birth registration may not be regarded as a child's fundamental right or parents may be unable to pay the required fees. Some indigenous groups and ethnic minorities may also be disadvantaged in receiving birth registration.⁴²¹ As a consequence, the negative outcomes for a child of not having been registered at birth can be severe. Unregistered children under five are mostly characterized by being poor, living in remote rural areas, suffering from impaired health, malnutrition and low levels of education (due to denied access to these services) as well as having higher mortality rates.⁴²² No registration at birth can further lead to children being denied their right to inherit property, not being allowed to hold a passport, to vote and to marry.⁴²³

It is recommended that in order to increase the number of registered birth, every child (no matter his or her gender, ethnicity, religion etc.) should be registered immediately after birth. Those children who were not registered should still be able to do so later on. Parents and communities have to be made aware about the importance of birth registration which should also be free of charge, accessible and well-managed. One possibility to increase birth registration within WV programming could be by integrating it into ttC (timed and targeted counselling). Working closely

⁴¹⁸ IAWGCP 2008, p. 6; Early Childhood Rights Indicators Group 2009, p. 66.

⁴¹⁹ UN 1989.

⁴²⁰ UNICEF 2006.

⁴²¹ UNESCO 2006, *Literacy for Life: 2006 Education for All (EFA) Global Monitoring Report*, pp. 91-92.

⁴²² WV 2009, *Part Three: Implementing the 7-11 Strategy*, p. 57.

⁴²³ Early Childhood Rights Indicators Group 2009, p. 65.

together with families at the household level provides an opportunity for child health workers (CHWs) or child health volunteers (CHVs) to counsel on and monitor birth registration.⁴²⁴

Questions

- How can birth registration among orphans and vulnerable children (including migrants, minority groups, children with disabilities, girls, children deprived of parental care and so forth) be improved?
- What data is available about the registration of neonatal deaths and deaths of children under five years of age?
- “Does the State have a written policy about the implementation of an official, nationwide, universal and free-of-charge birth registration system?”⁴²⁵

Further readings

Morris, S. S., Black, R. E. & Tomaskovic, L. 2003, ‘Predicting the distribution of under-five deaths by cause in countries without adequate vital registration systems’, *International Journal of Epidemiology*, no. 32, pp. 1041-1051.

Early Childhood Rights Indicators Group 2009, *Manual for Early Childhood Rights Indicators: A Guide for State Parties Reporting to the Committee on the Rights of the Child*, UNICEF, pp. 65-79.

4. Children Deprived of Parental Care

World Vision’s preferred option for child care is that: the family comes first.⁴²⁶ This corresponds with the UN Guidelines for the Alternative Care of Children, stating:

“The family being the fundamental group of society and the natural environment for the growth, well-being and protection of children, efforts should primarily be directed to enabling the child to remain in or return to the care of his/her parents, or when appropriate, other close family members. The State should ensure that families have access to forms of support in the care-giving role.”⁴²⁷

UNICEF (2009) defines children without parental care as “all children who are not living with at least one of their parents for whatever

UN Convention on the Rights of the Child (CRC):

“Children have the right to live with their families unless separation is in the child’s best interests” (Article 9)

“Children who are deprived of their family environment are entitled to special protection and assistance from the State” (Article 20)

“Every child has the right to a standard of living adequate for the child's physical, mental, spiritual, moral and social development“ (Article 27)

(UN 1989, *UN Convention on the Rights of the Child*)

⁴²⁴ WV 2009, *Part Three: Implementing the 7-11 Strategy*, p. 57.

⁴²⁵ Early Childhood Rights Indicators Group 2009, p. 70.

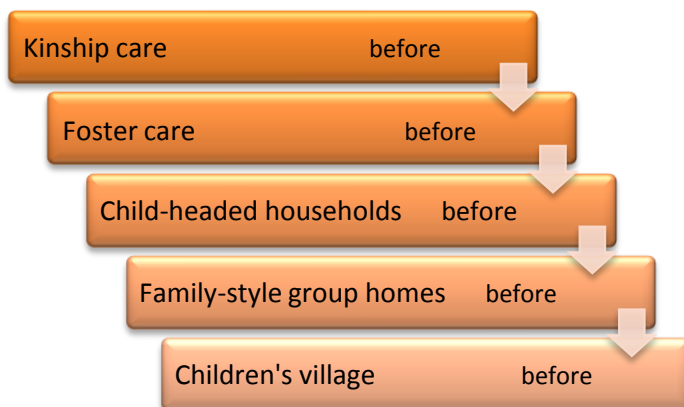
⁴²⁶ Oswald & Forbes 2009.

⁴²⁷ UN 2009, *Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development*, UN Human Rights Council General Assembly (15 June 2009), pp. 3-4.

reason and under whatever circumstances.”⁴²⁸ However, it is important to note that children deprived of parental care (CDOPC) are not necessarily orphans or those with lack of a family(-like) environment. WV states that: “Children Deprived of Parental Care are girls and boys in extremely vulnerable situations, including those who live in institutions, formal or informal foster care, or are otherwise separated from their parents or primary caregivers, or are living in situations of abuse, neglect and/or exploitation within the family.”⁴²⁹ Thus, in finding the best option for a CDOPC is to look at the broader picture first. In fact, most of these children live in institutions because of poverty, stigmatisation or discrimination.⁴³⁰ There are several elements to children being deprived of adequate care, protection and guidance. Thus, WV has developed different models of alternative care because each child is different and needs a solution that suits his or her individual circumstances, that is ‘in the child’s best interest’.

World Vision’s position is that children develop best and are most likely to reach their full potential within a family-based environment. Promoting the rights of the many children living in residential institutional care⁴³¹ must not be ignored, but should be a last option. The predominant reasons for why children in their early years should be living in a family setting is for them to have consistent attachment to a caring adult, to understand the basic roles of a mother, father and siblings as well as to learn integrating themselves into their society.⁴³² Oswald and Forbes (2009) suggest several alternative care models for CDOPC that are listed below in descending preference (Figure 1).

