DISCUSSION GUIDE FOR “CHILDREN IN CRISIS”
a video interview with Dr. Paul Wise

Developed by Dr. HyoJung Jang, SPICE

Organizing Questions

• What is the primary goal of the Children in Crisis program?
• Why is it important to understand the political and economic situations in an area in terms of the coordination of health services in that area?
• What are some examples of partnerships in the Children in Crisis program?
• What are some of the challenges faced by the Children in Crisis program?
• How is technology being utilized by the Children in Crisis program?

Summary

In this video, Dr. Paul Wise explains the primary goal of the Children in Crisis effort, which is to improve the health of children in the most difficult places in the world to work. The Children in Crisis program is different than many other efforts to provide services to children in these areas in that he sees the coordination of the best health services with the best understanding of the political and economic situations in the area as fundamental. He sees the need to have pediatricians, nutrition specialists, nurses, a whole variety of people who have technical health skills to work closely with political scientists—including people who worry about global security—in order to come up with new solutions, solutions that can actually function in these environments.
Introduction

Objectives  During and after the interview, students will:

- learn about the Children in Crisis program and what it does;
- learn about the nature of children’s health crises in areas of civil conflict and unstable governance;
- examine some of the complexities and challenges in delivering health services, with perspectives from political science, security, and health services;
- discuss the importance of building global-local partnerships to implement the interventions in an effective and sustainable way; and
- explore creative ways to solve some of the remaining challenges in addressing children’s health crises around the world.

Materials  Handout 1, Video Notes, 30 copies
Teacher Information, Video Transcript
“Children in Crisis” video, online at: https://spice.fsi.stanford.edu/multimedia/children-crisis

Equipment  Computer with Internet access and speakers
Computer projector

Teacher Preparation  Instructors and materials are based on a class size of 30 students. Adjust accordingly for different class sizes.

1. Make the appropriate number of copies of Handout 1, Video Notes.
2. Set up and test computer, projector, speakers, and video before starting the lesson. Confirm that you are able to play the video with adequate audio volume.

Procedures  1. Begin the lesson by leading students in a brief discussion about the importance of children’s health in their early years and what students currently know about children’s health around the world. Some suggested discussion points are provided below.

a. Children’s health in their early years is critical for their development and life course. How would you define children’s health and why? You may consider some of the components that influence children’s health, such as nutrition, hygiene, sanitation, physical stimulation, and so forth.

b. Relatedly, what measures would you use to assess children’s health? Some examples are children’s physical growth measurements, such as height and weight, and/or the presence of health conditions or diseases, among others.

c. What factors or conditions influence children’s health? You may think about individual-, family-, and societal-level factors that
may shape children’s health. For instance, environmental factors, the presence of caregivers, health care services, and policies and programs aimed at providing information and necessary intervention services to children, and the quality of the care from caregivers can influence children’s health. In addition to a potential lack of health services, parents and caregivers may not know much about children’s health conditions and what to do about them. For instance, they may lack information about nutrition, hygiene, and growth milestones.

d. Stunting (the impaired growth and development that children experience from poor nutrition, repeated infection, and inadequate psychosocial stimulation) and child mortality (the probability of dying between birth and exactly five years of age expressed per 1,000 live births) are some of the remaining issues in many parts of the world. Why would it be important to learn about and address that all children are healthy, growing, and developing well?

2. Inform students that they will now consider children’s health issues around the world in greater depth and some of the efforts to address them by watching a video lecture “Children in Crisis,” featuring Dr. Paul Wise, Professor of Pediatrics and Health Policy at Stanford University School of Medicine and a Senior Fellow at the Freeman Spogli Institute for International Studies, Stanford University.

3. Distribute one copy of Handout 1, Video Notes, to each student, and instruct students to complete the handout as they view the video. Allow students to read through the handout before they watch the video.

4. Play and project the video “Children in Crisis.” If necessary, allow students a couple of minutes to finalize their notes after the video ends.

5. Lead a classroom discussion to review and debrief the video. Some suggested discussion points are provided below.

a. What is the Children in Crisis program and its goal, according to Wise?

