HELEN KELLER INTL

Annual Report to GiveWell on Helen Keller International's Vitamin A Supplementation Activities

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1. Introduction

Helen Keller's extraordinary legacy is a testament to the power of resilience, determination, and vision. Overcoming significant health challenges, she became a global symbol of hope and possibility. Guided by her inspirational life, Helen Keller International (HKI) remains committed to empowering communities to break free from cycles of poverty through improved health, nutrition, and clear vision.

In Sub-Saharan Africa, Helen Keller's Vitamin A Supplementation (VAS) program is critical in addressing the region's high child mortality rates caused by preventable diseases. Vitamin A deficiency is a leading cause of weakened immune systems, leaving millions of children vulnerable to infections such as measles and diarrhea. By providing essential Vitamin A to children aged 6 to 59 months, the program strengthens immune responses, significantly reducing the risk of blindness, disease, and death.

Since its inception, Helen Keller VAS activities have saved countless lives, reinforcing the organization's mission to ensure that every child can reach their full potential. Through solid partnerships with Ministries of Health and international supporters, HKI continues to lead life-saving efforts to protect the most vulnerable children in Africa.

Between July 2023 and June 2024, we overcame challenges and meticulously documented our progress, shortfalls, and successes.

2. Executive Summary

This report highlights the outcomes, challenges, and progress of Helen Keller International's Vitamin A Supplementation (VAS) activities between July 2023 and June 2024, funded by GiveWell. The VAS program aims to combat Vitamin A deficiency, a major contributor to child mortality, by strengthening immune responses and reducing the risk of blindness, disease, and death in children aged 6 to 59 months. Over the reporting period, Helen Keller provided technical and financial support for VAS across 14 countries in Sub-Saharan Africa, helping to safeguard the health of millions of children.

Key Achievements

- **Coverage and Reach**: The program supported mass VAS campaigns in 10 countries, including Burkina Faso, Cameroon, Côte d'Ivoire, DR Congo, Guinea, Kenya, Madagascar, Mali, Niger, and Nigeria. These campaigns reached approximately 38.5 million children, with administrative coverage averaging 94%. In addition, 1.5 million children were reached through routine health services in four other countries: Mozambique, Senegal, Sierra Leone, and Tanzania.
- **Campaign Models**: VAS was delivered primarily through door-to-door campaigns in 8 countries, while Kenya and Nigeria employed a mixed approach, combining health facility-based services with outreach. Campaign durations ranged from 3 to 29 days, with rural areas in Burkina Faso and health facility-based campaigns typically requiring longer periods. Routine VAS services were implemented in Mozambique, Senegal, Sierra Leone, and Tanzania, reflecting a shift toward more sustainable delivery methods in some regions.
- **Integration with Other Health Services**: Several countries took a holistic approach by integrating VAS with other health interventions, including deworming, malnutrition screening, routine immunizations, and azithromycin distribution. In Côte d'Ivoire, VAS was delivered alongside azithromycin in 16 districts, and in Nigeria, VAS campaigns included maternal and child health services such as antenatal care, HIV testing, malaria prevention, and nutrition education.
- **Independent Monitoring and Accountability**: Helen Keller used independent monitors to track campaign performance in real-time across various countries, addressing coverage gaps through data-driven insights. Coverage ranged from 90% to 98% across most monitored regions. PowerBI dashboards provided real-time visibility, helping teams address logistical and operational challenges as they arose.

Challenges and Responses

- **Supply Chain and Stockouts**: Several countries experienced stockouts of Vitamin A capsules due to delays in procurement, poor stock management, and inaccurate population data. This was a major challenge in regions like Cameroon and Madagascar. Helen Keller responded by improving supply chain monitoring, increasing coordination with partners, and assisting Ministries of Health in refining population estimates for better targeting and planning.
- **Political Instability and Insecurity**: In regions such as Burkina Faso, Mali, Niger, and parts of Cameroon, political instability and security concerns disrupted campaign planning and implementation. Helen Keller adapted by working closely with local partners and using community-based distribution models to continue reaching children in conflict-affected areas.
- **Coordination Delays**: Campaign delays were also caused by competing priorities within Ministries of Health and insufficient proactivity from some country teams. To address this, Helen Keller implemented a campaign preparation checklist and enhanced coordination among partners to ensure more timely execution of campaigns.

Financial Management and Cost-Effectiveness

- **Cost Structure**: The majority of campaign expenses were attributed to personnel costs, with 75% of the total budget going to staffing. Distribution was the largest cost category, accounting for over 40% of the budget, while supervision and logistics were

other significant cost drivers. Efforts were made to optimize resources, such as streamlining training and supervision efforts, particularly in countries where recurring staff are employed across campaign rounds.

- **Sustainability Initiatives**: Helen Keller is actively supporting countries to transition from campaign-based VAS delivery to routine service models. Routine delivery is more sustainable in the long term and better integrated within existing health systems. In countries like Kenya, Senegal, and Côte d'Ivoire, Helen Keller has begun working with Ministries of Health to scale up routine VAS services, with some regions already seeing promising results.

Future Focus

- **Strengthening Routine Services**: One of the key priorities moving forward is to expand routine VAS services, reducing the reliance on bi-annual campaigns. Helen Keller is supporting countries in developing strategic plans for this transition, focusing on building health worker capacity, improving monitoring systems, and ensuring consistent supply chain management.
- **Supply Chain Management**: Addressing stockouts and improving the accuracy of population targeting remain top priorities. Helen Keller will continue to work with UNICEF and other partners to ensure more reliable procurement and distribution of Vitamin A capsules.
- **Data Quality and Monitoring**: Enhancing the accuracy of administrative data and ensuring that coverage data is fully integrated into national health information systems is a key goal. Independent monitoring will continue to play a critical role in identifying areas for improvement, and data-driven decision-making will remain at the core of program adjustments.

Conclusion

Helen Keller International's VAS program continues to play a vital role in improving child health across Sub-Saharan Africa, with substantial progress made in addressing Vitamin A deficiency. Despite challenges related to stockouts, political instability, and coordination delays, the program has successfully reached millions of children, providing them with the life-saving benefits of Vitamin A. Moving forward, the focus will be on transitioning more countries to routine-based service delivery, enhancing supply chain resilience, and continuing to improve the overall quality and sustainability of VAS programs.

Figure 1. Countries supported by Helen Keller Intl for Vitamin A Supplementation in Sub-Saharan Africa

3. VAS Campaign Management

Of the fourteen countries supported by Helen Keller for mass vitamin A supplementation activities, eight use a door-to-door distribution approach, where teams of two distributors deliver supplements directly to children's homes. These countries include Burkina Faso, Cameroon, Cote d'Ivoire, Guinea, Kenya, Madagascar, Mali, Niger. Two countries—Nigeria and Kenya—use a combination of health facility-based distribution and outreach events (fixed + outreach approach). The remaining four countries (Mozambique, Senegal, Sierra Leone, and Tanzania) deliver VAS through routine health services, supported by funding sources other than GiveWell donations.

In all countries, the preparation and implementation of VAS campaigns follow a strict process: **Planning – Implementation – Monitoring – Evaluation.**

For door-to-door campaigns, the distribution typically takes 3 to 5 days, while fixed + outreach usually lasts 1 to 2 weeks. However, the entire cycle, from planning to evaluation,

spans up to six months, as Vitamin A is distributed biannually. As a result, planning the next campaign starts almost immediately after the one concludes to ensure adherence to the six-month distribution cycle.

Table 1 provides an overview of the campaign models and durations for Vitamin A Supplementation (VAS) campaigns in GiveWell-supported countries. Most of the countries, including Burkina Faso, Cameroon, Côte d'Ivoire, DR Congo, Guinea, Madagascar, Mali, and Niger, use a door-to-door distribution model, where Vitamin A supplements are delivered directly to children's homes. In contrast, Kenya and Nigeria implement a fixed + outreach model, combining health facility-based distribution with outreach activities.

Campaign durations vary significantly across the countries. Burkina Faso has the longest campaign duration, with the door-to-door approach lasting 29 days in rural areas and 5 days in urban areas. Mali also has an extended campaign duration of 14 days. For the fixed + outreach model, Nigeria's campaign lasts 20 days, while Kenya's runs for 15 days. The remaining countries—Cameroon, Côte d'Ivoire, DR Congo, Guinea, Madagascar, and Niger—conduct shorter campaigns, typically ranging from 3 to 5 days.

Table 1. Campaign Features in GiveWell-supported countries

	Campaign model	Campaign duration (days)
Burkina Faso	Door-to-Door	5 in urban, 29 in rural
Cameroun	Door-to-Door	4
Cote d'Ivoire	Door-to-Door	5
DR Congo	Door-to-Door	4
Guinea	Door-to-Door	3
Kenya	Fixed + outreach	15
Madagascar	Door-to-Door	3
Mali	Door-to-Door	14
Niger	Door-to-Door	5
Nigeria	Fixed + outreach	20

Helen Keller's teams structure their support for vitamin A supplementation programs by aligning with the WHO's health system building blocks (Figure 2). These six key components guide the approach to delivering effective and sustainable vitamin A supplementation:

- **Leadership and Governance**: Helen Keller collaborates with Ministries of Health and other stakeholders to ensure strong leadership and governance. This includes developing policies, setting timelines, and ensuring accountability in the planning and implementation of vitamin A supplementation programs.
- **Health Financing**: The organization mobilizes financial resources to ensure that vitamin A supplementation programs are sustainably funded, while also working to prevent financial barriers to access for children and their families.
- **Service Delivery**: Helen Keller ensures that vitamin A supplementation campaigns provide effective, safe, and high-quality services, reaching children in both urban and rural areas when and where they are needed, in an equitable and efficient manner.
- **Supplies/Access to Essential Medicines**: Helen Keller focuses on ensuring a reliable supply of vitamin A capsules by improving supply chain management, so that essential medical products are consistently available, safe, and of assured quality.

- **Health Workforce**: Helen Keller works to strengthen the health workforce by ensuring that health workers involved in vitamin A distribution are well-trained, motivated, and equipped to deliver supplements effectively, whether through door-to-door campaigns or routine health services.
- **Health Information Systems**: The organization supports the collection, analysis, and use of health data to track vitamin A coverage, monitor campaign progress, and inform decision-making and resource allocation, ensuring that programs are data-driven and responsive to the needs of the population.

Figure 2. WHO building blocks of the health systems

Savigny and Adam (2009).

3.1. Governance

Coordination for vitamin A supplementation (VAS) campaigns begins at least three months before the expected campaign date. Each year, campaigns are organized around May-June for the first semester and October-November for the second semester. As a result, the national body coordinating the VAS campaign must initiate its efforts in February for the first semester and July for the second semester.

The Ministry of Health leads the national coordination body, which includes key partners involved in VAS delivery, such as UNICEF, Helen Keller, and Nutrition International. Depending on the campaign approach and services offered, various Ministry of Health departments may also be involved (e.g., Nutrition, Maternal and Child Health, Immunization, Malaria). This central coordination body establishes working groups at different levels (national, regional, district), aligning with the decision-making structure of the health system and addressing specific areas like supply chain, social mobilization, and monitoring.

Coordination bodies meet at various intervals to make key decisions about the upcoming campaign:

- **Initial Preparatory Meeting**: Held at least three months before the campaign, this meeting determines the approximate campaign dates, whether the VAS campaign will be integrated with other campaigns (e.g., measles or polio), the package of services to be offered, and the key tasks for campaign preparation. The frequency of future coordination meetings is also set, and working groups are established. Following this meeting, an official note outlining the campaign's features and dates is approved and shared with all stakeholders, including sub-national authorities and other partners.

- **Ongoing Coordination Meetings**: After the initial meeting, regular coordination meetings (often weekly) are held to monitor campaign preparations. In many countries, Helen Keller serves as the secretariat, ensuring meetings occur as scheduled and decisions are implemented. In countries where meetings are held online, Helen Keller also provides Internet support.

Helen Keller plays a crucial role in ensuring that information from the previous campaign is used to inform the upcoming one. Data from coverage surveys and independent monitoring are essential for identifying areas with low coverage and implementing solutions to improve future campaign outcomes.

To facilitate efficient coordination, Helen Keller has developed an activity checklist (Annex 1) used by all country teams. This checklist outlines deadlines for each step of the campaign preparation process, based on the expected campaign dates, and includes essential tasks for proper planning. Some steps focus on coordination with partners (e.g., confirming capsule availability two months before the campaign), while others relate to Helen Keller's internal processes (e.g., finalizing coverage survey consultant procurement one month before the campaign's end).

Planning for the Vitamin A Supplementation (VAS) campaign occurs at multiple levels: central, regional, district, and health facility.

After key decisions are made regarding the main campaign features, the central coordination body begins the planning process:

- It develops a comprehensive work plan for the entire campaign, covering all stages from preparation to evaluation, based on the established campaign dates.
- It determines population data to set coverage targets, which are then used to estimate the required human, material, and financial resources.
- It prepares budget estimates and coordinates with partners to assign regions they will support.
- It designs a micro-planning process and develops the tools needed for implementation.

Once the central planning is in place, micro-planning workshops are organized at the regional and district levels. These workshops bring together Ministry of Health management teams, health facility staff, key community members, and supporting partners. During micro-planning, the Ministry and partners agree on the specifics of campaign implementation. This includes determining the number of distributors, supervisors, and mobilizers needed, the duration of their involvement, the approach to social mobilization, the supplies required, and the methods for supportive supervision. Micro-plans are used to estimate the cost of the campaign in each region and are then submitted to the central coordination body for consolidation into the overall campaign budget.

Helen Keller teams actively participate in micro-planning in all supported regions, assisting the Ministry in identifying areas for improvement based on the results of previous campaigns. Our teams also ensure that the micro-plans are aligned with cost-effectiveness ratios to optimize resources.

