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Mr. Chairman, thank you for this opportunity to testify before the Subcommittee on the important issue of health and nutrition, particularly in the first 1,000 days window. I greatly appreciate your interest in this topic and hope that my testimony today will shed some light on how NGO's and faith-based organizations like World Vision are improving nutrition for mothers and children around the world.

Kent Hill sends his apologies that he was too ill to testify today. I am going to do my best to fill his shoes. My name is Lisa Bos and I am the senior policy advisor for health, education and WASH at World Vision US. World Vision is a Christian humanitarian organization working to improve the lives of children in nearly 100 countries. We have donors in every U.S. state and congressional district who support our ongoing work.

Good nutrition is an essential foundation for health and development, yet malnutrition continues to be the world's most serious health problem and the single biggest contributor to child mortality. As one of the largest private humanitarian organizations, World Vision has made addressing malnutrition a top priority as part of our approach to improving maternal and child health.

World Vision has several recommendations for what the US Government can do, and where Congress should focus when exercising its oversight, budgeting, and appropriations responsibilities, to contribute

to the best outcomes for mothers and children. We base them on our 63 years of relief, development, and advocacy experience and expertise and the evidence of what is most effective and efficient.

1. Prioritize community-based initiatives. Our experience shows that ownership by the community and involvement of key community leaders, such as faith leaders, is critical to ensuring changes in behavior that lead to improvements in maternal and child health.
2. Approach a child through the life-cycle, concentrating the start of life at conception through the first two years, and concentrate interventions, like those to ensure adequate nutrition, on these initial 1,000 days.
3. Ensure that food is adequate in volume and nutrition.
4. Include nutrition outcomes as an explicit objective of U.S. agricultural and other food security assistance programs.
5. Focus initiatives for mothers on their time of pregnancy, ensuring they are well-nourished, able to provide sufficient nutrition for their children, and give birth to healthy children.
6. Support and scale-up interventions that are proven to be effective, like breastfeeding, skilled birth attendants and frontline health workers, healthy timing and spacing of pregnancies, and consistent, safe access to clean water and sanitation.
7. Focus breastfeeding programs on support for mothers immediately after and in the 24 hours following childbirth, and continue through the first two years of life.
8. Improve partnering with NGOs, especially faith-based NGOs, including by consulting with them earlier and more consistently, leveraging public and private funding, coordinating and collaborating between initiatives regardless of funding source, and prioritizing initiatives aimed at improving governance at the local and national levels in the countries of partnership. Given the value-add of the rich community-based networks which FBOs possess, it makes sense to capitalize on these connections.

World Vision launched its Global Health and Nutrition Strategy in 2008. It provides the overall framework for achieving our Child Well-Being Outcomes in health and nutrition. We are committed to improving the health and nutrition of women and children, and contributing to the global reduction of under-five and maternal mortality. The strategy therefore focuses World Vision's health programming on preventive, community-based interventions for improved health and nutrition for mothers and children.

World Vision's Global Health and Nutrition Strategy takes a life-cycle approach, focusing on nutrition and related sector interventions throughout the life cycle. The first and highest-priority phase targets child development during the first 1,000 days: from conception through the first two years. A significant proportion of undernutrition begins in utero and results in low birth weight, particularly in Asia. Around the world, chronic undernutrition commonly develops in the first two years of life, with lifelong implications for health, education, and economic opportunities.

The first 1,000 days is the time with the highest risk of child mortality, as well as the period of most rapid physical and brain growth. Exposure to chronic malnutrition during this critical window can result in stunting which leads to impaired brain development, robbing a child of the ability to reach his/her full potential. There is strong evidence of the correlation between malnutrition and stunting, and long-term health and individual earning capacity. Therefore, it is critical that children receive good nutrition within this “window.” Interventions that prevent undernutrition during this time can be much more effective than those that target children who are already undernourished (for children already undernourished, nutrition initiatives however are still essential to ensure their survival and improve their health as much as possible) and prevention is at the core of all of World Vision’s work in health, nutrition and food security.