Figure 1: Alternative Care Models (from most to least preferred)



⁴²⁸ UNICEF, *Progress for Children: A Report Card on Child Protection*, no. 8, UNICEF, New York, USA, p. 19.

⁴²⁹ WVI 2007, *World Vision International Management Policy Children Deprived of Parental Care*, p. 1.

⁴³⁰ WVI 2007, *World Vision International Management Policy Children Deprived of Parental Care*.

⁴³¹ A residential institution is defined as “a group living arrangement of [four or more] children in which care is provided by remunerated adults who would not be regarded as traditional carers within the wider society. This implies a deliberated structure to the living arrangements for children and describes a professional relationship between adults and children rather than a parental relationship” (Tolfree, D. 1995, *Roofs and Roots: The care of separated children in the developing world*, London, Save the Children UK.)

⁴³² WVI 2007, p. 1; See also WVI 2006, *Children deprived of Parental Care: World Vision International Policy Position, Programming Standards and Toolkit*, p. 23ff. WV Standards for Residential Care (pp. 34-41); WVI 2006, *Children deprived of Parental Care: World Vision International Policy Position, Programming Standards and Toolkit*, pp. 3-6.

Source: Oswald, E. & Forbes, B. 2009, 'Because We Care: Programming Guidance for Children Deprived of Parental Care', *Keeping Children safe from abuse, exploitation and neglect: prevent, protect*, World Vision, California, USA.

UN Convention on the Rights of the Child (CRC):

“A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their wellbeing being and proportionate both to their circumstances and the offence”

(Article 40)

(UN 1989, *UN Convention on the Rights of the Child*)

This hierarchy, however, is not a fixed standardised concept. Depending on the individual circumstances, each of those approaches may be applicable and a 'lower rank' model may in fact be more suitable for a particular child, given the programme is effectively implemented. The WV Programming Guide for CDOPC (see Oswald & Forbes 2009, pp. 22-54) provides a detailed comparison of all models including their advantages and disadvantages. For example, although kinship care is the most preferred alternative model, children who have experienced abusive behaviours within their extended family or neighbourhood may not be best cared for by members of their kin group. Formalising kinship care by means of family monitoring mechanism could minimise this risk. In

contrast to informal kinship care, this model is more likely to ensure children are provided with their basic material and psychosocial needs. However, monitoring mechanisms may also potentially disrupt a family's traditional structure and coping mechanisms.⁴³³ In order to make informed decisions about which model to choose, the *World Vision International Policy Position, Programming Standards and Toolkit for CDOPC* herein provides a comprehensive set of guidelines, including goals and objectives, indicators as well as activities for programme design for NOs and SOs regarding alternative child care.⁴³⁴

Questions

- What are the possible advantages and disadvantages for infants and toddlers to live in institutional care facilities in comparison to older children?
- To what extent are different child care models applicable for children under five years of age?
- What impact does the alternative care model 'child-headed households' have on small children?

⁴³³ Oswald & Forbes 2009, p. 27.

⁴³⁴ WVI 2006, *Children deprived of Parental Care: World Vision International Policy Position, Programming Standards and Toolkit*, p. 23 ff.

5. Child Protection in WV Programming

5.1. WV Staff Background Check and Responsibilities

Children may be at risk of harm, not only by individuals within the communities in which they live, but also from programming staff operating in the field. World Vision recognizes that maintaining the protection of children has to be the primary responsibility of staff and volunteers. The organisation has therefore developed particular standards that are outlined in the 'World Vision Partnership Required Standards for Child Protection':⁴³⁵

1. Awareness raising about child abuse and the protection of children
2. Programme planning, implementation, monitoring and evaluation focusing on the participation and protection of children
3. Personnel - Recruitment and screening of staff, volunteers, interns, consultants and board members, plus screening of visitors⁴³⁶
4. Managing visitors to World Vision Projects
5. Behaviour protocols/codes of conduct for all those linked with WV⁴³⁷
6. Child abuse: Allegation/Incident Management Plan, including the support of the affected child(ren)
7. Protection of children in sponsorship programs
8. Advocacy on child protection and child rights
9. Communications about children
10. General confidentiality on all child information
11. Partner organizations and their commitments to child protection

5.2. Child Protection Incident Definition⁴³⁸

The WV guidance note 'Child Protection Incident Definitions and Response Protocols' informs WV offices on how to respond to child protection incidents. Any member of staff and other persons involved in WV programming are responsible to report incidents of child abuse or suspicions of child protection concerns to:

National Office Child Protection Focal Person (who submits a Child Protection Incident Report),

Regional Child Protection Coordinator,

WVI Child Protection Associate Director (Phone +1 626 348 4305), or to

WV Integrity and Risk Hotline: Phone (+44 20 7939 8708) or worldvision@control-risks.com

⁴³⁵ WVI 2000, *World Vision Partnership Required Standards for Child Protection*; WVI 2007, *Child Protection: Creating a safer Community for Children*.

⁴³⁶ WV n.d., *Guidance Note Child Protection Criminal Record or Police Background Checks*, World Vision International.

⁴³⁷ See WV n.d., *Declaration of Compliance Form*, World Vision International.

⁴³⁸ *Ibid*, p. 1.

WV Child Protection Incident Definitions are defined as follows:⁴³⁹

- 1) Gross violation of child rights to protection from physical or psychological abuse, neglect, exploitation or other forms of violence - including trafficking, sexual and labour exploitation, female genital mutilation and early marriage.
- 2) Any violation of the WVI Child Protection Policy and Standards which puts children in direct risk of harm.
- 3) Any death or serious injury of a child that is under World Vision's temporary care, or while participating in a WV activity, or caused by a World Vision staff, volunteer, intern, contractor, consultant, visitor, partner agency or donor/sponsor.

For more detailed information see also 'Child Protection Incident Level System' which differentiates WV's response to child protection incidents, according to WV's responsibility and liability.⁴⁴⁰ World Vision's guidance note on 'Child Protection Criminal Record or Police Background Checks' further implies that every WV staff and otherwise involved persons to provide a 'background check' from the government which shows any unlawful history of a person (including violations towards children and women).⁴⁴¹

Questions

- ◆ Practical fieldwork methodologies
 - How can we optimise an awareness of protection policies for WV staff working with young children in the field (including ethical guidelines)?