Common challenges:

- **Resistance to Integration**: While Helen Keller advocates for coupling VAS with polio or measles campaigns, partners leading these efforts sometimes resist due to concerns about increased complexity and the risk of lower coverage when multiple services are delivered simultaneously.
- **Delayed Coordination**: Despite efforts to encourage early coordination, competing priorities within the Ministry of Health and partners often result in late starts, causing delays in campaign preparation and planning.
- **Late Capsule Availability**: In several instances, confirmation of Vitamin A capsule availability occurred late in the planning process. This was due to insufficient prioritization by Helen Keller teams and partners. Delays in capsule shipments can take several months, leading to postponed campaigns.
- **Political Instability and Insecurity**: Increasing political instability and insecurity in some regions pose significant challenges to the preparation and implementation of VAS campaigns, disrupting timelines and logistics.

3.2. Finance

VAS campaign modalities do not change significantly between semesters. This means that supporting partners know how much is needed to support VAS in each region and can position themselves early based on their funding capacity. Helen Keller usually requests that UNICEF positions itself first to identify how many regions are at risk of not being supported and potentially decide to cover these regions.

The main variation occurs when VAS is integrated with polio. In that case, as usually the WHO and the Global Polio Eradication Initiative (GPEI) local implementing partners support two vaccinators per team, VAS supporting actors only have to support one extra distributor instead of two.

Helen Keller's financial support is provided through contracts with regional government entities. These contracts are built on the agreed-upon micro plans and list several deliverables representing each step of the campaign implementation. To prove that activities took place as planned, the government must report on these deliverables that are each associated with process and performance indicators (i.e., signed lists of participants to the training, supervision reports, and administrative coverage).

These contracts are prepared by Helen Keller teams and forwarded to the VAS management regional team for review and validation before being sent to the organization's central office for another level of review and validation. The review focuses on 3 main aspects:

- To ensure that the campaign is implemented at a reasonable cost, the micro plans must adhere to:
    - A ratio of the number of children to be supplemented per day and distribution team (i.e., 50 children per team per day).

- A ratio of the number of teams to be supervised by each supervisor per day (i.e., 2 teams per day and per supervisor).
- A ratio of the number of households to be reached by each social mobilizer.
- A reasonable cost per child supplemented (i.e., $0.2 to $0.3 per supplement).

Table 2 outlines the expected allocation of costs across various categories within the campaign budget, which micro plans are required to follow. Each category is assigned a percentage to guide the distribution of resources. **Planning and coordination** are expected to represent no more than 5% of the total budget, covering the administrative tasks needed to organize the campaign. **Training** is allocated up to 10%, ensuring the preparation and education of personnel involved. **Logistics**, which includes transportation and supply management, is also capped at 5%. The largest portion of the budget, at least 40%, is dedicated to **distribution**, ensuring the effective delivery of services to the target population. **Supervision** accounts for up to 25%, providing oversight and quality control throughout the campaign. **Social mobilization** receives up to 10%, aimed at raising awareness and encouraging community participation. Finally, **monitoring and evaluation** are allocated up to 5% of the budget, allowing for the assessment of the campaign's effectiveness and outcomes. This balanced allocation prioritizes direct service delivery and supervision to ensure efficient and impactful campaign implementation.

Table 2. Expected ratio for each cost category for campaign budget

Cost Category	Expected ratio (%)
Planning and coordination	At most 5%
Training	At most 10%
Logistic	At most 5%
Distribution	At least 40%
Supervision	At most 25%
Social mobilization	At most 10%
Monitoring evaluation	At most 5%

- The government must demonstrate its capacity and eligibility to deliver the services as per the micro plans:
  - It must evaluate the risks to the campaign implementation and propose mitigation strategies (i.e. insecurity, political instability, natural disasters).
  - It must demonstrate that its financial systems and processes for managing the funds meet high-quality standards (i.e., a government official dedicated bank account, management of financial ledgers).
  - Government actors involved in the campaign are screened through multiple CSI watchlists (i.e. European Union sanction list, US Bureau of Industry and Security).

Common challenges:

- **Lack of financial visibility**: at times, partners do not have clear financial visibility from one semester to the next, and the information about their capacity to support some regions is only provided late in the campaign preparation process, giving too little time for Helen Keller teams to conduct due diligence and proper planning process required to support a new region.
- **Difficult contracting negotiations**: Negotiations with ministries are often difficult, and proposed micro plans are too expensive. Notably, the number of supervisors in all campaigns is very high.
- **Late start of planning**: Helen Keller teams at times make the mistake of starting planning with supported regions too late, waiting for exact campaign dates to be known, while microplanning could have already been initiated. This leads to delayed contracting process and funds not being available in time in the region. The campaign in Guinea had to be delayed for such reason in the first semester of 2024.

3.3. Service delivery

The **package of services** offered during VAS campaigns varies from country to country. Deworming, if tablets are available in the country, is usually systematically integrated with VAS. Regional governments determine additional services to be integrated based on local contexts. **Table 3** shows that in the first semester of 2024, countries delivered a comprehensive package of health services alongside Vitamin A Supplementation (VAS), integrating interventions to enhance child and maternal health. Burkina Faso, Mali, and Niger combined VAS with malnutrition screening and deworming, while Cameroon expanded services to include routine immunizations, epidemic disease detection, and health coverage registration. Côte d'Ivoire introduced Azithromycin distribution, and the Democratic Republic of the Congo (DRC) and Madagascar added polio vaccinations. Kenya focused on VAS, deworming, and MUAC screening, while Nigeria delivered the broadest range, incorporating antenatal care, routine immunizations, malaria prevention, HIV testing, and nutrition education. This integrated approach demonstrates a strong commitment to addressing diverse health needs.

Table 3. Package of services delivered during the first semester of 2024

Country	Services delivered
Burkina Faso	VAS, Screening for malnutrition, Deworming
Cameroon	Vitamin A Supplementation, Deworming, routine immunization catch-up, detection of diseases with epidemic potential, community registration on universal health cover
Cote d'Ivoire	Vitamin A Supplementation, Azithromycin distribution (in 16 Districts in collaboration with FHI 360)
DRC	Vitamin A Supplementation, Deworming, Polio
Guinea	VAS, Routine immunization catch-up, Deworming, birth registration
Kenya	Vitamin A supplementation, Deworming. and MUAC screening (in Nairobi and Baringo)
Madagascar	Vitamin A supplementation, Polio
Mali	Vitamin A Supplementation, Screening for malnutrition, Deworming
Niger	VAS, Screening for malnutrition, Deworming

Nigeria	Vitamin A Supplementation, Antenatal care, deworming, routine immunizations, malaria prevention, HIV testing and counseling, and nutrition education.

After defining the delivery model and the package of services, the Ministry of Health takes the lead in preparing **social mobilization** efforts.

The two main reasons for children not to be supplemented are that distributors did not visit their households (hence the critical importance of adequate micro plans) and that caregivers were not aware of the campaign.

It is, therefore, essential that social mobilization be conducted thoroughly and that evidence generated by coverage surveys on the reasons for children not being supplemented during the previous campaign be used to ensure that all caregivers are sensitized.

For instance, while posters are often praised and requested in large numbers by ministries and are costly, coverage surveys show they are among the least effective mobilization tools. In contrast, the most cost-effective strategy is using town criers with megaphones to inform the community along with health workers and key informants engaging directly with caregivers to highlight the importance of the campaign and VAS.

Key steps in preparing for social mobilization include:

- Preparing communication tools at the central level (Messages, T-shirts, posters, banners, radio, and TV spots).
- Disseminating TV and radio spots at central and subnational levels.
- Organizing sensitization meetings with administrative and community leaders.
- Recruiting and training town criers and social mobilizers to pass on messages before and during the campaign.
- Managing refusal cases during the campaign.

Helen Keller's teams actively participate in the entire process, from developing the tools to evaluating the implementation of social mobilization.

Supervision Preparation
Supervision is one of the critical stages in mass distribution activities, ensuring the quality of implementation at every stage. There are four key phases for effective supervision:

- **Development of supervision tools and guidelines**. Helen Keller verifies that guidelines and templates exist or participates in their development, review, and validation.
- **Identification of national and local supervisors**. Helen Keller supports the Ministry of Health to identify qualified supervisors at both the national and local levels.
- **Distribution of supervisors by district/region and development of supervision plan**. Helen Keller supports the Ministry of Health in developing a supervision plan that ensures each supervisor oversees at least two distribution teams daily, focusing on areas like hygiene standards, communication, and accurate tally sheet completion. Ideally, teams should not be informed in advance about a supervisor visit.

- **Supervision of activities**. Helen Keller staff are part of supervision teams in every region or district where we operate. In regions without regular Helen Keller presence, we coordinate with national or regional authorities to ensure that supervision is conducted. During supervision, the teams work closely with government counterparts to ensure adherence to all aspects of implementation protocols. Every evening, supervisors report to the district Ministry of Health addressing any implementation issues encountered and the actions taken to address them. They also prepare for the following day's supervision activities.

Helen Keller teams actively participate in supervision in all regions supported.

Common challenges:

- **Complexity of urban centers**: Coverage often remains below minimum thresholds in large urban centers, calling for continuous strengthening of delivery strategies. Urban centers must be mapped adequately, and decisions must be made with the Ministry and partners that not all areas must be covered, such as formal residential areas where population wealth places children at a lower risk of vitamin A deficiency.
- **Planning and mobilization shortfalls**: The most typical reasons for children not being supplemented are lack of awareness and households being missed by distributors, calling for continuous efforts towards better mapping of distributors and social mobilizers catchment areas.

3.4. Management of supply chain and essential commodities

The estimated need for vitamin A capsules is based on the target population, making it crucial for all partners to agree on the population data for targeting. This process is typically managed by UNICEF, which handles the procurement and transportation of supplies to the country.

An essential aspect of forecasting capsule needs is accurately assessing the number of capsules already available in the country. Helen Keller collaborates with the regions it supports, along with central ministry teams, to estimate the remaining stock at all levels. However, stock management is often inadequate, and the data provided by the Ministry is not always reliable. For example, in Madagascar, UNICEF reported that approximately 6 million capsules have gone unaccounted for over the last five years due to poor reporting and stock management practices.
During coordination, partners must also agree on the logistics of dispatching capsules from the national warehouse to the field. While UNICEF typically oversees this logistical step, in some countries, Helen Keller also assists with transportation to ensure timely delivery.

Helen Keller provides the necessary funds to procure or produce essential supplies and facilitates their transfer to the operational level (Health District and Health Area). Each Helen Keller team verifies that all regions/districts receive the necessary tools and supplies for effective VAS distribution. These supplies include tally sheets, pen, chalks, clipboards, scissors, megaphones, and other essential items.

Common challenges:

- **Vitamin A Capsule Stockouts:** Late in the campaign preparation process, it is often discovered that there are insufficient vitamin A capsules to meet the needs of the campaign. This issue stems from delays in procurement by UNICEF, inadequate reporting of capsule usage by regional teams, or inaccuracies in population data used for forecasting. For instance, during the first round of 2023 in Cameroon, only 66% of the required stock was available, and most capsules were delivered to districts just 1 to 2 days before the campaign. This left insufficient time to verify whether the stock met targets and to ensure timely distribution to health facilities.
- **Limited Involvement of Helen Keller:** Since UNICEF manages the capsule procurement and distribution, Helen Keller teams have had limited involvement in the forecasting process and in verifying capsule stock levels in the regions we support. This lack of engagement hampers our ability to address potential shortages early on.
- **Deworming Tablet Stockouts:** Deworming tablets are frequently in short supply, which affects the ability to cover all children during campaigns. In countries like Mali, the absence of deworming tablets can lead to campaign delays, as some refuse to proceed without them.
- **Management of Other Supplies:** The management of campaign supplies, such as equipment, needs better efficiency. For example, in the DRC, scissors are replaced every three years, while in other countries, they are still purchased annually, indicating room for improvement in supply management practices.

3.5. Health Workforce

All human resources needs, including distributors, social mobilizers, and supervisors, are calculated during the micro-planning stage. Each type of actor receives a per diem that adheres to the Ministry of Health policies and procedures.

Figure 3 describes how training occurs at multiple levels during the campaign preparation.