“Children are well-nourished” is one of World Vision’s Child Well-Being Outcomes, a goal for every child in every place we work. This means not only that children have enough food to eat, but also that the food is nutritious. It also means that we focus on mothers during and after their pregnancies to ensure that they themselves are well-nourished so that they can have healthy babies and can effectively breast feed.

Breastfeeding is the first, and best, cost-effective intervention for newborn babies. Breast milk maximizes a child’s physical and mental potential by supporting the rapid growth and critical brain development that occurs from birth to two years of age. Appropriate breastfeeding has a high impact on reducing infant and child mortality. It should start immediately (within the first hour of birth) for the infant to benefit to the maximum. Whenever possible, infants should be breastfed exclusively, with no other liquids or solids, and on demand until six months of age, and then mothers should continue breastfeeding until the child is at least two years old, with complementary feeding introduced beginning at six months. Especially in countries that continue to have low initial and length of breastfeeding rates, programs need particularly emphasize support to mothers immediately after birth and within the first 24 hours when positioning and attachment are so important to early success.

Cost analysis of breastfeeding programs range from $0.05 to $0.95 per capita annually. World Vision has found that the cost decreases as programs scale up; in programs with 150,000 to 250,000 participants, our experience indicates a cost on average of $0.25 per child.

There are challenges with breastfeeding programs, however, as critical factors come into play which impact a mother's ability to breastfeed her child until the critical age of 2. For example, if a mother becomes pregnant again, she may prematurely stop breastfeeding, often leading to significant malnutrition. So programs like those that support the healthy timing and spacing of pregnancy are also critical to ensuring the success of breastfeeding programs, which is why World Vision uses approaches that integrate nutrition specific interventions – direct interventions like breastfeeding – with nutrition sensitive interventions like birth spacing education and WASH programs. But while we're speaking directly about the thousand days approach to lessen malnutrition and improve health, I think it's very important to note that World Vision views our work through a gender-focused lens that provides us with an opportunity to look closely at all of the factors within a mother's life that will either help her to sustain new behaviors and beliefs or that can prevent the adoption of the desired behaviors. Creating that enabling environment for success is key to helping mothers and their young children become truly resilient.

To that end, there are specific approaches that World Vision uses in our development programming which directly address the maternal and child health needs of communities but also allow for context specific adaptations where economic strengthening is a critical component for improving the lives of mothers and children. The 1,000 days approach fits squarely within our food security framework, along with factors like WASH, gender, resilience, and economic strengthening.

Timed and targeted counseling (ttC) is an integral part of WV's development programming, which is being rolled out globally. Community health workers (CHWs) and volunteers provide primary health care and nutrition counseling at the individual/household level for influencing behavior change, using a cohort and lifecycle-specific approach. Information given is timed to when behaviors can best be put into practice and targeted to both those who practice the recommended behaviors and those who influence adoption of the behaviors. The approach targets the whole household—husband, in laws, and other influencers of behaviors—and is therefore, able to promote issue awareness, knowledge, behavior change, demand for services, and identification of social barriers, ultimately empowering caregivers and children to keep themselves healthy.

Community health workers and volunteers make a series of visits to households with pregnant women and mothers of children under age 2, organizing a series of health and nutrition messages to be communicated at the most appropriate times, using a counseling and dialogue-based approach. The visits are timed and targeted according to the "life cycle" approach (early pregnancy and mid-pregnancy visits; late pregnancy/first week of life, and one month visits; and visits at 6 months, 9 months, 18 months, and 24 months of age). Caregivers are provided with information, counseling, and support to promote the practice of healthy behaviors.

In emergencies and areas with high levels of acute malnutrition, World Vision uses the Community-based Management of Acute Malnutrition (CMAM) approach to rehabilitate malnourished children. CMAM uses a case-finding and triage approach to match malnourished children with treatment best suited to their medical and nutritional needs.