Wise says that “The primary goal of the Children in Crisis program is to improve the health of children in the most difficult places in the world to work” especially “in areas of civil war, conflict, chronic political instability, and areas where the governments don’t function very well.” In short, Children in Crisis is a multidisciplinary and multi-sectoral effort (drawing on expertise of “pediatricians, nutrition specialists, nurses, a whole variety of people who have technical health skills, and political scientists”) to provide quality health services to children in some of the most disadvantaged places on earth.

b. What are some benefits that Children in Crisis can provide?

It can improve the health of children who are (or at a high risk of being) malnourished, stunted, and/or suffering from infections and who

1 https://www.who.int/nutrition/healthygrowthproj_stunted_videos/en/
2 https://www.unicef.org/infobycountry/stats_popup1.html
otherwise do not have access to health services due to economic and political factors of the country or region in which they live.

c. How is the Children in Crisis program different from other efforts? According to Wise, “The Children in Crisis program is different than many other efforts to provide services to children in these areas in that we see it as fundamental the working together the coordinating of the best health services with the best understanding of the political and economic situations in the area. Therefore, we need to have pediatricians, nutrition specialists, nurses, a whole variety of people who have technical health skills work closely with political scientists, people who worry about global security, in order to come up with new solutions, solutions that can actually function in these environments.”

d. In which countries/world regions in Children in Crisis in operation? What are some of the political and economic situations like?
   Central Africa, Central America (including Guatemala), the Middle East, and Southeast Asia. Political instability due to civil wars and other factors, and extreme poverty are some of the characteristics of some of countries in these regions.

e. What does the global-local partnership model look like in providing health services for children in some of the most difficult places?
   According to Wise, Children in Crisis teams “always work with local partners” rather than having a team of experts from Stanford “parachuting in to work.” Thus, the global-local partnership model is essentially “building long-term, strong relationships with groups that have long been committed to working in these areas.”

f. What are some advantages and challenges in building partnerships with local “partners working on the ground”? How does that make a difference?
   According to Wise, it can produce “greater confidence that the kinds of strategies being developed will actually function in the real world.” More effective and local-specific solutions are possible. (Answers may vary and can include: greater success for the intervention program, sustainability of the program, ownership from the local community, local-specific strategies and solutions, etc.)

g. Which country in Central America does Wise say is “one of the primary commitments”? What conditions in that country have “created major challenges and generated profound challenges for the provision of services like child health services”?
   Guatemala, and its “civil conflict, political instability, and extreme poverty has created major challenges and generated profound challenges for the provision of services, like child health services.”

h. What is the community health worker program? What do the community health workers do?
   The community health worker program is a program that “tackles the problem with nutrition and infection” among children in villages. The community health workers go “out in their communities to take the height
and weight of every child from birth until the age of five every two months
to try to identify any child that is beginning to fall off their growth curve
and then intervene.” This addresses the problem with nutrition and
infection, which can lead to stunting and even death. The community
workers also implement the intervention program that “includes food
supplementation, which is giving highly nutritious food to the family,
working with the parents (particularly the mother) to improve the child’s
nutrition to try to address the infections that keep on coming.”

i. What is the number of children under the program at any given
time?
1500 children in the program at any given time. (About 20 villages)

j. What does “taking the height and weight of every child from birth
until the age of five” measure and screen children for?
Malnutrition and infections, which can lead to stunting and even
premature death.

k. How has the program improved child mortality, severe
malnutrition, and hygiene?
The intervention program includes “food supplementation, which is
giving highly nutritious food to the family, working with the parents—
particularly the mother—to improve the child’s nutrition to try to address
the infections that keep on coming.” “The child mortality rate has fallen
dramatically with this program. And severe malnutrition has virtually
been eliminated because the program catches children before they become
severely malnourished and gets them back to a more normal growth curve
because of the intervention program before they can really fall into this
very deadly spiral of an infection and poor nutrition.”

l. What were some of the challenges and how were they addressed?
The time required to train local community health workers, which was
about “three years of ongoing work and training,” was too long and a
barrier to disseminate this to other communities. To address this problem,
they collaborated with the Computer Sciences Department at Stanford
University to create a mobile application that graphs and interprets the
height and weight data recorded by the community health workers. Now
the training time is three months and the usage of the app on a tablet leads
the community health workers to “the appropriate protocol for how to
intervene.”