Figure 3. Cascade training for campaign preparation

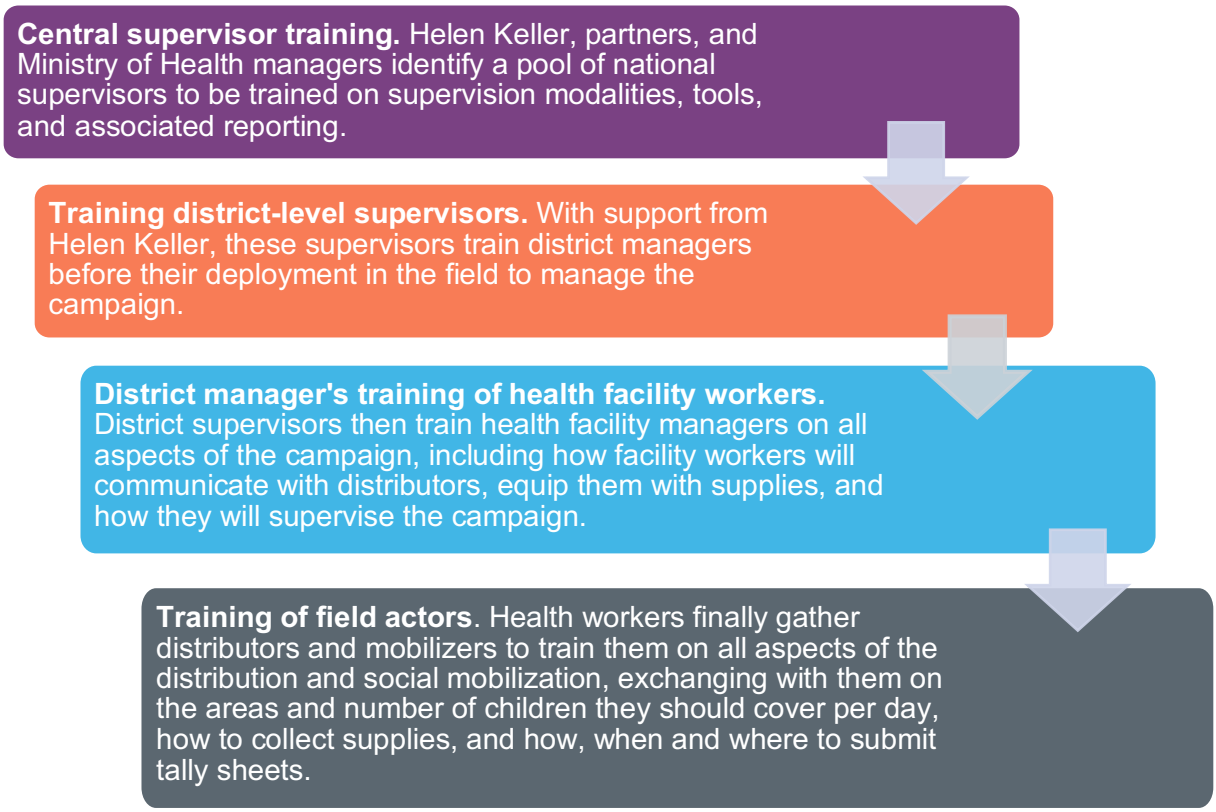


Table 4 accounts for the number of personnel supported for the campaign preparation (planning and training), implementation (distributors and mobilizers supported), supervision and evaluation (campaign performance review workshop after the campaign is over). During the first semester of 2024, Helen Keller supported a significant workforce for Vitamin A Supplementation (VAS) campaigns across several countries. A total of 640 national and regional actors were involved in planning, with the largest contributions from Niger (255) and Cameroon (231). District-level planning was supported by 2,548 actors, with Niger leading (1,521). For district training, 5,514 actors were involved, with Côte d'Ivoire and Niger contributing 1,602 and 1,395 respectively. Health worker training was extensive, with 81,966 workers trained, the majority in Cameroon (56,433).

In terms of mobilization, 67,784 mobilizers were supported across countries, with Kenya having the largest share (25,294). A total of 139,890 distributors were supported, with the highest numbers in Cameroon (33,054) and Nigeria (27,759). Supervision efforts were also substantial, with 790 national/regional actors and 8,403 district-level actors involved. Health worker supervision was provided to 9,846 individuals, with Cameroon again leading in this area (2,684).

For evaluation activities, 1,998 district actors and 7,973 health workers were supported, ensuring proper oversight and assessment of the campaigns' implementation.

Table 4. Total workforce supported by Helen Keller for VAS campaigns, 1st semester of 2024

	Burkina Faso	Cameroon	Cote d'Ivoire	Guinea	Kenya	Madagascar	Mali	Niger	Nigeria	Total
Natl / Regl actors planning	54	231	80	12		4	4	255		640
District actors planning	325	446	200				56	1,521		2,548
District actors training	971	837	1,602			709	-	1,395		5,514
Health workers training		56,433		12,057			9,085	4,391		81,966
Mobilizers supported	3,711	16,864	1,921	1,831	25,294		7,178	6,903	4,082	67,784
Distributors supported	5,217	33,054	9,374	9,306	6,576	22,514	8,306	17,784	27,759	139,890
Natl / Regl actors supervision	59	140	42	60		47	118	159	165	790
District actors supervision	335	906	40	240	748	100	177	915	4,942	8,403
Health workers supervision	1,101	2,684	1,602	989	71		779	1,743	877	9,846
District actors evaluation		791		794			100	313		1,998
Health workers evaluation		4,811					1,534	1,628		7,973

Note: For Nigeria, distributors are community health promoters who assist with distributing services.

Common challenges:

- **High training costs**: As the same distributors are often recruited from one round of campaign to the next, efficiencies could be made in training costs as they would not need to be re-trained every six months.
- **High supervision costs**: The cost of supervision typically accounts for 30% of campaign expenses. A significant portion of this cost arises from the high per diem rates for national and regional supervisors, which are often much higher than those for local supervisors. However, local supervisors may be more effective due to their in-depth knowledge of the areas they oversee. Negotiating these costs with Ministries can be challenging, partly because of the highly centralized systems in place.

3.6. Information system

Helen Keller supports the Ministry of Health in managing data for monitoring Vitamin A Supplementation (VAS) campaigns through several key activities:

- **Technical Assistance**: Helen Keller provides technical support in developing and validating data collection tools, including tally sheets, to ensure accurate and efficient data capture.
- **Tool Distribution**: Helen Keller assists in creating and distributing these tools to the districts it supports. Tools are typically provided to health facility workers during training sessions and then distributed to campaign distributors during their training.
- **Monitoring and Supervision**: During supervision, Helen Keller teams ensure that tally sheets are accurately completed in the supported districts. They monitor the timely submission of daily reports at the health facility and district levels.
- **Data Analysis and Feedback**: Helen Keller teams offer technical assistance for the daily analysis of submitted data during debriefing meetings, ensuring feedback is promptly shared with both distribution and supervision teams. This process ensures that recommendations for improving data quality and campaign execution are implemented during the campaign.
- **Post-Campaign Review**: Shortly after the campaign concludes, Helen Keller assists the Ministry of Health in organizing district-level workshops to review the campaign's performance and develop recommendations for improvement in future campaigns.

Common challenges:

- **Unreliable Administrative Data:** Coverage surveys consistently show that administrative data overestimates coverage, often due to incomplete tally sheets or compilation errors. Additionally, target population numbers are frequently underestimated, skewing the results.
- **Outdated Population Data:** Many countries rely on outdated census data, often more than a decade old, leading to underestimation of target populations. For example, in Cameroon, external migration and internal displacements caused major discrepancies, with some areas reporting household numbers 400% higher than expected during the 2023 PECS survey.
- **Data Gaps from Other Regions:** Helen Keller Intl is the sole organization conducting coverage surveys, leaving gaps in coverage data for regions supported by other partners, making it difficult to fully assess campaign effectiveness.
- **Limited Integration of Data:** Coverage and administrative data are often not incorporated into national health information systems, hindering the ability to track long-term campaign performance and make informed decisions for future interventions.

3.7. Campaign timeline progress for fiscal year 24

A minimum period of 4 months and a maximum period of 6 months is expected between 2 campaigns. Over the years, it has often been difficult to respect these timelines. Key challenges included:

- Ineffective coordination between VAS partners, or even between departments of the Ministry of Health.
- Poor planning to ensure the availability of vitamin A capsules in sufficient quantities.
- Delays in implementing micro-planning activities.
- Delays in developing, submitting, and approving contracts between Helen Keller and government entities, thus impacting the timely availability of funds.
- Contextual challenges such as natural disasters, political instability, or insecurity.

Table 5 shows how the time intervals between campaigns fluctuate both within and across countries. The most significant delay occurred in Niger, where massive floods blocked activities for three months, leading to a 96-day delay. In Madagascar, the campaign faced a major delay of 61 days due to funding shortages. Partners (Nutrition International) announced insufficient funds to organize the campaign in regions not supported by Helen Keller, and although Helen Keller eventually extended to support to cover these regions, the delay in securing financial assistance resulted in significant postponement.

Table 5. Dates of campaigns and variations between expected and effective dates of start

Country	2022 S1	2022 S2	2023 S1	S2 2023 (Expected)	S2 2023 (Effective)	Difference (days)	S1 2024 (Expected)	S1 2024 (Effective)	Différence (days)

Burkina Faso	20-Jun	01-Dec	18-Jun	13-Dec	01-Dec	-12	01-Jun	20-Jun	19
Cameroun	15-May	03-Dec	15-Jun	13-Dec	10-Dec	-3	10-May	10-May	0
Cote d'Ivoire	24-Jun	03-Dec	25-Jun	20-Dec	23-Nov	-27	26-May	21-Jun	26
DR Congo	01-Jun	15-Nov	15-May	15-Nov	16-Nov	1	16-May	13-Jun	28
Guinea	25-Jun	15-Dec	28-Jul	24-Jan	12-Dec	-43	18-Jun	28-Jun	10
Kenya	01-Jun	15-Nov	01-Jun	11-Nov	15-Oct	-27	27-Apr	13-May	16
Madagascar					15-Dec		10-May	10-Jul	61
Mali	10-Jun	15-Dec	10-Aug	28-Jan	25-Dec	-34	25-Jun	25-Jul	30
Niger	05-Jun	14-Dec	20-Jun	16-Dec	12-Dec	-4	24-Jun	28-Sep	96
Nigeria	01-Jul	01-Dec	10-Jun	18-Nov	18-Nov	0	05-Jun	25-May	-11

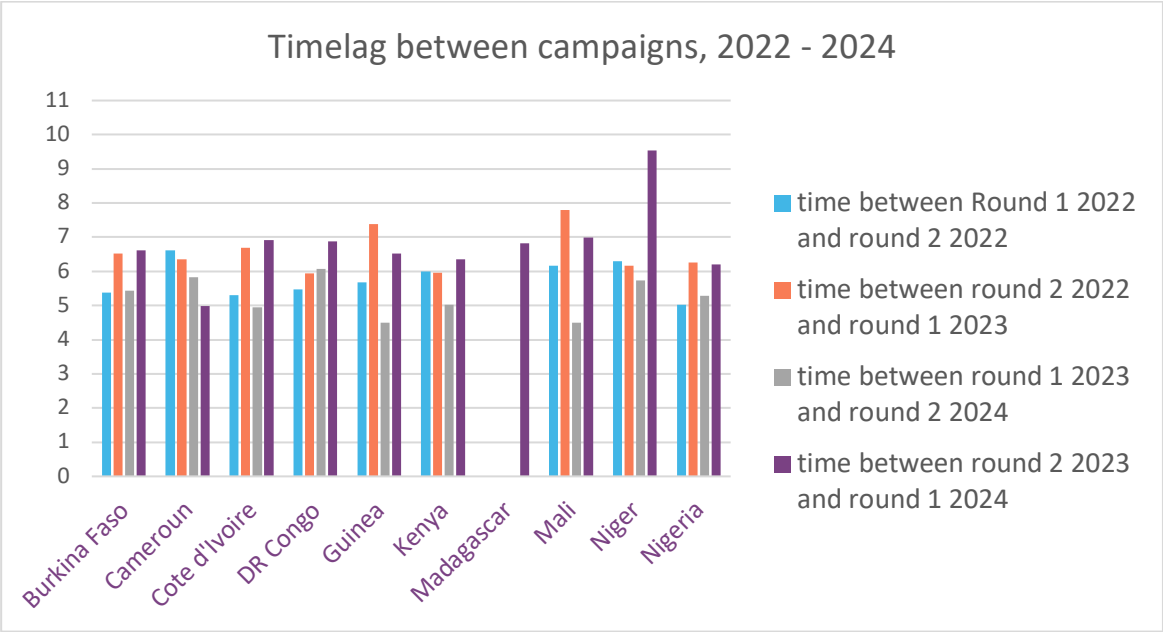
A total of 22 campaigns were conducted slightly more than six months, while 17 campaigns adhered to the recommended timeframe (Figure 5). In the first semester of 2024, only Cameroon and Nigeria met the six-month interval between campaigns., while other countries exceeded this period. Niger experienced the longest, with a 96-day gap. In Mali, the campaign was postponed by 30 days due to the late delivery of albendazole, which was ultimately provided by World Vision after the government failed to procure it on time. Although vitamin A was available, the campaign was postponed until all supplies were in place.

Guinea's campaign was delayed by 10 days due to the Ministry of Health's last-minute decision to combine routine vaccination catch-up with vitamin A supplementation. Additionally, delays in the vitamin A supply chain and late preparation of sub-agreement contracts by Helen Keller contributed to the postponement.

It is also important to note that the figures presented are country averages, as campaign timeliness often varies across regions within a country.

As noted in Table 5 above, **Figure 4** below shows that while some countries successfully maintained the six-month gap between campaigns, others experienced longer intervals. The data indicates that only a few countries, such as Cameroon and Nigeria, consistently adhered to the six-month period in their campaign scheduling. However, many countries faced delays, with intervals exceeding the recommended six months. Niger, for example, experienced the most significant delay of 96 days (approximately three months), largely due to natural disasters and logistical challenges. Other countries, like Madagascar and Mali, also encountered delays ranging from one to two months, attributed to funding shortages and supply chain issues. Overall, the figure underscores the variability in campaign timelines across countries, reflecting a need for strengthened coordination and logistical support to ensure more consistent adherence to the six-month interval between VAS campaigns.

Figure 4. Number of months between campaigns, 2022 to 2024



4. Countries reports

Table 6 below shows that between July 2023 and June 2024, Helen Keller supported the distribution of vitamin A capsules across multiple countries, achieving an overall administrative coverage of 94% for both the second semester of 2023 and the first semester of 2024. Notably, Burkina Faso and DR Congo exceeded their targets, reaching 106% and 101% of their respective child populations in the first semester of 2024. Cameroon maintained a high and consistent coverage of 99% across both periods. However, countries like Côte d'Ivoire and Guinea saw lower coverage rates, with Côte d'Ivoire achieving only 83% in 2024 and Guinea reaching 85%. Challenges were also observed in Kenya and Madagascar, with both reporting coverage around 90% for 2024. Overall, the campaigns successfully reached a large proportion of the targeted populations, though variability in coverage across countries highlights areas for improvement in future campaigns.

A total of 36 million capsules were distributed with support from Helen Keller Intl in the second semester of 2023 and 38 million in the first semester of 2024. As the Niger campaign only took place at the end of September 2024, it is expected that around 45 million capsules will have been distributed for this semester.