With the CMAM method, most malnourished children can be rehabilitated at home with only a small number needing to travel for in-patient care. Families of all CMAM participants, as well as children with moderate malnutrition, receive supplementary food rations to help prevent a decline in nutritional status. CMAM programs also work to integrate treatment with a variety of other longer-term interventions that are designed to reduce the incidence of malnutrition, and improve public health and food security in a sustainable manner.

The financial cost to address acute malnutrition is high, usually because there is a lack of functioning infrastructure, trained staff and health services, and limited food availability. With CMAM, malnourished children are found and treated early, before complications occur and more costly inpatient treatment is required. However, despite the success of programs like CMAM, investments in better health infrastructure and investments to address chronic food insecurity in communities would help in the long term to reduce the need for more expensive interventions. CMAM funding is provided mainly through the Office of Foreign Disaster Assistance (OFDA) within USAID for emergencies. We would recommend that USAID also expand funding for interventions like CMAM in development programs in countries with high levels of acute malnutrition, such as India, Nigeria, and Indonesia, which currently have very low rates of CMAM coverage.

I'd like to also share a bit about a USAID-funded Food Security and Risk Reduction Development Assistance Program – or DAP – in western Honduras that World Vision implemented over five years. Kent Hill was able to visit this program in 2011, two years after its completion.

Like most Food for Peace development food aid programs, it enabled us to integrate effectively all that is needed to make progress on nutrition and food security for the most vulnerable. Even more important, in this case, coordination between the DAP and a World Vision privately-funded program in the same part of Honduras strengthened nutrition outcomes made possible by the giving of thousands of individual Americans over the course of the next several years. Because of USAID's role, the Honduran DAP enabled World Vision to initiate the direct participation of local governments.

The municipalities in western Honduras had not previously addressed the problem of malnutrition in a concerted manner. When the DAP started in 2004, more than half of Hondurans lived in extreme poverty, with 72% affected by food insecurity. Children's high levels of malnutrition – 46% chronic malnutrition, 30% under-weight, and only 23% of newborns receiving exclusive breastfeeding – were not addressed locally because nutritional interventions were centralized in the Ministry of Health. Through the DAP, World Vision spurred 17 local governments to introduce food security and nutrition in their development plans and budgets for the first time.

In 2011, USAID evaluated the DAP for sustainability. It was shown that, two years after USAID funding ended, we sustained the seven percent decrease in underweight children thanks to dramatically improved access to trained nutrition workers and maternal education. Skilled birth attendants now served under local community ownership. Household food security continued to improve. Farmer field schools piloted under the DAP had become well established. Local government services were strengthened. All of this benefited 128 communities and more than 157,000 people in the western part of the country.

I use this example from Honduras because it illustrates clearly the role the US government can play in helping partners leverage other programs and funding opportunities to develop strong, sustainable programs with community ownership and results. This is the type of collaboration that the US government needs to continue to support with NGOs, since these NGOs are a vital partner in promoting sustainability in community-based programs.

Addressing nutrition as part of maternal and child health programs is critical to reducing stunting and reducing the number of preventable child deaths where malnourishment is often an underlying cause. In many cases, these interventions are not costly and lead to behavior change that is sustainable generation after generation. With the new USAID nutrition strategy, we are hopeful that nutrition programming and outcomes will be better aligned across government agencies. A large piece of the strategy is the need to scale up interventions. Implementing partners like World Vision are well positioned to play a key role in this part of the strategy, particularly at the community and household level where interventions are most needed and where we have been working side by side with communities for years.

Achieving our goal for improving maternal and child health also depends on integrating multiple actions and behaviors to promote nutrition. It means helping people get not only the proper amount of calories but also nutrient-dense foods as well. Nutrition outcomes MUST be an explicit objective of U.S. agricultural and other food security assistance programs, particularly for a child's first 1000 days, starting with a mother's pregnancy.