5.3. Training Materials on Child Protection

This section gives three examples of how child protection can be promoted in ADPs using community-based activities. The following methods may all be used to promote child protection policies in relation to early childhood and simultaneously emphasize WV's community-based focus that actively involves families in processes of programme design.

⁴³⁹ Harm, injury or death caused by natural causes, accidents or natural disasters in communities are not considered child protection incidents, unless they fit one of the points listed in the definition below.

⁴⁴⁰ WVI 2009, *World Vision International Guidance Note: Child Protection Incident Definitions and Response Protocols*, pp. 2-6.

⁴⁴¹ WVI n.d., *Guidance Note Child Protection Criminal Record or Police Background Checks*, World Vision International.

5.3.1. *The Balloon Game*⁴⁴²

Purpose

- To demonstrate the need to prepare and plan child protection activities in ADPs
- To gain awareness of gaps in the ability to protect children
- To become aware of practical child protection activities that can be developed in ADPs

Activity

- Participants are divided into three groups and take on the roles of ‘bad people’, ‘children’ and ‘protectors’
- The bad people’s strategy is to get the children, that is they ‘exploit and abuse’ them by popping their balloons
- The protectors’ task is to not let the bad people popping the children’s balloons
- The children are at risk as the bad people are going to get them

Discussion and Learning

- When the game has finished the facilitator asks the group different questions (e.g. what was difficult for the protectors to prevent the bad people to get the children? What could the protectors do better?)
- WV staff explains to participants what their real child protection work involves (explain the challenges and what is WV doing against it)

5.3.2. *What if...*⁴⁴³

Purpose

- To make the participants understand that what they want for their children is what everyone who lives in similarly difficult circumstances wants for their own children. This relates also to any other cultural context including WV staff backgrounds.

Activity

- The facilitator draws a simple picture of a child on a flip chart
- The participants close their eyes
- The facilitator lets the participants imagine: “your child has just been raped.” Then, “your niece or nephew has just been raped.” Then, “you have just been raped”

⁴⁴² WV n.d., *A Child Protection Activity and Learning: The Balloon Game*, World Vision.

⁴⁴³ WV n.d., *A Child Protection/Life in all its Fullness Learning Activity: What if...*, World Vision.

- After the participants open their eyes the facilitator asks them how they are feeling and what they would want to happen, what kind of services or support they would want for their child, niece or nephew and for themselves.

Discussion and Learning

- WV staff and participants can relate with each other. Understanding develops through emotional and spiritual connection.
- Child protection gap analysis – what are the local and cultural child protection practices? – using analysis for WV ADP project design.

NOTE: any life issue affecting young children can be used (e.g. what if... your child couldn't see / lived in a war zone / lived on the street? What would you want for them?)

5.3.3. *The Squeeze Game*⁴⁴⁴

Purpose

- To understand the negative effects of chronic and traumatic stress on a child who lives in an especially difficult circumstance.

The Activity

- All the participants stand (or sit)
- Participants get in a fighting stance
- On the command 'squeeze' participants squeeze their bodies (arms, fists, shoulders, bottom, legs, feet and toes, stomachs etc.)
- After 20-30 seconds participants stop squeezing
- The facilitator asks the participants about their thoughts, feelings and body reactions. If no one says "I could not breathe", the facilitator asks "who could not breathe?" and just about everyone will raise their hands.

Discussion and Learning

- Children living in especially difficult circumstances live in a state of physical and bio-psychosocial stress.
- Children under stress cannot breathe, thus cannot think well, thus have difficulties learning, thus have difficulties to pursue their hopes and dreams and therefore will not experience life in all its fullness.

⁴⁴⁴ WV n.d., *The Squeeze Game and Life in all its Fullness*.

- WV programming is to assist children to get them into life circumstances that will help them maintain or regain their bio-psychological health.

◆ Early Childhood Participation

6. Scientific Background

Child care and protection are primary concerns in WV programming. However, research has shown that many children experiencing harm are either not listened to or believed. Some children do not even have anyone they can trust to turn to.⁴⁴⁵ In particular, small children may be considered to be mostly passive living beings, which they are not. It is therefore important to identify indicators and develop tools to respond to children right from the beginning. In order to facilitate young children's empowerment we should also distance ourselves from seeing children as mere 'victims' of abuse and violence. That is to say, children should be regarded as active participants within their communities who need to have their voices heard in all matters affecting them.

6.1. Definition of Child Participation

Two things are important to consider when talking about child participation. First, children need to be encouraged to talk and ask questions, to be listened to and be taken seriously in order for them to effectively challenge abuses on their rights, to express their opinions, to learn to take responsibility and to make better decisions and to develop abilities to think critically. Secondly, adults need to be informed by children about their situations, their thoughts, feelings and fears in order to be able to protect them.⁴⁴⁶ According to Gerison Lansdown (2004), an independent children's right consultant, child participation does *not* mean "inappropriate burdening of children, disrespect for parents and excessive freedom without corresponding responsibilities" (p. 5). Rather, in his view participation is much more to be considered as an "inclusive and respectful dialogue with children" in ways that enables them to contribute their ideas and suggestions on creating activities and organizing daily procedures in which they are involved (p. 5). In short:

*"Children's participation is an ongoing process of children's expression of opinions and active involvement in decision-making at different levels in matters that concern them. It requires information-sharing and dialogue between children and adults based on mutual respect and power sharing."*⁴⁴⁷

⁴⁴⁵ Myers n.d., p. 65

⁴⁴⁶ IAWGCP 2008; Lansdown 2004.

⁴⁴⁷ Lansdown 2004, p. 5.

The question is: How do we define, measure and promote participation among children as young as 0-5 years old?