Table 6. Capsules distributed with Helen Keller support between July 2023 and June 2024

	S2 - 2023			S1 - 2024			
	Nb. children targeted	Nb. children reached	Administrative coverage	Nb. Children targeted in the RFMF July 2023)	Nb. children targeted	Nb. children reached	Administrative coverage
Burkina Faso	1,092,488	1,119,578	102%	1,289,158	1,240,653	1,316,733	106%
Cameroun	5,833,851	5,747,946	99%	5,824,470	6,363,659	6,268,341	99%
Cote d'Ivoire	3,236,348	2,937,074	91%	4,654,325	5,180,887	4,275,333	83%
DR Congo	8,006,201	7,955,556	99%	9,379,417	10,531,672	10,650,495	101%
Guinea	2,413,615	2,203,496	91%	1,779,278	2,237,452	1,901,834	85%
Kenya	3,716,143	3,357,446	90%	3,497,297	3,871,439	3,345,489	86%
Madagascar					3,259,112	2,933,358	90%
Mali	2,011,133	1,872,365	93%	2,053,898	2,129,241	2,172,619	102%
Niger	6,361,641	5,438,281	85%	6,609,745	6,924,961		
Nigeria	5,893,770	5,544,101	94%	4,802,018	6,064,880	5,640,455	93%
Total	38,565,190	36,175,843	94%	39,889,606	47,803,956	38,504,657	94%

4.1. Burkina Faso

Vitamin A supplementation (VAS) in Burkina Faso is supported by UNICEF, Helen Keller International, and the Health Sector Strengthening Project (PRSS), which is implemented with World Bank assistance. This intervention leverages the Ministry of Health's decentralized structures, including 13 regional health directorates and 70 health districts.

For several years, the approach—known as Journées de Supplémentation en Vitamine A Plus (JVA+)—has remained consistent:

In rural areas, community health workers, who receive monthly incentives funded by the government and the World Bank, visit households in their catchment areas to deliver VAS, deworming, and malnutrition screening. They are given a month to complete this task.

In urban areas, a 4-day door-to-door campaign is conducted using distributors specifically recruited for the task.

One key distinction in Burkina Faso's support model is that distributors in rural areas do not receive additional training, as they are typically the same individuals from one campaign to the next.

In fiscal year 2024, two campaigns were held: in December 2023 and June 2024. In December 2023, Helen Keller supported four regions, while UNICEF covered the remaining nine. By June 2024, Helen Keller extended its support to one additional region (Centre-Sud) due to a lack of funding from UNICEF.

The JVA+ model demonstrates potential for sustainability, largely due to the government's commitment to maintaining monthly incentives for community health workers. Additionally, the country has a strong tradition of adhering to the recommended 4-6 month intervals between campaigns, thanks to a robust planning process.

However, challenges persist, particularly in urban areas, where insufficient stocks of vitamin A capsules and inaccurate target population data have resulted in lower coverage.

Looking ahead, a key priority is to enhance the sustainability of the JVA+ approach by increasing the government's financial ownership of the program. Continued support from partners will be essential during this transition. Additionally, Helen Keller is in discussions with the Bill and Melinda Gates Foundation (BMGF) and GiveWell about the potential to distribute azithromycin to children under five alongside VAS in all districts.

4.2. Cameroon

In Cameroon, Vitamin A supplements are distributed to children aged 6 to 59 months through door-to-door campaigns during Mother and Child Health and Nutrition Action Week (MCHNAW). The country also continues to conduct frequent polio campaigns, offering a valuable opportunity to pair these efforts with VAS distribution. While polio campaigns are expected to continue in 2024 and 2025, the exact geographic coverage and timing remain unclear. In the second half of 2023, VAS was successfully coupled with polio campaigns in the four regions of Adamaoua, North, Extreme North, and East.

Helen Keller International supports the operational costs of VAS campaigns in all 10 regions of Cameroon, while UNICEF handles the procurement and transportation of Vitamin A capsules.

These campaigns provide a comprehensive package of services for both mothers and children. In addition to Vitamin A supplementation, children receive deworming treatments, routine immunization catch-ups, and access to other interventions, including malaria prevention for pregnant women, bed net distribution, and community registration for Universal Health Coverage (CSU).

Vitamin A is also distributed through routine health services, targeting all children aged 6 to 59 months. However, it is easier to reach children aged 6 to 11 months through immunization and growth monitoring activities. National VAS coverage through routine services remains low, at just 17% for the first semester of 2024. To strengthen routine VAS distribution, Helen Keller supported an operational study between 2021 and 2022 in two districts, Kaele and Guididiguis, which showed promising results, including 90% survey coverage and a cost of $0.74 per supplement. By the end of the first semester of 2024, routine VAS coverage in these districts remained high, at 87.5% and 92.2%, despite reduced financial support from Helen Keller.

Looking ahead, Helen Keller plans to provide institutional support to the Ministry of Health in developing and validating strategic documents, including a transition plan to move from campaign-based distribution to routine VAS supplementation.

However, challenges remain:

- **Inaccurate Population Data**: Insecurity, both within Cameroon and in neighboring countries like the Central African Republic and the Democratic Republic of Congo, drives significant internal and external migration. These population shifts, particularly in the Centre and Littoral regions, result in inaccurate population data, complicating planning and coverage estimates.
- **Recurrent Vitamin A Capsule Shortages**: Inaccurate population data has also contributed to recurrent shortages of Vitamin A capsules in recent years.
- **Insecurity in the North-West and South-West Regions**: Long-standing insecurity in these regions has posed challenges to campaign implementation. Despite this, Helen Keller has adapted by partnering with local community organizations to ensure quality execution of activities.

Cameroon’s Ministry of Health remains committed to providing twice-yearly Vitamin A supplements to children aged 6 to 59 months to reduce infant and child morbidity and mortality. Strengthening the integration of VAS into routine health services, beginning with the development of a national strategy, is key to achieving this goal and transitioning from campaigns to routine supplementation over the coming years.

4.3. Côte d’Ivoire

In Côte d'Ivoire, during the 2nd semester of 2023 and the 1st semester of 2024, VAS delivery used two approaches:

- **Campaign Approach:** In 40 districts, twice-yearly supplementation was delivered to children through a 4-day door-to-door mass distribution campaign organized in June and December.

- **Routine Services Approach**: In 73 districts, supplementation was delivered to children through routine services alongside immunization and growth promotion monitoring. Distribution occurred in facilities or during home visits and outreach sessions in preschools. However, coverage remained low (<50%) in most districts, prompting the organization of catch-up events at the end of each semester.

The long-term goal is to transition all districts to the routine model in the coming years.

Due to reduced funding UNICEF, Helen Keller fully support campaigns in 40 districts where the campaign model is used.

In fiscal year 2024, VAS distribution was coupled with azithromycin in 7 districts in the second semester of 2023 and 16 districts in the first semester of 2024. To support this combined distribution an additional distributor was added to each campaign team, funded by FHI360. Discussions are on-going about expanding this combined distribution. A total of 150,143 children aged 1-11 months were reached.

For the **routine approach**, distribution is carried out by health workers at the health facility and community health workers within their catchment areas.

Given the Ministry of Health's preference to shift exclusively to the routine model and low coverage associated with this approach, Helen Keller advocated for a gradual transition of districts from the campaign model to routine services. This transition aims to improve performance through monthly self-monitoring of coverage by health workers. This approach is currently being implemented in 8 health districts in the Poro and Tchologo regions, with an evaluation phase to determine next steps.

One of the significant challenges of the VAS program in Côte d'Ivoire is the persistently low coverage under the routine model, necessitating catch-up events that cost as much as campaigns but are less effective in terms of coverage.

Looking ahead, the priority is to ensure a smooth transition from campaigns to routine and routine distribution while improving routing coverage through monthly self-monitoring approach. Helen Keller also aims to support the Ministry of Health in scaling up azithromycin distribution through the VAS campaign platform. This would be another path towards an efficient approach to reducing infant and child mortality.

4.4. Democratic Republic of Congo

In fiscal year 2024, Helen Keller supported Vitamin A Supplementation (VAS) in nine provinces during the second semester of 2023 and in 13 provinces during the first semester of 2024, utilizing networks of community health workers known as "Comités d'Acteurs Communautaires" (CACs).

A unique aspect of the mass distribution approach in the Democratic Republic of Congo (DRC) is that, in most provinces, distributors are provided a one-time payment of approximately $10, regardless of the distribution duration. This contrasts with other countries, where distributors are typically compensated on a daily basis. VAS campaigns in DRC are door-to-door and generally span four days. While routine VAS distribution also occurs through health facilities via the "Preschool Consultation" platform (primarily for growth monitoring), coverage is estimated to be around 20%.

Helen Keller and UNICEF are the primary partners supporting the Ministry of Health for VAS, while Vitamin Angels supplies vitamin A capsules and albendazole tablets to 15 provinces, and UNICEF does so for 11 provinces.

DRC, like Cameroon and Niger, continues to conduct frequent polio campaigns, which presents an excellent opportunity to couple VAS distribution with these campaigns, as was done during fiscal year 2024.

Key challenges in implementing the VAS program include:

- **Target harmonization**: When coupling VAS with polio campaigns, the target population for VAS (children aged 6-59 months) differs from the polio target for the same age group. The Expanded Program on Immunization (EPI) uses the number of children vaccinated in the most recent campaign, while the nutrition sector uses census data adjusted for natural population growth. This discrepancy in target populations creates a challenge in aligning the two programs.
- **Capsule management**: The management of vitamin A capsules remains weak at the Ministry level, and coordination between UNICEF, the Ministry of Health, and Vitamin Angels is ineffective, often resulting in frequent shortages and confusion regarding stock availability.

Looking ahead, the prospects for the VAS program in DRC include:

Continuing to support VAS in 13 provinces, utilizing either the intensive community-based routine approach or integrating VAS with polio/measles campaigns.

Implementing a pilot routine VAS program, which will include a comprehensive child survival package, in six health zones within the “Direction Provinciale de la Santé” of Kongo Central. This pilot will also involve a cost-benefit analysis in the six target health zones, which will be compared to six control health zones to evaluate the program's effectiveness.

4.5. Guinea

Guinea delivers Vitamin A Supplements (VAS) through a four-day door-to-door campaign approach. The main partners, along with Childfund, support VAS delivery and the provision of deworming tablets. Additional services provided during these campaigns include deworming and birth registration.

A network of community health workers (CHWs) conducts the supplementation. Since there is no government incentive system in place for these CHWs, Helen Keller International and UNICEF provide a per diem during the distribution. These partners also cover the costs related to micro-planning, procurement and transportation of inputs, management tools, training, distribution, supervision, social mobilization, and monitoring and evaluation.

Deworming was conducted during the second round of 2023 but was not included in the first semester of 2024 due to stockouts. Routine catch-up immunization was integrated into the first round of VAS distribution in 2024.

Helen Keller International has supported the Ministry of Health in conducting a situational analysis to explore possible approaches for integrating VAS into routine primary healthcare services. The goal is to increase the cost-effectiveness and sustainability of VAS services. The findings from this study were used to finalize a routine transition plan and to develop an implementation guide for the identified approaches.

One of Guinea's distinguishing factors is the involvement of administrative authorities, including governors, prefects, and sub-prefects, in VAS implementation, even in remote areas. Their involvement in the campaigns serves as a motivating factor for health workers.

Despite several years of implementing VAS interventions, there are ongoing challenges. A key issue is the inconsistent adherence to the WHO-recommended 4-6 month interval between VAS doses, due to weaknesses in planning. Furthermore, Guinea's extensive mining areas attract large foreign populations, making it difficult to accurately estimate target populations and leading to low VAS coverage in these regions.

Looking ahead, two key priorities have been identified:

- **Improving the quality of VAS mass distribution activities**, focusing on both the implementation process and increasing coverage.
- **Ensuring a gradual and effective transition to a more sustainable VAS distribution strategy**, which would allow for consistent and adequate coverage of children moving forward.

4.6. Kenya

Helen Keller worked closely with the Ministry of Health at the national level and the county health departments in all 25 counties to ensure that services reached all eligible children. A variety of delivery models were employed, including routine VAS delivery at health facilities alongside other child health services, distribution through Early Childhood Development and Education (ECDE) centers, accelerated outreach efforts, and door-to-door campaigns during the Malezi Bora campaigns at the end of each semester. In all counties, Vitamin A supplementation was combined with deworming, and in some counties, child malnutrition screening using Mid-Upper Arm Circumference (MUAC) assessments was also integrated.

The program emphasized strengthening routine VAS delivery throughout both semesters. In the second semester of 2023, Baringo and Taita Taveta counties began implementing routine VAS, and in the first semester of 2024, routine services were expanded to additional counties, including Kwale, Laikipia, Kirinyaga, and Tharaka Nithi. These counties adopted routine delivery as their primary model for distributing VAS and deworming treatments. Helen Keller focused on building the capacity of health workers by supporting target setting, mapping all eligible children, monitoring monthly progress, providing feedback, ensuring the availability of Vitamin A capsules, conducting training and supervision, and facilitating regular data reviews. These efforts helped to strengthen the health systems in these counties and ensured they could effectively manage and sustain routine VAS delivery.

Figures 5 and 6 illustrate the cumulative coverage during the first semester of 2024 compared to spikes in the second round of 2023 for both age cohorts. The key finding illustrated in Figures 6 and 7 is the contrast between steady, continuous coverage achieved through routine service delivery and the more typical distribution spikes associated with campaign-based approaches, especially toward the end of the semester during Malezi Bora campaigns. This steady progress indicates that counties employing routine delivery models—such as Baringo and Taita Taveta—were able to distribute VAS gradually over time, rather than relying solely on the intense, short-term efforts of campaigns. The data suggest that, while campaign-based distribution may result in immediate spikes in coverage, the integration of VAS into routine health services ensures a more sustained and stable

approach, ultimately contributing to better long-term coverage and health system sustainability.