Optional Activities
For a more in-depth exploration of the topics and themes raised in the
video lecture, a list of activity ideas is provided below.

Reflections:
Have students write a paragraph for one or more of the following
prompts:
• What stood out to you the most and why?
• What new information have you learned from the video lecture and
the lesson?
• How does your knowledge of children’s health issues around the world in terms of individuals as well as broader political and economic factors help you to understand the complexity of children’s health issues?

Group project options:

a. Option 1. Mapping infant/child mortality. Infant mortality is the number of deaths per 1,000 live births of children under one year of age. Child mortality is the death of children under the age of five and remains a global concern. Students in groups of 3–5 can pick a specific country and identify where infant or child mortality is some of the highest and identify some of the contributing factors at the societal level, including political and economic factors. Students can use the following link to access the data on infant and child mortality around the world from the World Bank:
   https://data.worldbank.org/indicator/SP.DYN.IMRT.IN
   https://data.worldbank.org/indicator/SH.DYN.MORT?view=map

b. Option 2. Messaging poster: (This option can be combined with Option 1.) Create a health messaging poster aimed at disseminating important information about child nutrition, hygiene and sanitation, and health, using pictures and drawings such that they are easily understandable even without knowing how to read. Numbers and short messages can be included.

c. Option 3. Designing intervention: (This option can be combined with Option 1.) Create a plan of intervention in a country or region where infant and child mortality is high. Develop a detailed plan with a proposed budget for an intervention that aims to provide preventable healthcare services in a location that has the following conditions:
   i. ethnic group villages where the spoken language is different than the national language
   ii. extreme poverty
   iii. government’s lack of capacity to provide quality health care services
   iv. lack of basic infrastructure, such as running water, electricity, roads, the Internet, etc.
VIDEO NOTES

You are about to watch a 12-minute video lecture by Dr. Paul Wise, Professor of Pediatrics and Health Policy at Stanford University School of Medicine and Senior Fellow at the Freeman Spogli Institute for International Studies, Stanford University. Dr. Wise will share details about the “Children in Crisis” efforts. Use the space below to take notes on his comments.

Part 1: What is “Children in Crisis”?
Children in Crisis is...

What is the goal of Children in Crisis?

What are some benefits that Children in Crisis can provide?

How is the Children in Crisis program different from other efforts? What services do they provide? Who/which actors are involved?
In which countries/world regions is Children in Crisis in operation?

Part 2: How does “Children in Crisis” work?

a. Global-local partnership model:

b. What are some advantages and challenges in building partnerships with local “partners working on the ground”? How does that make a difference?

c. What is the Community Health Worker program? Who are the actors involved and how does it function?

d. Number of villages and children under the program at any given time:

e. Intervention details:
f. Impact of the program:


g. Challenges:

h. How were the challenges addressed?
The primary goal of the Children in Crisis effort is to improve the health of children in the most difficult places in the world to work. To focus on children in areas of civil war, conflict, chronic political instability, and areas where the governments don’t function very well. So our focus is trying to get the best health services—preventive services—to the kids in some of the most difficult places on earth.

The Children in Crisis program is different than many other efforts to provide services to children in these areas in that we see it as fundamental the working together the coordinating of the best health services with the best understanding of the political and economic situations in the area. Therefore, we need to have pediatricians, nutrition specialists, nurses, a whole variety of people who have technical health skills work closely with political scientists, people who worry about global security, in order to come up with new solutions, solutions that can actually function in these environments.

We are very committed to working in the areas, basically places in the news, like the Middle East, but also places that the news has forgotten. Places in Central Africa, where the fighting comes and goes, but services, security really are nonexistent in these areas. Central America, which was plagued by civil war and political instability for many, many years. And we still see the remnants of that political turmoil in the failure of the system to provide adequate services to women and children.

But we always work with local partners. It’s not that Stanford is parachuting in to work in these areas, but building long-term strong relationships with groups that have long been committed to working in these areas. So, in Central America and the Middle East, and Africa, and increasingly maybe now in Southeast Asia, we seek out and build relationships with partners working on the ground. And because of that we have greater confidence that the kinds of strategies being developed will actually function in the real world.