According to Tolfree and Woodhead (1998), children's participation is first and foremost a process of "enabling them to explore the ways in which they perceive the world and communicate their ideas in ways that are meaningful for them".⁴⁴⁸ In addition, the Inter-Agency Working Group on Children's Participation (IAWGCP) states that "*the right to expression of opinion is a fundamental right from the moment of birth. It is not earned or granted at a certain age.*"⁴⁴⁹ Right from the beginning, children should be encouraged to view themselves as active members of the family, able to take part in and influence daily life situations. The positive outcomes are that children will gain more confidence, self-esteem and higher levels of motivation. This may be particularly of relevance in many developing countries in terms of children's early engagement into household activities, as well as their willingness to get involved.⁴⁵⁰

Children's participation in early childhood is in fact very important, because attitudes for active participation are predefined during the first years of a child's life. In other words, children's early involvement positively influences a person's participation and community engagement later on. Developing a positive sense of self, confidence and the ability to express oneself is established within the early years of life. In particular, the interaction between mother and child is a very important determinant. Young children already communicate with their attachment persons through sounds and signals. They indicate what their needs are and are thus able to influence other people's behaviours.⁴⁵¹

6.2. Problem Statement

The most obvious issue regarding participation in early childhood is supposedly young children's invisibility and powerlessness. That is, young children might not be taken seriously in expressing their points of view and are considered to be incompetent in their perceptions and understandings of certain subject matters. Consequently, decisions are made *about* (not necessarily *for*) children without their consultation by the adult community. The general concept of young children being passive recipients of assistance further extends into development programming. That is to say, the voices of children are largely absent in research and professional practice.⁴⁵² When children's real needs are in that way disregarded in development programming - which is by these means child-

⁴⁴⁸ Tolfree & Woodhead 1998, p. 21.

⁴⁴⁹ IAWGCP 2008, p. 8.

⁴⁵⁰ GTZ 2007, p. 9.

⁴⁵¹ Arnold 2000, p. 8.

⁴⁵² Clark & Statham 2005, p. 45.

centred not child-focused, with the purpose of supporting (not empowering) children as separate individuals from other members of their community - these programmes might not be as effective as they could be with children's active participation.

Nonetheless, we need to be aware that children's early involvement in social development is not an easy undertaking; this is because early childhood development (ECD) itself is a social construct. That means that understandings of parent-child relationships as well as assumptions about children's competencies and child rights differ cross-culturally. Though, it also means that the early stages of life are labelled as a time of immaturity, passivity and dependence.⁴⁵³ In this context, children's perceptions and understandings of things can be quite different from those of adults who might, consequently, misinterpret children's needs.⁴⁵⁴

Participation means *real engagement* of children in Early Childhood Development (ECD) programmes according to their age and abilities. This requires adults to start taking children's perceptions of their immediate environments seriously as well as taking on children's feedback on programme interventions (e.g. asking for children's opinions about the best child-friendly design of a day-care centre). Another problem may still be lack of appropriate methods and sufficient time of staff to monitor and record children's reflections on ECD programming interventions.⁴⁵⁵

6.3. Child Participation Requirements

Early childhood participation requires a holistic approach on young children's participation in community life and ECD programming, in terms of their different needs (e.g. children from different cultural backgrounds, children with disabilities, boys and girls etc.) as well as regarding their many competencies in building opinions and developing ideas. Harry Shier's 'Pathways to Participation' might be useful as a basic framework of how young children can be involved in decision-making processes. The five levels of participation that he describes include:⁴⁵⁶

1. Children are listened to
2. Children are supported in expressing their views
3. Children's views are taken into account
4. Children are involved in decision-making processes
5. Children share power and responsibilities for decision-making

⁴⁵³ Lansdown 2004, p. 4.

⁴⁵⁴ Clark & Statham 2005, p. 46.

⁴⁵⁵ Bartlett 1998.

⁴⁵⁶ Shier, H. 2001, 'Pathways to Participation: Openings, Opportunities and Obligations', *Children and Society*, vol. 15, p. 110.

Emotional, physical and verbal reactions of infants and toddlers are well-being indicators reflecting children's needs. Thus, parents and caregivers need to be attentive observers to interpret young children's behaviours.⁴⁵⁷ However, adults also need to actively assist children to express themselves; that is they must not just be passive observers, but active facilitators. In order for children to feel encouraged to share their ideas and opinions it requires comfortable adult-child interactions as well as a setting where children feel safe.⁴⁵⁸ Most importantly, early childhood participation requires a level of communication that is preferred by young children in terms of promoting ways in which they can express themselves best (e.g. through drawing or mapping, sorting and ranking games, drama, music and dance, role-play, group work, child-to-child interaction etc.).⁴⁵⁹

We also need to take into account cultural differences regarding acceptable ways of expressing one's feelings as well as issues to be discussed with people other than close relatives or friends. Ethical issues need to be considered and it also has to be ensured that children understand the meaning of an informed consent and its implications, i.e. children must have a choice of whether they want to participate in development processes or not.⁴⁶⁰ Finally, we have to make sure that the 'invisible' (i.e. silent, withdrawn, unresponsive, depressed and marginalized) children are included in these processes in order to understand their particular point of view, feelings and needs. Children with mental or physical disabilities also require special attention in order to establish conditions which ensure dignity, promote self-reliance, and facilitate the child's active participation within his or her community.⁴⁶¹ Generally, it may be useful to outline some basic principles that need to be considered to facilitate young children's meaningful participation:⁴⁶²

1. An ethical approach: transparency, honesty and accountability
2. Children's participation is relevant and voluntary
3. A child-friendly, enabling environment
4. Equality of opportunity
5. Staff are effective and confident
6. Participation promotes the safety and protection of children
7. Ensuring follow-up and evaluation

⁴⁵⁷ Bartlett 1998.

⁴⁵⁸ Tolfree & Woodhead 1998 p. 21

⁴⁵⁹ See also Lansdown 2004, p. 5. "Respecting the rights of young children to be heard necessitates a preparedness to listen to their views in ways appropriate to them - through music, movement, dance, storytelling, role play, drawing, painting and photography, as well as through more conventional dialogue."

⁴⁶⁰ Tolfree & Woodhead 1998.

⁴⁶¹ See UN 1989.

⁴⁶² WV Africa 2008, pp. 8-12.