Figure 5. Cumulative coverage, semester 2, 2023, routine delivery counties, Kenya

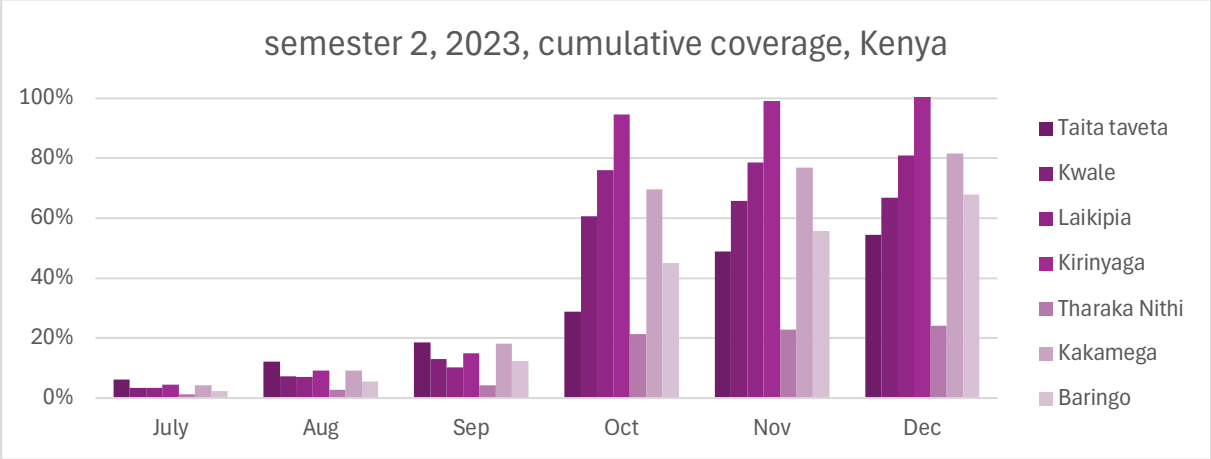
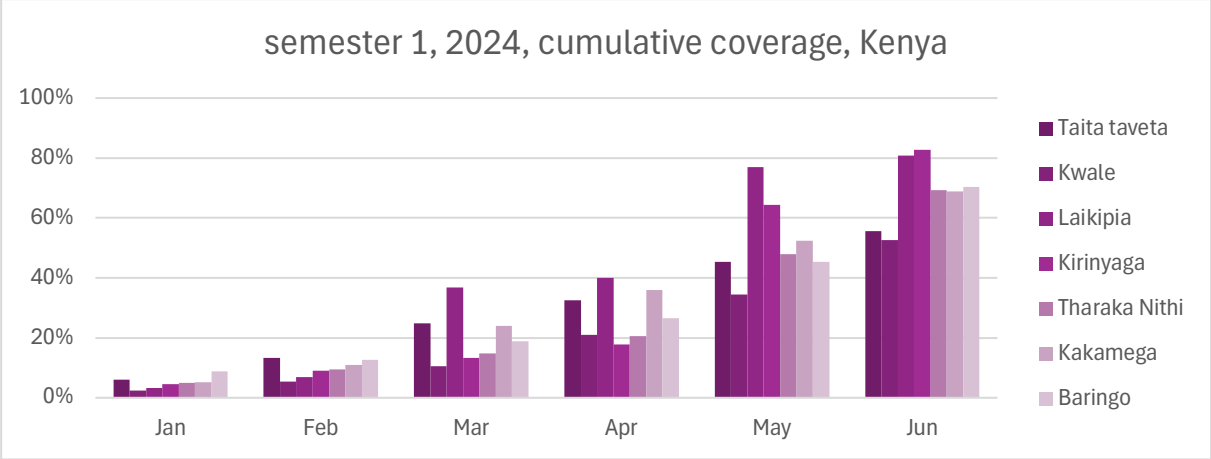


Figure 6. Cumulative coverage, semester 1, 2024, routine delivery counties, kenya



Helen Keller also supported the government in developing a national Vitamin A and deworming training guide, which was piloted in several counties and is now ready for nationwide dissemination. This guide offers a standardized training package to strengthen the capacity of county health managers and health workers in delivering integrated Vitamin A supplementation (VAS) and deworming services.

A key innovation introduced by the Ministry of Health is the digitization of the VAS supply chain. An online platform was created to enable real-time tracking of Vitamin A capsule stocks at all levels of the health system, helping to address supply chain issues.

Despite these advancements, Kenya continues to face challenges in transitioning to routine VAS services. Health actors still heavily rely on catch-up activities rather than fully integrating VAS into routine services. Persistent stockouts of supplies and inadequate resources in many counties further hinder the ability of health workers and managers to implement activities effectively.

Starting in January 2025, Helen Keller will phase out its support in 24 counties, continuing its involvement in only 4 counties. The focus in these remaining counties will be on strengthening the integration of VAS into routine health services.

4.7. Madagascar

Helen Keller supported a VAS campaign for the first time during the 1st semester of 2024.

Initially, Helen Keller expected to support four regions and to scale up to 8 regions by the 2nd semester of 2024. However, in May 2024, just a few weeks before the campaign start date, the Ministry of Health announced a funding shortfall for regions not supported by Helen Keller and UNICEF. The Ministry warned that the joint VAS and polio campaign would not proceed if some regions remained unsupported. As a result, the Ministry postponed the campaign by two months in an attempt to secure additional funding, but these efforts were unsuccessful. Eventually, Helen Keller stepped in to provide financial support for the 12 previously unsupported provinces, allowing the campaign to move forward.

The campaign lasted 5 days and adopted a door-to-door strategy. It was preceded by training for distributors, logistical support for delivering inputs to the last mile, supervision, and support for data management and reporting.

Despite the commitment of the Ministry and its partners to ensure twice-yearly supplementation for children aged 6-59 months, several challenges persist:

- **Coordination issues:** While integrating Vitamin A distribution with the polio campaign provides an opportunity for better resource management, collaboration between the nutrition and immunization programs is insufficient, hindering optimal planning.
- **Low education levels of community agents:** This presents a major challenge to the quality and coverage of VAS. Without adequate training, distributors often make errors in identifying target children, delivering key messages, and recording distribution data.
- **Supply chain issues:** Sub-optimal supply management remains a significant obstacle to effective implementation.

UNICEF and the Ministry of Health are also actively promoting the integration of VAS into routine health services. In June 2024, they organized a workshop to reflect on the transition to more sustainable approaches to distributing Vitamin A through routine services and, with support from Helen Keller, developed a roadmap describing how to integrate VAS in routine systems that should be implemented starting in 2025.

For the future, key priorities include improving the quality of vitamin A mass distribution activities through better planning, better coordination between stakeholders and improved supply chain management and the implementation of the roadmap for transition of Vas into routine services.

4.8. Mali

Vitamin A supplementation in Mali is coordinated by the Ministry of Health, with support from Helen Keller Intl and UNICEF. World Vision supports the provision of deworming tablets.

The campaign, known as the Week of Intensification of Nutrition Activities (SIAN), is conducted over four days using a door-to-door distribution model.

Previously, the whole campaign was managed at the central level. However, since 2023, the Ministry has decentralized planning to the district level to better tailor the campaign to specific local needs and contexts thereby improving coverage.

Community health workers deliver several services during the campaign including Vitamin A, deworming, and malnutrition screening.

Helen Keller supports three regions, while UNICEF covers the rest of the country.

Despite these efforts, several challenges hinder the effective implementation of VAS interventions in Mali:

- **Planning delays** due to supply stockouts and lack of coordination between different departments within the Ministry of Health.
- **Insecurity in certain areas**, which negatively affects the quality of distribution activities, supervision and independent monitoring.

In Mali, one of the priorities for the coming year is to ensure the quality implementation of VAS campaigns in the context of insecurity. Discussions have also begun on developing a transition plan towards more sustainable approaches for Vitamin A distribution, with a situational analysis planned for FY25.

4.9. Niger

In Niger, Vitamin A supplementation campaigns are conducted door-to-door during National Micronutrient Days (NMD), which take place twice a year. These campaigns often combined with other health interventions such as polio or measles vaccinations.

The Ministry of Health's Directorate of Nutrition organizes the campaigns through decentralized health structures across eight regions and 72 districts. Community distributors implement the 4-day campaigns.

Helen Keller International, UNICEF, and WHO are the main partners. However, for the last two years, due to a lack of funding from UNICEF for VAS, Helen Keller has shouldered the full costs of implementing the campaigns in all eight regions of the country.

The Vitamin A supplementation and deworming campaign for the second half of 2023 took place in December 2023. Due to funding constraints caused by ECOWAS sanctions following the July 2023 coup d'état, the campaign was conducted in phases. In the regions of Agadez, Dosso, Diffa, Niamey, and Tahoua, the campaign was held from December 22 to 25, 2023. In Maradi, it was organized from December 24 to 28, 2023. As for Tillabéry and Zinder, the campaign took place from December 27 to 30, 2023.

For the first semester of 2024, a VAS and polio campaign was initially planned in June but was postponed to September 2024 due to several factors: Vitamin A capsules did not arrive in the country until the end of June, the Ministry of Health decided to combine VAS and deworming with the second round of the polio campaign and malnutrition screening, and torrential rains in August 2024 made Niamey inaccessible while widespread flooding caused significant damage across the country.

Despite consistently achieving high coverage, there are several challenges that hinder the planning and implementation of VAS campaigns. These include delays in planning, suboptimal capsules management, weak coordination and information sharing, and insecurity all of which must be addressed every six months.

Looking to the future, Helen Keller started implementing a VAS routine study in 2 regions, Tahoua and Dosso in Niger, to explore more sustainable approaches.

4.10. Nigeria

For Fiscal Year 2024, Helen Keller International provided technical and logistical support for the Maternal, Newborn, and Child Health Week (MNCHW), a week-long bi-annual campaign organized by the National Primary Health Care Development Agency (NPHCDA), State Primary Health Care Development Agencies (SPHCDA), and State Ministries of Health (SMoH).

The campaign is designed as a one-time delivery mechanism that provides multiple health services aimed at significantly increasing coverage of key preventive and curative interventions. These services are targeted to improve the health of mothers and children under five years of age.

The services offered during the campaign include Vitamin A supplementation, deworming, routine immunization, nutrition screening using MUAC tapes, birth registration, family planning, health and nutrition education (covering topics like handwashing, early initiation of breastfeeding, exclusive breastfeeding, appropriate complementary feeding, hygiene, and sanitation), anti-malaria prophylaxis, iron and folic acid supplementation, multiple micronutrient supplementation for pregnant women, as well as HIV/AIDS testing and counseling.

Helen Keller, alongside key partners such as UNICEF, Nutrition International, and Vitamin Angels, played a critical role in supporting the MNCHW campaign.

Comprehensive pre- and post-campaign activities were carried out, including microplanning meetings at the national, state, and local government levels, training sessions, social mobilization, supervision, and data review meetings.

Helen Keller International has also increasingly engaged with state leaders to explore the possibility of testing new approaches for integrating Vitamin A distribution into routine health system services. The goal is to develop a pilot or research project to generate evidence on the feasibility and acceptability of this integrated approach.

Several challenges were encountered during the preparation and implementation of the campaign, including:

- **Insecurity**: Random and targeted kidnappings for ransom, clashes between farmers and herders, and banditry in various states created fear and anxiety for beneficiaries, health workers, and supervisors, affecting the campaign's implementation.
- **Unexpected changes to campaign dates**: In some states, Ministries made impromptu changes to the campaign schedule, leading to delays in the commencement and completion of activities, particularly in the Federal Capital Territory (FCT).

- **Economic challenges**: The removal of fuel subsidies and new economic policies under the current administration significantly impacted the pre-implementation and campaign activities. Rising costs of transportation, food, and other goods and services increased the burden on stakeholders and hindered the supervision of activities.

5. Countries not supported by GiveWell

Helen Keller supports the Ministry of Health in strengthening routine services in Mozambique, Senegal, Sierra Leone, and Tanzania.

Table 7 shows the number of children reached in these countries. Between July 2023 and June 2024, Helen Keller supported the distribution of Vitamin A capsules through routine-only services in Mozambique, Sierra Leone, and Tanzania. In Mozambique, 599,588 children were reached (85% coverage) in the second semester (S2) of 2023, and 588,380 children were reached (81% coverage) in the first semester (S1) of 2024. In Sierra Leone, 413,563 children were reached (84% coverage) in S2 2023, and 414,962 children were reached (82% coverage) in S1 2024. Tanzania exceeded its targets, reaching 489,933 children (132% coverage) in S2 2023 and 454,541 children (124% coverage) in S1 2024. Across all three countries, a total of 1.5 million children were reached in both semesters. No data is available for Senegal as health workers retain all data as part of an ongoing strike.

Table 7. Capsules distributed with Helen Keller support between July 2023 and June 2024 in routine only services

	S2 - 2023			S1 - 2024		
	Nb. children targeted	Nb. children reached	Administrative coverage	Nb. children targeted	Nb. children reached	Administrative coverage
Mozambique	703,455	599,588	85%	723,763	588,380	81%
Sierra Leone	495,194	413,563	84%	506,861	414,962	82%
Tanzania	352,073	489,933	132%	367,298	454,541	124%
Total	1,550,722	1,503,084		1,597,922	1,457,883	

5.1. Mozambique

The Ministry of Health leads vitamin A supplementation and deworming in Mozambique through the Department of Nutrition, which has its extension at the provincial and district levels through the Provincial Directorates of Health (DPS) and District Service for Women and Social Action (SDSMAS), respectively, represented at each level by a Nutrition focal point.