Some of the best maternal and child nutrition outcomes are found with the Title II Food for Peace programs, which reduce stunting of children while also improving household incomes and household dietary practices. They provide good examples of how nutrition-specific activities – such as exclusive breastfeeding until 6 months and appropriate complimentary foods after 6 months – and nutrition sensitive activities – such as potable water, sanitation, and production of more nutritious foods – work together to improve child nutrition.

The role of the faith community is also vital if we are going to reach the most rural and hard-to-reach communities. We have found that educating and mobilizing faith leaders to talk to their congregations and communities about what are sometimes viewed as "taboo" child and maternal health issues can be the most effective catalyst for change. The U.S. government must continue to engage deeply with the faith community to ensure that programs recognize the convening power and reach of faith-based organizations in the developing world.

World Vision engages faith leaders because most people in the world have a faith of some kind. The Pew Research Center's Forum on Religion & Public Life reports that 5.8 billion adults and children are

affiliated with a religion, 84% of the 2010 world population of 6.9 billion. We see this first-hand as a faith-based organization working in more than 100 countries.[1] So faith leaders have considerable influence in their communities. Unfortunately, like other leaders, some faith leaders sometimes spread misinformation, creating social barriers that prevent people from visiting clinics, receiving vaccinations, and using birth spacing methods. Misguided influence can also encourage child marriage and the poor treatment of women and girls, and discourage the involvement of men in maternal and child health. Our training process for faith leaders replaces misinformation and stigma with truth and acceptance. Our program teaches about birth spacing and the importance of good nutrition for children and pregnant women. It encourages greater involvement of men at all levels (family planning, HIV testing, health visits of mother and child, etc.).

All too often, development programs focus on supply of commodities or services to communities. This does not necessarily lead to better child or maternal health outcomes if the demand for services is not there. This again is where US government programs could be doing better in their work with NGOs, and in particular faith-based organizations, because FBOs are well positioned to generate community level demand for improved health service delivery and enable multi-sectoral integration to advance results. We are also well positioned to engage local faith communities and civil society to ensure that local and national governments are meeting their commitments to maternal and child survival, which is a key component for long-term sustainability and country ownership of maternal and child health programs.

I also want to make sure we don't lose sight of the need to respond to the needs of mothers and children in fragile and conflict-ridden communities, such as South Sudan. World Vision staff have seen the deplorable health conditions that are affecting over half of that country which is currently embroiled in a political and military crisis. This conflict has caused the death of thousands of people over the last several months. We have a firsthand understanding of the importance of the investment of USAID/OFDA in providing lifesaving materials such as clean water, sanitation supplies and facilities, food and other lifesaving goods for, most critically, women and children. The support of USAID in South Sudan is keeping that country alive through this critical time in its nascent life especially with the current political crisis in the country.

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[1] Pew Forum on Religion and Public Life, "The Global Religious Landscape: A Report on the Size and Distribution of the World's Major Religious Groups as of 2010," December 2012: www.pewforum.org/2012/12/18/global-religious-landscape-exec

Along with providing critical lifesaving supplies, USAID is providing needed support through its JHPIEGO grant to World Vision, which has helped to start to develop the country's health system. In addition to the immediate lifesaving support, we would ask that the support to the country's health system continue where the conflict has not "hit " – in places like Western Equatoria, for example. We sometimes see in places like this that important health work can be overshadowed by conflict in other parts of the county. By providing this support, it will ensure the continuation of essential health services to people not only affected by the crisis, but also in the host community. By assisting stable locations in the country to receive health services, there will also be an extra added incentive for communities and parties to "keep the peace" in their areas. All that I have said here about South Sudan also applies to Somalia; there is much work in health programs that should be done in this fragile state.

Improved health for the world's poorest people is not only a moral imperative but also a pragmatic investment for peace, security, and worldwide economic growth and nutrition. Thank you, Mr. Chairman, for this opportunity to testify today and I look forward to our continued discussion on how we can better respond to the needs of mothers and children around the world. I welcome any questions you may have for me.