Children's point of view

A project undertaken in the UK with 4-5 year old children used visual images to communicate their views on public health issues. Children depicted the local environment as it was at the time of the research as well as they wanted or imagined it to be. Children thereby identified their own needs in ways that adults had not thought of. For example, parents assumed that children would prefer grass play areas, however children wanted concrete. The children argued that grass would hide broken glass, dog excrements and discarded needles from drug addicts. (Lansdown 2004, p. 6)

6.4. Benefits of Child Participation⁴⁶³

There are many benefits of young children participating both in everyday life and development programming:

- Child participation is part of the process of socialization in which children realize that they have a voice and the freedom to express themselves and they learn having respect for people's different opinions.
- Encouragement to express one's opinion can lead to decision-making and critical thinking skills and thereby improve children's later school performance. It allows children to communicate their ideas, concerns, beliefs and feelings with reference to their own individual circumstances. Moreover, children who participate in decision-making processes are more likely to also become active citizens as adults.
- Promoting child participation leads to contextualizing children's position in their communities and avoids ideas of universal concepts of early childhood. Thus, WV staff has an opportunity to gain valuable insights of children's actual experiences, rather than what adults may expect.
- Participation empowers children in building capacities and confidence. Empowerment through access to information, involvement in decision-making processes as well as encouragement to speak up makes children less vulnerable to harm and more likely to challenge abusive behaviours.
- Child participation can improve adult-children relationships and lead to adults' self-reflection and better interaction within the wider community which can also promote non-violent forms of solving conflicts.
- Decisions about the use of government services and resources are better informed and consequently more effective when children's opinions and concerns are taken into consideration.

⁴⁶³ See Bartlett 1998, p. 17; Tolfree & Woodhead 1998, pp. 20-21; IAWGCP 2008, pp. 8-9; Lansdown 2005; Early Childhood Rights Indicators Group 2009, p. 78.

6.5. Children Participate ‘In Context’

Figure 2 (right): Social influences on children’s understandings and abilities to participate.

The degree to which a child participates within a particular social setting depends on the level of understanding towards his or her environment as well as everyday human interconnections. A child’s inclusion in a society’s daily affairs is influenced by context-specific elements that are also culturally determined. The ways in which children experience expectations but also support from adults builds the basis for developing a certain sense of self and an attitude towards others. Differences in societies’ cultural structures will lead parents to have different expectations on what skills and behaviours their children should have acquired by the age of five.⁴⁶⁴ Thus, our focus needs to start at the community level as well as taking into consideration the individual child, since each child is subject to specific circumstances, even within the same cultural context.

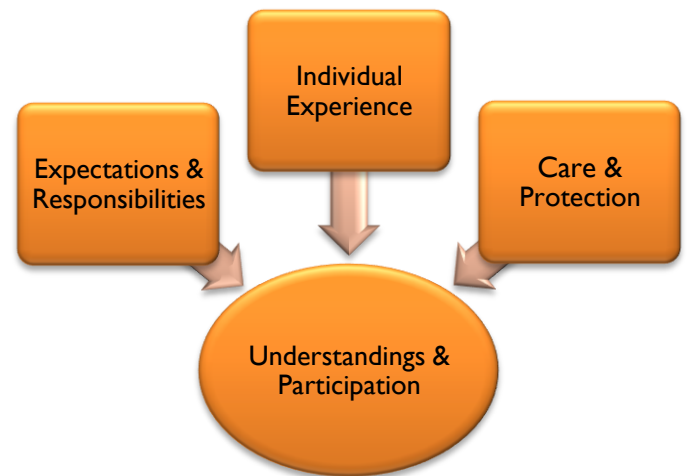
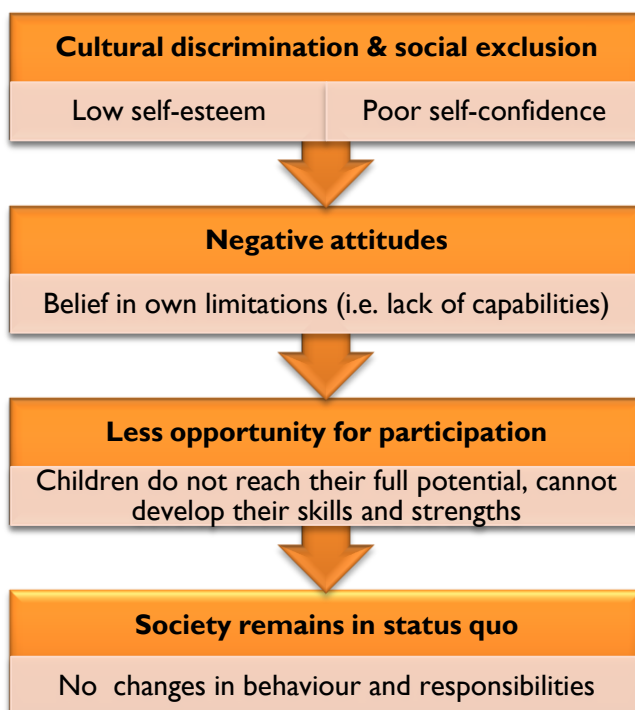


Figure 3: Child Participation and Social Change



Focusing on early childhood and the right for children to participate is not only a question regarding age, but it has further to do with issues about gender, class, ethnicity and the like. Thus, “discrimination and social exclusion will often lead to lower self-esteem, poor self-confidence and less opportunity for participation and the consequent development of skills and strengths”.⁴⁶⁵ If children’s opinions are valued and if children are encouraged to participate from an early age on, they will grow to become adults who are capable of building and maintaining strong communities.

⁴⁶⁴ See, for example, Hess, R. et al. (1980). Research has shown that “in Japan mothers’ expectations focused on emotional control, respect for the status and authority of parents and certain areas of self-sufficiency. In the US, mothers expected earlier achievement of the social skills of empathy, negotiation, initiative, assertiveness and persuasiveness” [UK & Brazil].

⁴⁶⁵ Lansdown 2004, p. 8.

Questions

- What policies are in place that promote the view of young children to participate in all decisions affecting their lives?
- How do we measure participation in children under five years of age?
- How can WV staff promote an awareness of as well as a commitment to implementing child participation within the family and other care giving settings?