One of the primary commitments is a Central American country Guatemala, which sits just below Mexico and borders Belize, Honduras, and El Salvador. And Guatemala experiences a running civil war for many years, beginning in the mid-1960s and peace accords are finally signed in the late 1990s. However, the country has not recovered.

The other issue is that Guatemala is an extremely poor country and civil conflict, political instability and extreme poverty has created major challenges and has generated profound challenges for the provision of services like child health services. And so, our efforts are to create strategies that can actually work in these areas. And we partnered with groups in Guatemala particularly in one area of Guatemala, a community health program, where local villagers in
these indigenous Mayan Indian villages have created a system where local people are trained in basic health service provision, prevention, dental care, health education, to ensure that health services actually reach the people in need. And we work very closely with this program to address what is really recognized throughout the areas of fundamental problem, which is child nutrition that children don’t grow well because of inadequate food and poor sanitation, which means that they are constantly getting sick and each time they get sick their nutrition fails because their nutrition is poor and they are more likely to get sick and you get a spiral of infection and poor nutrition that ultimately for many of these children unfortunately has meant their death.

And the community health worker program has tackled this problem with nutrition and infection and now has an active program to ensure that every kid is adequately nourished. So the community health workers are out in their communities taking the height and weight of every child from birth until the age of five every two months to try to identify any child that is beginning to fall off their growth curve and then intervene. You just can’t identify the kids, you’ve got to do something about it.

So they have an intervention program that includes food supplementation, which is giving highly nutritious food to the family, working with the parents—particularly the mother—to improve the child’s nutrition to try to address the infections that keep on coming. And the program now serves about 20 villages. There are about 1500 children in the program at any given time. And the child mortality rate has fallen dramatically with this program. And severe malnutrition has virtually been eliminated because the program catches children before they become severely malnourished and gets them back to a more normal growth curve because of the intervention program before they can really fall into this very deadly spiral of an infection and poor nutrition. So the program is functioning now for almost ten years and has been extremely successful.

However, one of the problems that we have is that it takes a lot of training for community health workers to learn how to graph a growth curve to see whether a child is falling off their curve or not, and to interpret that graph and respond appropriately. It takes about three years of ongoing work and training. They are now very good at it. However, it’s definitely a barrier to the dissemination of a program like this to other community health worker programs around the world that may not have three years and the ability to train people.

So we went to the Computer Sciences Department here at Stanford, which of course is world famous. And say can you help us figure out a way to overcome this barrier to sort of leapfrog the requirements for training? And they created with computer science students and faculty a mobile app that sits on an android tablet that will basically do all the graphing functions that the health promoters have had to do on paper in the past. So the promoters the health workers just have to put in the child’s height and weight for that day and then the program takes over. And it will plot the child on a curve, it will interpret the curve, it will convey this to the health worker, it will lead them to the appropriate protocol for how to intervene, it will alert the leadership of the program that this new child in severe malnutrition in such and such community. It uploads to the cloud in a very secure way and we now have the ability to rapidly deploy this nutrition surveillance and the intervention program in other communities because the training requirements have been reduced from three years [to]—it looks like probably—close to three months because community health workers are really good at using the tablet after the first week or so of experimenting with it they get really good. Everybody has cell phones. Most of the community health workers, not all of them, but most are young and so they take to the technology very, very quickly. And the way that the community health program has
been developed and used in the system, you only need five little android tablets to serve 1500 children. So it doesn’t cost a lot to get these tablets bought and out there into the field. It’s very inexpensive and there are other places around the world who are waiting for us to develop these programs so that they can begin to implement them or at least try to implement them in different parts of the world.

So it’s a good illustration of how Stanford University in the United States sitting in Silicon Valley can help deliver critical health services in some of the most complicated environments to work. In essence to leapfrog longstanding traditional barriers to the provision of critical services. And while we recognize that people in Silicon Valley are often creating apps to change the world every other day, this application grew out of a direct collaboration with the community health workers in the field. We have a computer science graduate from Stanford living in Guatemala every day working in the field with the community health workers developing and refining this technology and so it’s the best of what Stanford can bring wedded to a deep commitment to respect the insides the capabilities the strengths of local communities working in very complicated environments. Environments that have been plagued by violence, conflict, and political instability. Our effort is to take advantage of the strengths in these communities as well as attend to their profound needs.