VAS is delivered through three platforms: routinely in the health facilities, through outreach events called “Mobile brigades” and is integrated in the primary health care package delivered by the trained community health workers for hard-to-reach communities.

Figures 7 and 8 show that in the Tete province, intense outreach sessions were organized in August 2023 that significantly boosted coverage, but overall, these sessions were

integrated in the routine management of the health system for the following semester and for both semesters in Gaza, providing a regular increase of cumulative coverage to reach more than 80% supplemented through routine services in both provinces.

During the second round of 2023 and the first round of 2024, Helen Keller supported two provinces, Gaza and Tete. Helen Keller integrated Vitamin A supplementation (VAS) and deworming with malnutrition screening. All children identified with malnutrition were referred to health facilities for appropriate interventions. The screening for malnutrition was conducted both during mobile brigades and by community health workers as part of community-level services. A total of 15,769 children were screened, of which 384 were identified as malnourished and referred for treatment at the nearest health facility.

Figure 7.Cumulative coverage, semester 2, 2023, routine delivery counties, Mozambique

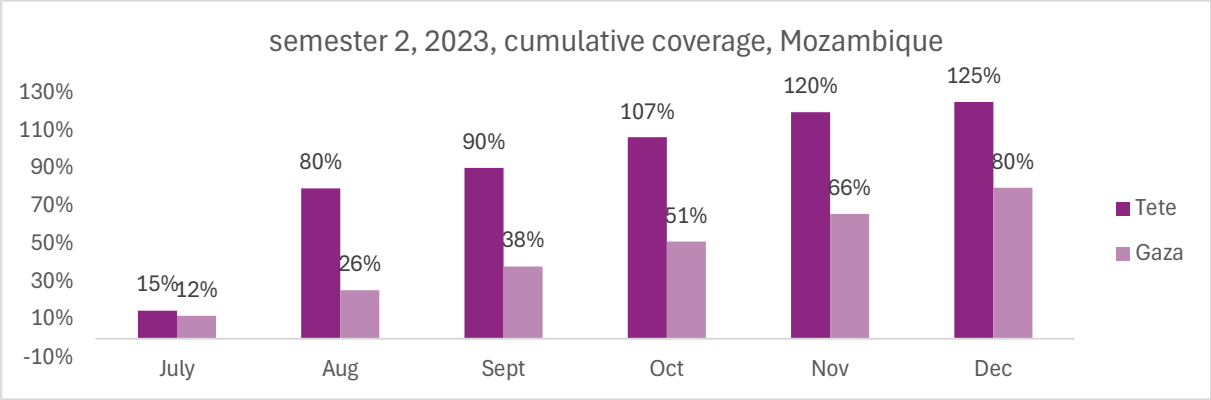
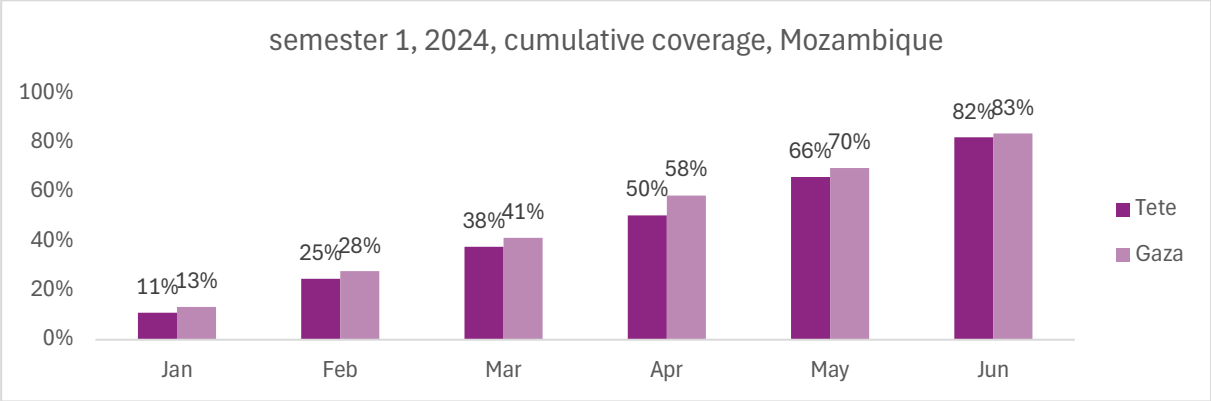


Figure 8. Cumulative coverage, semester 1, 2024, routine delivery counties, Mozambique



However, several challenges remain including stockout of supplies, limited capacity of field workers, and weak coordination between facility and community workers.

The support provided by Helen Keller included training health workers, supervision of activities and conducting data review meetings.

In the coming year, Helen Keller will focus on strengthening the capacity of community health workers to increase VAS coverage while reducing reliance on mobile brigades. Since these workers are integrated into the health system, they offer a more sustainable approach to delivering services, particularly as the government continues to invest in community health.

5.2. Senegal

During the Fiscal Year 2024, Helen Keller continued supporting the integration of VAS into routine health services in 17 Districts in three regions.

In Senegal, VAS for children aged 6-59 months has been delivered through routine services for over ten years. Despite a significant reduction in under-5 mortality, the government considers VAS to be a critical high-impact child survival intervention.

For many years, routine VAS coverage remained below 50%. However, in recent years, thanks to Helen Keller's approach of monthly monitoring by health workers, coverage has improved to 80%. Various platforms are used to distribute vitamin A routinely including consultation of sick children, vaccination, growth promotion monitoring, home visits, community screening sites for malnutrition, and schools.

For the past two years, Senegal's health system has been severely affected by a prolonged health workers' strike, which has involved withholding health and nutrition data. As a result, no VAS data are available for the two semesters of Fiscal Year 2024. This data retention poses a significant challenge for the health system, extending beyond the VAS program.

Despite this, the Senegalese government has set target of achieving at least 80% coverage across all 14 regions. While distribution activities continue at the health facility and community levels, the lack of visibility on key indicators remains a concern. In response, Helen Keller plans to conduct a survey to assess coverage and identify bottlenecks to identify effective solutions.

5.3. Sierra Leone

Sierra Leone integrated Vitamin A Supplementation (VAS) into the routine Expanded Program on Immunization (EPI) in 2017. However, since healthy children over 12 months typically do not access routine health services, the Ministry of Health complements these services with outreach activities organized by health facilities to reach hard-to-access populations.

These outreach sessions, which include deworming and nutrition counseling for caregivers on child-feeding practices, are conducted over six days in May and June during the first semester and in November and December during the second semester.

The Ministry of Health (MoH) manages all nutrition and VAS activities nationwide through the Directorate of Food and Nutrition (DFN), the Directorate of Policy, Planning, and Information (DPPI), and the EPI directorates. At the district level, District Health Management Teams (DHMTs) — composed of nutritionists, EPI officers, M&E officers, and community health worker focal points — are responsible for planning, implementing, and monitoring VAS programs, with support from the national MoH.

In the second semester of 2023, Helen Keller Intl provided technical and logistical support to five of the 16 districts to help plan and implement these outreach activities. Capacity building and data review meetings were also conducted to improve service quality at the health facility level.

5.4. Tanzania

Vitamin A Supplementation (VAS) delivery in Tanzania is integrated with screening for acute malnutrition using MUAC tapes for children aged 6-59 months and deworming for children aged 12-59 months. These services are provided through the Child Health and Nutrition Month (CHNM), a month-long campaign organized at the end of each semester, using a combination of fixed and outreach models.

In the Mara region, with Helen Keller's support, coverage rates of 132% and 124% were achieved during the second semester of 2023 and the first semester of 2024, respectively. These unusually high coverage rates suggest that the population targets provided by the Ministry are inaccurate, highlighting the need for improved data accuracy as VAS transitions to routine integration within health systems.

In the first semester of 2024, Helen Keller conducted a bottleneck analysis study, which included a cross-sectional household survey and a qualitative assessment of the health system. The study aimed to identify the system's weaknesses, strengths, and opportunities that can be leveraged for piloting routine VAS delivery.

During the second semester of 2024, Helen Keller Intl will develop a study protocol for a barrier analysis focused on routine VAS delivery, paving the way for piloting the integration of VAS into routine health services.

6. Monitoring, Evaluation, Accountability and Learning for VAS program.

6.1. Independent monitoring

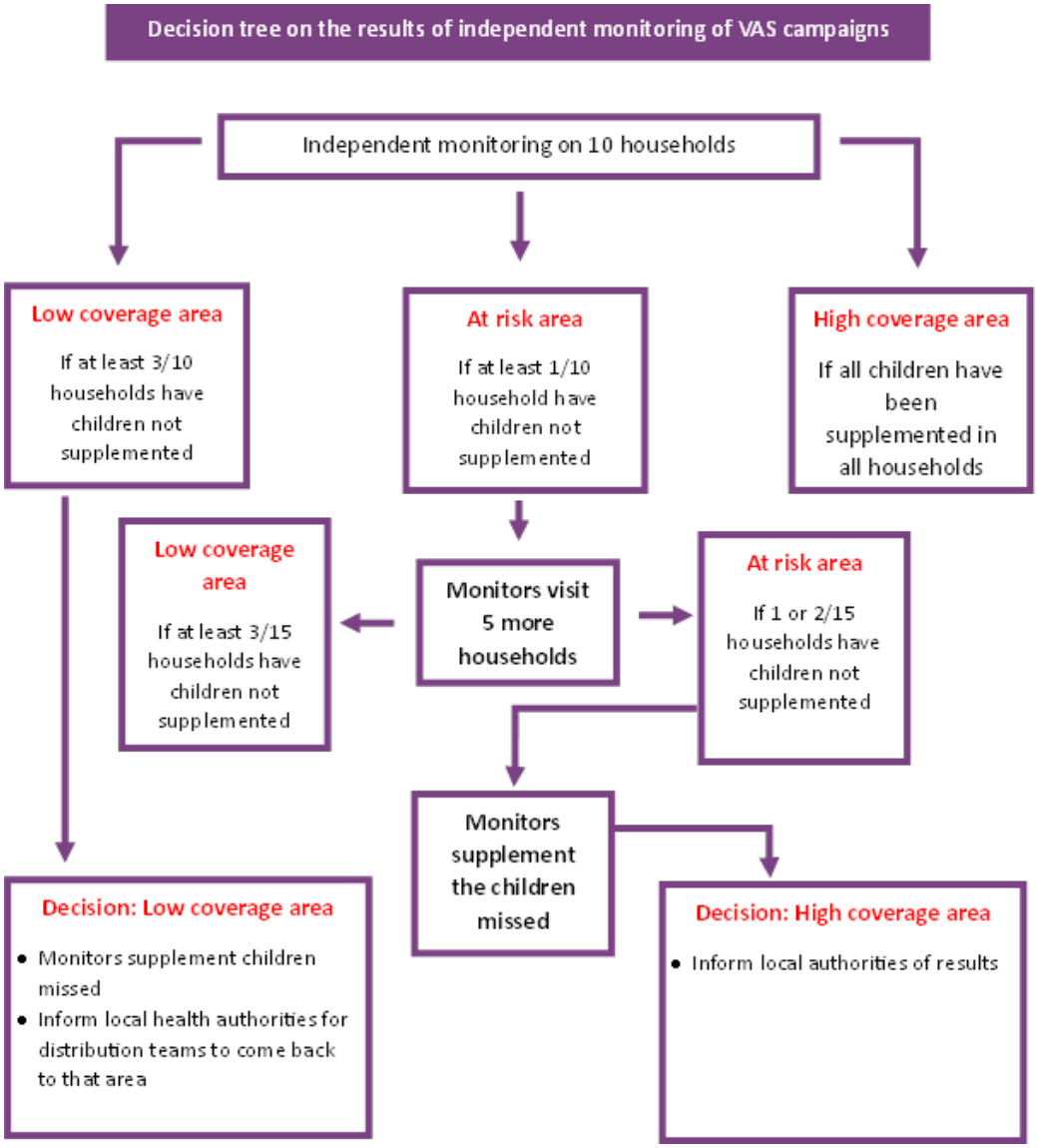
Independent monitoring consists of sending monitors to hard-to-reach areas during VAS campaigns to verify whether the distribution teams have reached the intended children as planned. If communities are missed or insufficiently covered, monitors immediately alert the Ministry of Health.

Although independent monitoring was planned for countries with VAS campaigns, in Kenya and Madagascar, Helen Keller teams delayed the procurement process, resulting in a failure to contract with an independent agency on time.

While independent monitoring has been implemented in some countries, it has not been systematic. Additionally, the methodology required improvement to align more closely with the approach used for polio campaigns. To address this, a toolkit was developed to guide country teams in preparing the independent monitoring, including detailed decision tree outlining the monitor's actions in the field (**Figure 9**).

The tree begins with the identification of target areas for monitoring, moving through a series of decision points such as the availability of supplies, effectiveness of community outreach, and adherence to campaign protocols. At each branch, specific actions or evaluations are outlined, leading to either a successful campaign review or identification of gaps that require further investigation or corrective action. The decision tree provides a systematic approach to ensure comprehensive and consistent monitoring across different campaign settings, improving the quality and effectiveness of VAS delivery.

Figure 9. Decision tree for independent monitors of VAS campaigns



As independent monitoring takes place, the data collected by the monitors are uploaded on the Survey CTO platform and immediately available to Helen Keller teams through a PowerBI dashboard, allowing our teams to address challenges as they arise (**Figure 10**).