7. World Vision Background

7.1. Definition of Participation

World Vision's basic framework for children's right to participate is outlined in the UN Convention on the Rights of the Child (CRC).⁴⁶⁶ Article 12 of the CRC expresses a child's right to participation in declaring that:

"States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."

Article 13 of the UN Convention on the Rights of the Child further states that:

"The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice"

Within the framework of World Vision's Child Well-being Outcomes, children ought to be "respected participants in decisions that affect their lives."⁴⁶⁷ That means:

Children actively participate in decisions that affect their lives (i.e. children describe a family decision about something that concerned them, that they were consulted about and they shared their thoughts or ideas on)

⁴⁶⁶ See also CRC Articles 14 [freedom of thought, conscience and religion], 15 [freedom of peaceful assembly], 17 [access to information], 23 [mentally or physically disabled children as active participants in the community] and 31 [children participate freely in cultural life and the arts]

⁴⁶⁷ WV 2009, *Child Well-Being Outcomes*, p. 1.

7.2. A Biblical Perspective on Child Participation

World Vision's biblical perspective on child participation is that "the human race, including every child, is created in the image of God and given a mandate to participate in the stewardship of God's unfolding Creation (Genesis 1:26-28)."⁴⁶⁸ In accordance with the CRC, the Bible also tells us to value every child as active participant within his or her family who should be guided appropriately by his or her parents. Through human interrelationships children learn to get involved into community life by providing their own opinions and ideas. Jesus himself said: "Let the little children come to me, and do not hinder them, for the kingdom of God belongs to such as these. I tell you the truth, anyone who will not receive the Kingdom of God like a little child will never enter it. And he took the children in his arms, put his hands on them and blessed them" (Mark 10:14-16, NIV). One way to interpret this message may be to recognize 'little children' as setting an example of how we should be open to this world. Small children are not yet shaped by the multiple influences and concerns their parents have to deal with. However, they are very much aware of their immediate environment, their needs and attachment to other people. The fundamental task will be to see and understand the world with children's eyes.

7.3. CWBO Indicators: Children Participate in Decision-making Processes⁴⁶⁹

7.3.1. *Context-specific Indicators*

- Children's ideas are shared and considered (i.e. parents or caregivers cite examples of ideas proposed by children which were accepted and implemented in practice)⁴⁸
- Children who currently participate in a children's clubs or group on a regular basis (at least once a month)
- Children who report that they have been involved in community projects, beyond implementation (i.e. they are at least consulted in the planning or monitoring/evaluation)
- Children plan and implement advocacy or development initiatives or activities in the community
- Communities with child organisations (child leadership committee or forum, child representatives on advisory committees) and a platform for leadership to listen to and consider children's views
- Children have improved confidence and self-esteem as a result of their participation in decision making processes or groups

⁴⁶⁸ WV 2003, *A Biblical Perspective on Child Rights*, p. 12.

⁴⁶⁹ WVI 2009, *Compendium of Indicators - version 1.6: Girls and boys are cared for, protected and participating*, p. 8 [celebration and registration at birth] & p. 9 [children are respected participants in decisions that affect their lives].

⁴⁸ This indicator should be disaggregated by gender.

- Children are satisfied with their level of their participation in decisions that affect them
- Schools with active children's councils, representatives or similar system, to ensure children's voices are heard by school boards and influence decision making
- Parents and caregivers listen to children's ideas and involve them in decisions that affect their lives
- Children know that it is their right to participate in decisions that affect their lives
- Children are asked their opinions but have little choice about the way that they can express those views or the range of ideas they can express

7.3.2. *National Level Indicators*

- Existence of national child parliament or child representatives to parliament
- Child parliamentarians who are OVCs or from traditionally marginalised backgrounds
- National policies for child protection and wellbeing explicitly call for child consultation and participation
- Children have opportunities to interact with and influence government leaders and decision makers
- Policies are created to formally recognize children and young people's participation/representation in disaster risk reduction structures and local and national government decision-making processes
- Accountability and transparency mechanisms are in place for disaster risk reduction resource management or oversight at the community level, involving CYP

World Vision's CWBO indicators for child participation may be less applicable for young children on the national level, considering that this would include children's active contribution to government decisions in the political realm. Nonetheless, on the community level there is much room for children to get actively involved in decision-making processes within their families, in public institutions (e.g. day-care centres, pre-schools and the like) as well as in WV development programming in its early planning and monitoring stages.

8. Participation: Research & Development (R&D) *with or about* Children

Fundamental to the concept of child participation in development processes is the notion that children are *active* citizens within their communities, not passive observers. This view corresponds with Article 12 and 13 of the UN Convention on the Rights of the Child (CRC) in saying that children are not merely passive recipients of adult care and protection. Rather, children of all ages have the right to express their views - that is they actively participate - in all matters affecting their lives (see section 2.1, p. x). However, depending on children's levels of understanding (in particular determined by age) we also have to distinguish between different levels of participation.

Lansdown (2004) suggests three different degrees of participation:⁴⁷⁰

1) **Consultative processes**

- Adult initiated
- Adult led and managed
- Lacking any possibility for children to control outcomes

2) **Participatory processes**

- Adult initiated
- Involving partnership with children
- Empowering children to influence or challenge both process and outcomes
- Allowing for increasing levels of self-directed action by children over a period of time

3) **Self-initiated processes**

- The issues of concern being identified by children themselves
- Adults serving as facilitators rather than leaders
- Children controlling the process

Lansdown (2005) adds that "all [degrees of participation] are valid and necessitate a commitment to listening to children and taking them seriously but allow for differing degrees of actual engagement. However, it is important to recognise that the boundaries between them are rarely clear cut, and many initiatives can span more than one level".⁴⁷¹ In this context, we may conclude that child participation in fact occurs on various levels, though it is generally measured by the ways in which interactions between adults and children take place. How could this be referred to different levels of involvement with regard to WV research and development programming?

⁴⁷⁰ Lansdown 2004, pp. 6-7.

⁴⁷¹ Ibid, p. 7.