Figure 10.Screenshot of the independent monitoring power BI dashboard for Cameroon

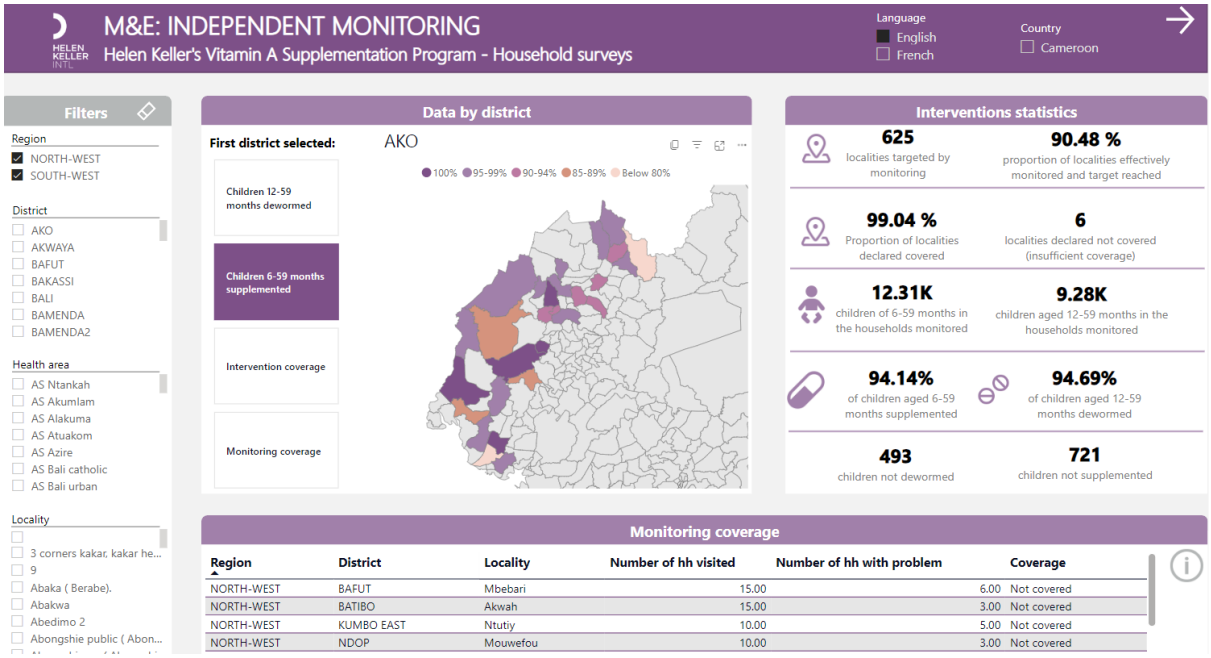


Table 8 presents the results of independent monitoring for Vitamin A Supplementation (VAS) campaigns conducted between July 2023 and June 2024 across multiple countries. From July 2023 to June 2024, independent monitoring of Vitamin A Supplementation (VAS) campaigns was conducted across several countries. Coverage ranged from 90% to 98% across the monitored communities. In Burkina Faso, 79 communities were visited, with 14 uncovered, resulting in 93% coverage. Cameroon saw higher coverage, with 95% and 94% in semesters 2 of 2023 and 1 of 2024, respectively, across over 2,200 communities visited. Côte d'Ivoire achieved 98% coverage in semester 2 of 2023 and 95% in semester 1 of 2024. Guinea maintained high coverage of 98% and 94% in its two semesters. Mali faced more uncovered communities, with coverage at 94% in semester 2 of 2023 and 92% in semester 1 of 2024. Niger reported consistent coverage of 97% across both semesters. In Nigeria, coverage was slightly lower in semester 1 of 2024 at 91% compared to 94% in semester 2 of 2023. Finally, the Democratic Republic of Congo (RDC) had coverage of 90% and 92% across semesters 2 of 2023 and 1 of 2024, respectively, indicating a strong overall performance in reaching children with VAS despite some localized challenges.

Table 8. Results of Independent monitoring, July 2023 to June 2024

Country	Semester	Number of communities visited	Nb. Of communities visited declared covered	Nb. Of communities visited declared uncovered	Number of children in households within monitored localities	Number of children non supplemented during monitoring	Number of children supplemented during revisits	Nb. Of communities revisited	Coverage measured by independent monitors
Burkina Faso	S1 - 2024	79	65	14	2,129	143	30	10	93%
Cameroun	S2 - 2023	1,644	1,463	181	35,487	1,806	1,868	181	95%
	S1 - 2024	616	610	6	12,048	706	704	6	94%
Côte d'Ivoire	S2 - 2023	301	255	46	19,354	314	NA	NA	98%
	S1 - 2024	310	267	43	7,627	364	256	43	95%
Guinea	S2 - 2023	400	386	14	10,173	200	258	14	98%
	S1 - 2024	129	129	0	4,192	255	0	0	94%
Mali	S2 - 2023	396	351	45	10,314	606	1,825	45	94%
	S1 - 2024	242	188	54	8,041	655	1,542	30	92%
Niger	S2 - 2023	246	NA	NA	12,141	379	NA	NA	97%
	S1 - 2024	208	NA	NA	5,492	178	NA	NA	97%
Nigeria	S2 - 2023	1,051	1,051	NA	632,310	36,609	NA	NA	94%
	S1 - 2024	1,051	1,051	NA	1,241,969	1,124,899	NA	NA	91%
RDC	S2 - 2023	234	223	11	4,947	504	N/A	11	90%
	S1 - 2024	1,179	1,037	142	28,860	2,281	N/A	105	92%

In Nigeria, independent monitors collected data from caregivers and health workers across all Local Government Areas (LGA) in states supported by Helen Keller. During the second round of 2023 and the first round of 2024, monitoring was conducted in 1,051 LGAs across five states (Adamawa, Benue, Ebonyi, Nasarawa, Taraba) and the Federal Capital Territory (Abuja), supported by another donor. The monitoring focused on key indicators to assess the campaign's effectiveness including (i) caregivers' and health workers' knowledge of Vitamin A, (ii) channels through which Vitamin A messages were communicated, and (iii) areas covered during health talks. These metrics are crucial for understanding the reach and impact of the campaign.

6.2. Post-event coverage surveys

A second key component of Helen Keller's monitoring system is the post-event coverage surveys, conducted within six weeks of a campaign's conclusion. These surveys use representative sampling to provide reliable estimates of VAS (Vitamin A Supplementation) coverage and identify reasons for nonreceipt.

In 2024, several important adjustments were made to these surveys in collaboration with GiveWell:

Aggregation of Regions: Surveys now aggregate all Helen Keller-supported regions into a single stratum. Previously, each region was treated as an independent stratum, selected based on its risk for low coverage, with multiple strata included in a single survey.

Survey Secrecy: To avoid bias, the Ministry of Health in regions targeted for the survey is not informed before the campaign's end, ensuring local managers do not exert extra effort beyond the norm, which could skew results.

Enhanced Questionnaires: All questionnaires now include a satisfaction question to assess caregivers', distributors', and health workers' satisfaction with the services received.

- Coverage is measured for the entire semester, distinguishing between:
- Children supplemented only during the campaign.
- Children supplemented both during the campaign and at another time.
- Children supplemented only at another time.
- Children not supplemented at all.
- The number of times children received VAS during the semester is also tracked to gauge both campaign and routine VAS delivery impacts.

Improved Quality Control: Helen Keller switched to the Survey CTO platform, enabling tighter control measures like monitoring time spent per survey or per household and verifying census data for enumeration areas.

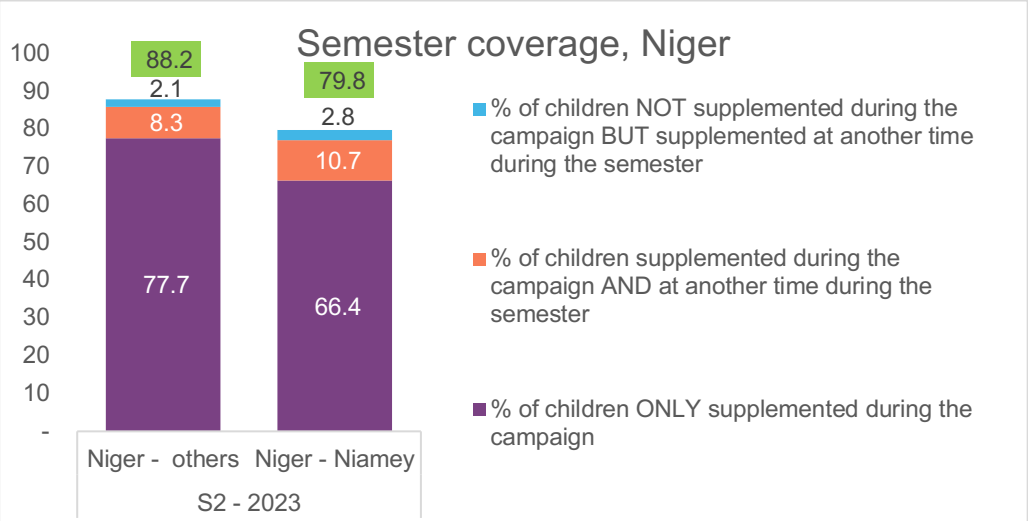
- Supervisors listen to 10% of interviews to check data accuracy.
- Independent monitors re-survey 10% of clusters to ensure reliability, including conducting an initial census.

Each country organizes one survey per year, alternating between the first and second semesters. In the first semester of 2024, five countries were identified: Kenya, Mali, Niger, Guinea, and Madagascar. However, the survey was delayed in Kenya due to procurement issues, and in Niger, flooding and campaign delays led to a postponement.

Between the second semester of 2023 and the first semester of 2024, 13 post-event coverage surveys were completed. These surveys distinguished between children

supplemented through the campaign, those supplemented via both the campaign and other platforms during the semester, and those reached only through non-campaign methods. Figures displaying semester coverage (marked in green) include both campaign and out-of-campaign supplementation results.

Figure 11. Results of coverage surveys in Niger, semester 2 of 2023.



In **Figure 11**, the survey results from Niger's second semester of 2023 show two distinct strata: one covering all regions except the capital city, Niamey, and another focusing solely on Niamey. The distinction was made due to the challenges of achieving high coverage rates in large urban areas.

The survey revealed that 76.1% of children in Niamey received supplementation, compared to 86% in the other regions, indicating that while the campaign was largely successful nationwide, Niamey lagged behind in coverage.

In Niamey, 51.7% of unsupplemented children were not reached because distributors failed to visit their homes. Additionally, 19.2% of caregivers were unaware of the campaign. Similar issues were noted in other regions, where 61.7% reported missed visits and 25.8% were unaware of the campaign, highlighting key areas for improvement.

Figure 12. Results of coverage surveys in Nigeria, semester 2 of 2023.

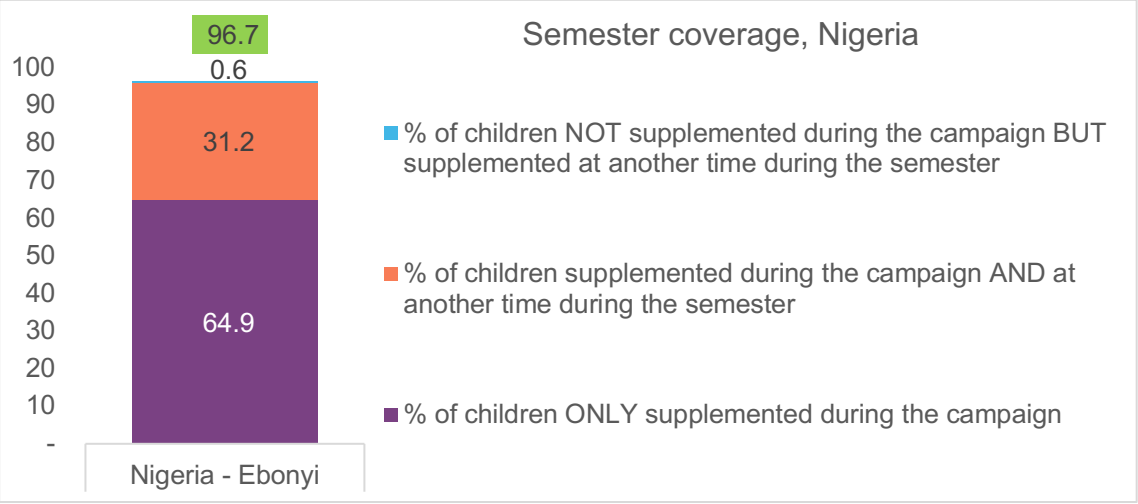
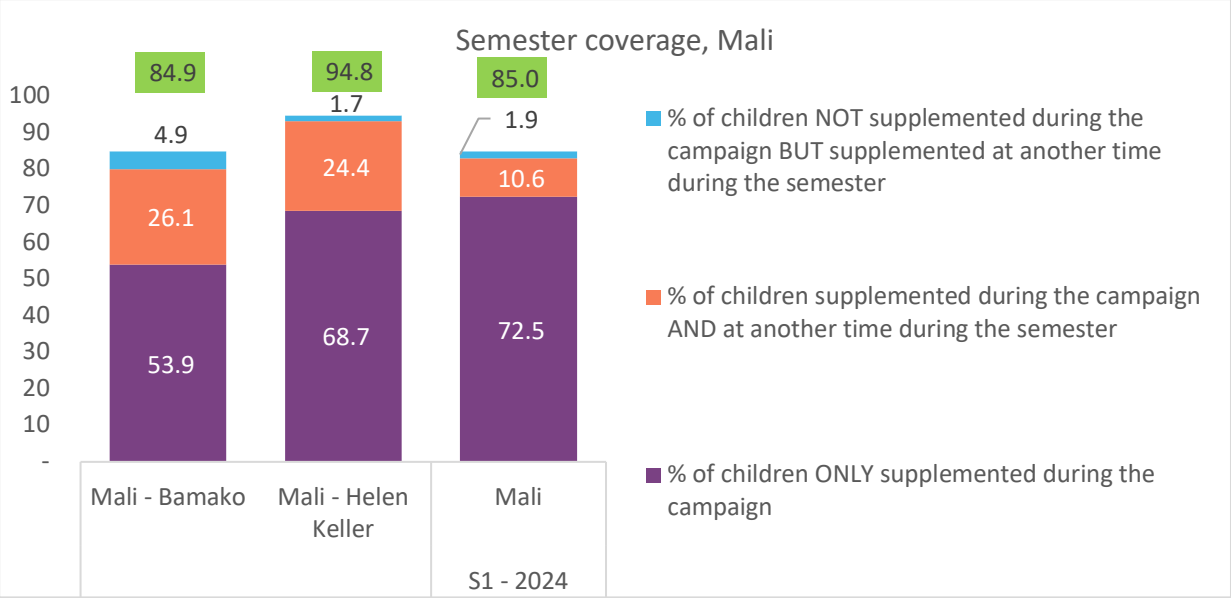