World Vision defines four categories of research *with* or *about* children:

- 1) Research about children, with children's active participation
- 2) Research about a subject that is indirectly related to children
- 3) Research about children, without children's active participation
- 4) Research about a subject that is indirectly related to children, without children's active participation

“Research *with* children implies that children are active participants in the research process”

“Research *about* children implies that children are the subjects of the research”

World Vision's present focus is predominantly on category 3, however the organisation's aim is towards focusing more on category 1.⁴⁷² In the following section we will be looking at two examples of how even very young children may be able to contribute to development programming.

9. Early Childhood Participation Models

9.1. The Mosaic Approach

The Mosaic Approach can be understood as a methodology that “[brings] together different pieces of information or material to make a picture from children's viewpoints”.⁴⁷³ This approach can be a valuable tool in participatory research on young children because it acknowledges their own perceptions and aims at working together *with* children to understand their individual viewpoints. More specifically, observational and interviewing methodologies can be combined with methods that enable especially young children to contribute their own thoughts and ideas, for example, by using certain visual tools such as cameras or drawing pictures.

This can have a very positive effect on children's development regarding their sense of self (identity) and control over their lives. The mosaic approach may be a useful method to facilitate young children's engagement into research in providing a forum for better adult-child communication. This means that young children are enabled to articulate their feelings and experiences of their own world to adults. For example, Clark and Statham (2005) explain two studies in which children aged three and four years defined and explained their experiences of certain spaces they used to live in. They expressed their feelings in association with particular people, (access to) places, objects and routines. The authors also list several tools that can be applied as part of the mosaic approach:

⁴⁷² WV 2007, *WV's Draft Guidelines For Research & Development (R&D) with or about Children*

⁴⁷³ Clark & Statham 2005, p. 47.

- Child observation (narrative accounts)
- Child interviews (short and structured)
- Cameras and book-making (children take photographs of important things in their environments and put them together in a book)
- Child-led tours (children direct tours of the site)
- Map-making (children represent the site using drawings or photographs)
- Magic carpet (slide show of familiar and unfamiliar places, i.e. an ‘imaginary journey’)
- Adult interviews (informal, practitioners-parents)

The mosaic approach has proved itself to be a useful tool in the design of certain projects. For example, in one study conducted by Clark and Moss (2001) in England, children under five were given early disposable cameras to capture things that were important to them within their environment. By using this method, adults were able to gain young children’s own views on the appropriate design of an early childhood centre.⁴⁷⁴ In sum, the mosaic approach acknowledges that “children are experts in their own lives” and gaining access to their worlds requires us to facilitate and listen to children communicating in their own languages.⁴⁷⁵ First and foremost, however, it is important to understand that this approach is not only essentially child-focused (see our brief discussion in the introductory part of this paper) as well as aiming to actively work together with children, but it is also applicable to children of all ages, even the very young.

Further readings

Clark, A. 2005, ‘Ways of seeing: using the Mosaic approach to listen to young children's perspective’, In A. Clark, A. T. Kjørholt & P. Moss (eds.), *Beyond listening: Children's Perspectives on Early Childhood Services*, Policy Press, Bristol, UK.

Clark, A. 2006, *Spaces to Play: Gathering Children's Perspectives*, Thomas Coram Research Unit, Institute of Education, London, UK.

9.2. The Child-to-Child Approach

The Child-to-Child Approach (CtC) strongly incorporates elements of World Vision’s holistic viewpoint as well as the organisation’s rights-based approach to child participation and can be a valuable tool in early childhood development. “The Child-to-Child Approach is an educational process that links children's learning with taking action to promote the health, wellbeing and development of themselves, their families and their communities. Through participating in Child-to-Child activities⁴⁷⁶ the personal, physical, social, emotional, moral and intellectual development of

⁴⁷⁴ Clark & Moss 2001.

⁴⁷⁵ Clark & Statham 2005, p. 54.

⁴⁷⁶ With regard to an early childhood focus, CtC particularly emphasizes the notion of ‘play’. For further information see Otaala & Rajagopalan 2003; Child-to-Child Trust 2004, pp. 141-155.

children is enhanced.”⁴⁷⁷ In this context, the CtC sees children as ‘agents of change’, as ‘partners’ of and ‘co-researchers’ with adults.⁴⁷⁸ In other words, the child-to-child approach considers children to be not only the ‘objects’ of development programming, but rather the participating ‘subjects’ in the actual planning processes.⁴⁷⁹

The approach further links child rights with responsibilities in order to develop a sense of partnership between children and adults as well as in enhancing children’s self-esteem. The problem is still that despite children’s early involvement in domestic and productive work within the family setting, their capacities for decision-making as well as their overall status remains low. The child-to-child approach has originally been targeted towards older children, with the assumption that younger children would automatically benefit in this way. However, in recent years it has been more and more recognized that focussing on young children directly will have much greater benefits for them. The Child-to-child Trust explains the fundamental process of this approach in terms of several steps that are applicable in diverse cultural contexts. Its major advantages are: ⁴⁸⁰

- It links what children *learn* with what they *do*
- It links what children do in *class* (the *learning place* in the diagram) with what they do in the *home* or *community* (the *living place*)
- The activities are not taught in one lesson and then forgotten; they are learned and developed over a longer period of time.

The child-to-child approach is closely linked to issues concerning all other CWBOs. This particularly includes elements regarding health education, ECCD programming as well as interactions on the household level.⁴⁸¹ Most importantly, CtC helps children to gain credibility within the adult realm. That is to say adults including teachers, parents and other caregivers become much more aware of children’s competencies which can also positively influence their attitudes and behaviours towards younger generations. Essentially, CtC acknowledges that children are “expert observers of their environment with an intimate understanding of the social conditions in which they are living”.⁴⁸² Young children need to be regarded as participants to, rather than recipients of development assistance. They need to be responded to, rather than just making decisions as well as acting for them.

⁴⁷⁷ Child-to-Child Trust 2009, *CtC: Our Approaches*, viewed 14 April 2010, <http://www.child-to-child.org/about/approach.html>.

⁴⁷⁸ Pridmore 2003, p. 4.

⁴⁷⁹ Gibbs, S., Pridmore, P. & Zaveri, S. 2003, ‘Promoting children’s participation’ in P. Pridmore, *New Directions for Child-to-Child*, London, UK.

⁴⁸⁰ Child-to-Child Trust 2004, pp. 121-122.

⁴⁸¹ Child-to-Child Trust 2004.

⁴⁸² Gibbs et al. 2003, p. 30.

10. Recommendations for Action

1) Recommendations for policy makers

- ◆ Bring early childhood care, protection and participation into the political discourse!

2) Recommendations for ADP staff

- ◆ Be sensitive to culturally-determined differences in early child care practices, because they are not universally the same; e.g. what may be considered to be an acceptable way of punishing young children in one context might not be acceptable in another (see also different forms of child abuse).
- ◆ Take on a cultural relativist approach:
 - 4) Gain an understanding of other people's values in terms of their own culture
 - 5) Engage in a dialogue with community members to achieve a mutual understanding among all stakeholders (i.e. beneficiaries as well as programming staff) of how young children ought to be treated in ways that is in their own best interest; e.g. use focus group discussions (FGDs) on early childhood care and protection
 - 6) Do NOT tolerate abusive behaviours towards young children
- ◆ Be aware that a community is not a homogenous unit, i.e. adults and children within the same community may experience their environments very differently (depending on factors such as gender, ethnicity, social class and so forth).
- ◆ Be aware of socio-cultural, economic and political power structures on the local level that 1) include or exclude certain individuals, and 2) influence the adoption or rejection of early child care models.
- ◆ Raise awareness on the individual, family and community level about *all* children's rights to be protected and participating:
 - 3) Identify infants and young children that are particularly at risk of lacking protection and social inclusion (e.g. migrants, ethnic minorities, girls, children with disabilities, orphans, children affected by HIV and AIDS and so forth)
 - 4) Develop ways of better protecting and integrating marginalised U5s into their families and community daily life
- ◆ Use practical learning games that involve community members from all different levels in order to communicate issues on child protection to adults as well as children.

- ◆ Improve birth registration (i.e. availability and accessibility) for infants and young children to provide them with an identity as well as with access to basic social services.
- ◆ Implement care models that are in the best interest of the young child
 - 3) First preference: Strengthen existing family bonds and relationships between young children and their key attachment persons; i.e. the family as primary unit in which a child should grow up
 - 4) Alternative models of care: Contextualize possible solutions for the individual child if the family setting does not provide children with adequate protection; i.e. parents are unable to care for their children properly or children are getting abused (physically, emotionally or spiritually)
- ◆ Ensure high child protection standards when carrying out fieldwork locally; be responsible for the protection of the children you are working with.
- ◆ Train yourself and others to understand the specific needs of infants and young children; avoid to only making assumptions about what children's preferences are.
 - 4) Listen to children and take them seriously
 - 5) Develop tools that enable us to correctly interpret children's needs; i.e. see the world with children's eyes
 - 6) Involving children more actively in decision-making processes

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Conclusion

Early childhood development (ECD) is a crucial period in terms of children's vulnerability to certain risks as well as regarding its determinative effect on later development processes. ECD is also an area to be considered in an effort to break the vicious cycle of intergenerational poverty. As a basic framework, World Vision's *Child Well-being Outcome* are of great value, though in terms of a specific focus on early childhood there is a need for adaptations, including clarifications regarding certain terminologies and means for measuring particular outcomes. In this context, the World Vision Institute aims to encourage an ongoing dialogue and knowledge exchange within the WV partnership as well as in collaboration with scientific experts. There are several themes in relation to ECD that should be analysed more in-depth, such as issues regarding foundational life skills education, measurements for spiritual wellbeing and nurture as well as definitions of and requirements for participation of children under five. Considering the complex interconnection between WV's CWBOs as well as cross-cultural differences in understanding them, the issue of contextualisation is predominant in development programming. Another essential message is that we have to take children seriously (no matter their age), as they are very much aware of their immediate environment and already capable of communicating their needs. Most basically, the concept of early childhood development is a social construct and we need to look beyond common assumptions that have assigned young children a passive role within their communities. Infants and young children must not be seen as being separate from their social environment and thus there is need to work in close collaboration with parents and local institutions, in particular with regard to behaviour change communication. Essentially, in order to develop a more specific knowledge base on ECD we need to create a forum for discussion to share ideas and research material. Building a pool of experts is the first step to constructive knowledge exchange in order to eventually develop frameworks and guidelines that are actually applicable in the field. Finally, we should note that tackling development issues in early childhood is not a cure for solving problems later in life. But, improving ECD processes is an essential part, in fact it is THE starting point, of World Vision's holistic perspective on child well-being. We only have this opportunity once, and if we miss it then our children will have to pay a high price, now and in the future.

Early childhood development (ECD) is a crucial period in terms of children's vulnerability to certain risks as well as regarding its determinative effect on later development processes. **A lack of basic needs during early childhood can lead to severe negative impacts in later lifecycle stages; some deficits have irreversible consequences.** ECD is also an area to be considered in an effort to break the vicious cycle of intergenerational poverty. Focusing on early childhood will be a most useful and cost-effective strategy for World Vision's goal to reduce child poverty as a whole. The starting point is to raise awareness of the importance of children's early development stages as the best time to start tackling this overall objective.

As a basic framework, World Vision's Child Well-being Outcome (CWBO) are of great value, though in terms of a specific focus on early childhood there is a need for adaptations, including clarifications regarding certain terminologies and means for measuring particular outcomes. This research paper is based on a broad review of past and recent literature in addition to support provided by experts within WV International and science.

All WV's CWBOs - with regard to health, education, spiritual nurture and child protection, care and participation - are essentially interlinked and pose a similar set of questions, namely: to what extent have issues on ECD been directly incorporated into the existing set of WV's CWBO indicators? How are the different forms of 'well-being' in early childhood to be defined and measured? How can these indicators be contextualised on the local level? The findings of this paper provide a broad overview of relevant themes relating to early childhood and leave much room to investigate individual topics more in-depth.