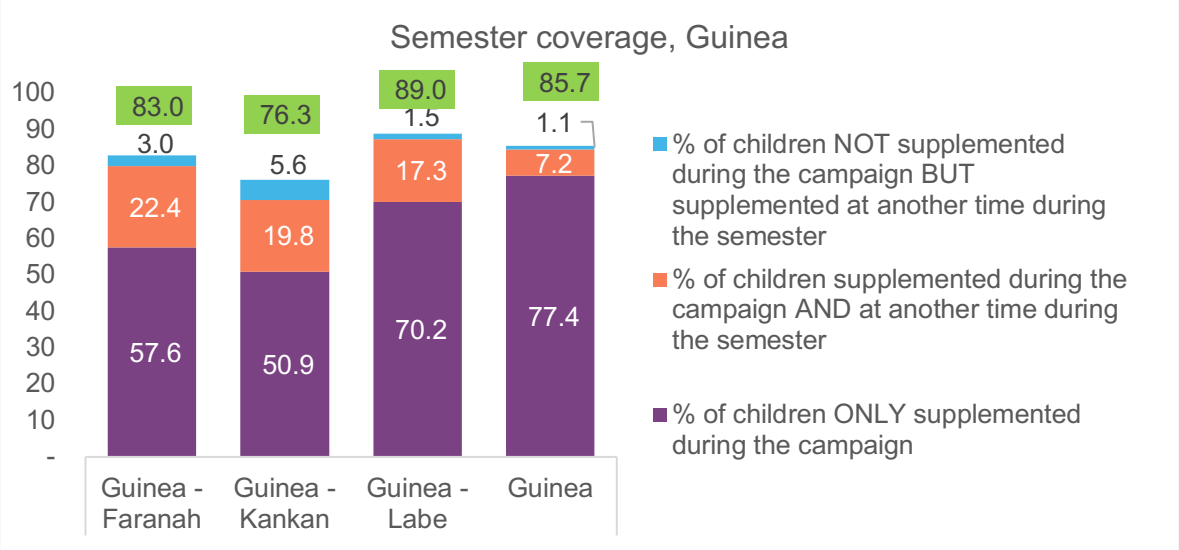
Figure 12 illustrates that a survey conducted during the same period in Ebonyi State, Nigeria, revealed a very high campaign coverage of 96.1%. The primary reason cited for the few children who were not supplemented was a lack of awareness about the campaign.

Figure 13. Results of coverage surveys in Mali, semester 2 of 2023 and semester 1 of 2024.



The coverage survey results for Mali in semester 2 of 2023 and semester 1 of 2024 indicate strong Vitamin A supplementation across the country (**Figure 13**). In 2023, coverage was above 80% in both the capital city of Bamako and the other regions, with significantly higher coverage outside of Bamako. By 2024, all regions supported by Helen Keller were grouped into a single stratum, with a coverage rate of 83.1%. This shows consistent performance in ensuring Vitamin A supplementation, with rural areas continuing to achieve higher coverage compared to the capital.

Figure 14.Results of coverage surveys in Guinea, semester 2 of 2023.



The results of the coverage survey conducted in Guinea for semester 2 of 2023 reveal that Vitamin A supplementation reached a significant proportion of children across the surveyed regions, with overall coverage exceeding 90% (**Figure 14**). However, three distinct strata were surveyed, as it was anticipated (and later confirmed) that coverage would be lower in

the Kankan region. Known for its mining activities, Kankan experiences regular population movements and contains numerous informal settlements, making planning for supplementation more complex. While coverage in Kankan was lower than in the other surveyed regions (Labe and Faranah), it still reached at least 80% of children.

The survey results from Kankan and the other regions were used to inform planning and social mobilization for the first semester of 2024. These efforts contributed to an overall coverage rate of 84.6% for all regions supported by Helen Keller, and 85.7% when including children reached through routine services. Despite these successes, further improvements in outreach and communication are necessary to ensure even higher coverage in challenging regions like Kankan.

Figure 15. Results of coverage surveys in Madagascar, semester 2 of 2023 and semester 1 of 2024

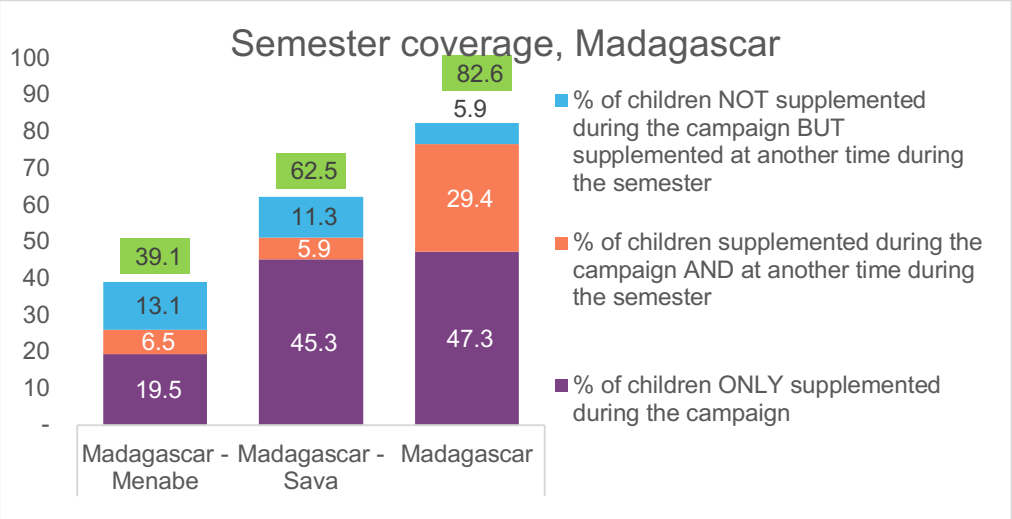


Figure 15 presents the results of coverage surveys in Madagascar during the second semester of 2023 and the first semester of 2024. Following the polio campaign organized at the end of 2023, Helen Keller conducted a coverage survey as a baseline to evaluate the need for future support in Vitamin A Supplementation (VAS) in the regions of Menabe and Sava. The results revealed very low coverage rates during the polio campaign, with Menabe reaching only 26% and Sava 51.2%. These low figures underscored the critical importance of Helen Keller's involvement in VAS, even when such campaigns are combined with polio efforts.

By the first semester of 2024, after Helen Keller provided support to eight regions in Madagascar, there was a significant improvement in VAS coverage, which rose to 76.7%. While this marked a considerable increase, further work will be required in future rounds to continue improving planning, capsule management, and social mobilization to achieve even higher coverage rates.

Figure 16. Number of capsules received by children supplemented in the semester

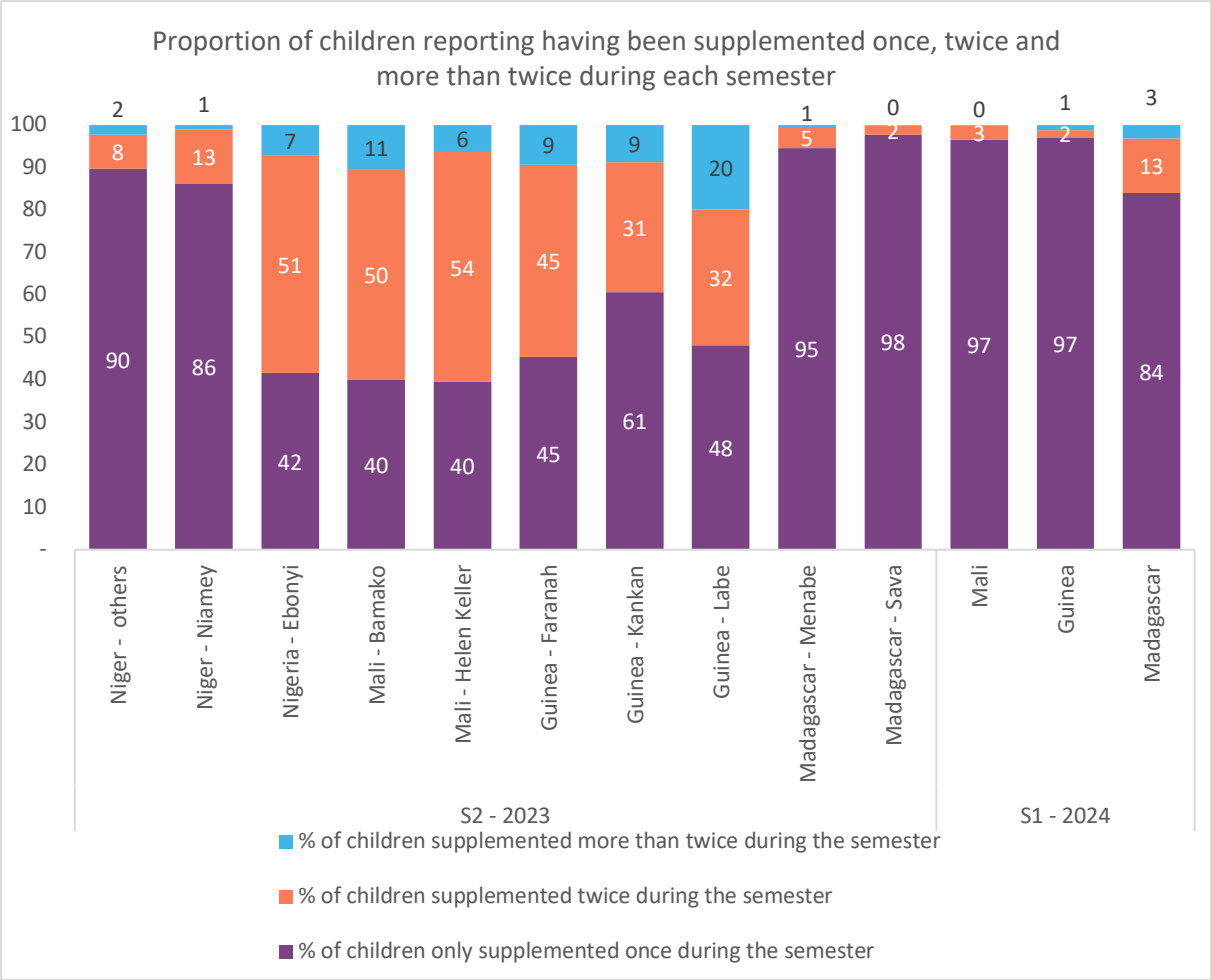
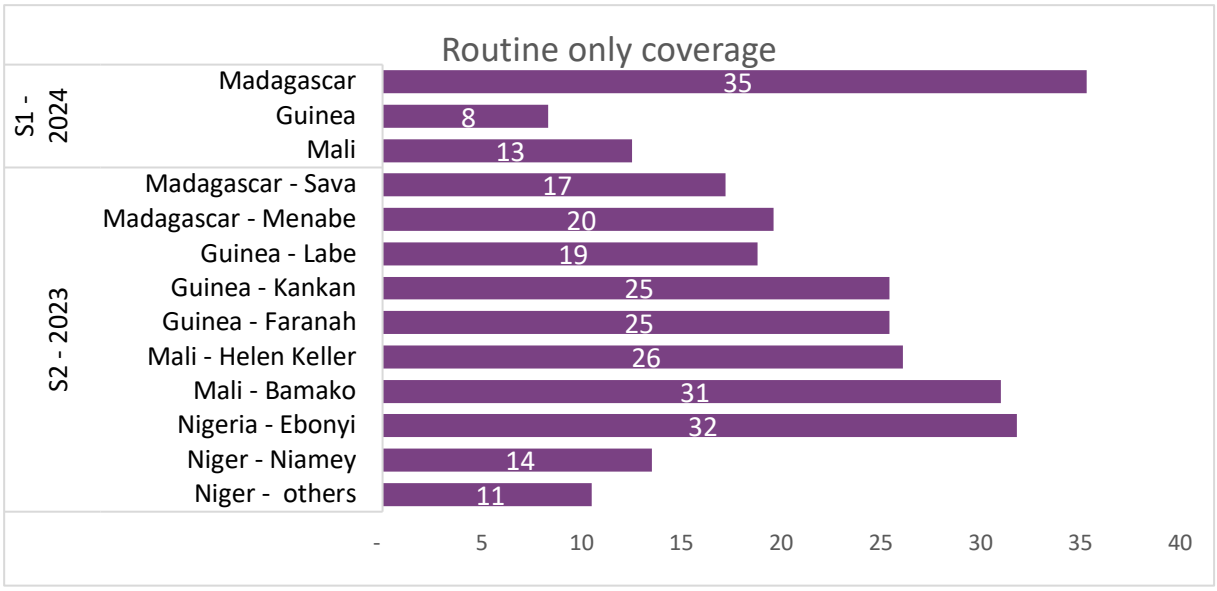


Figure 16 illustrates the responses from caregivers regarding the number of times children received supplements during the semester. Many children in Nigeria, Mali, and Guinea were reported to have been supplemented twice within that period. However, when caregivers were asked about the timing of these supplements outside of the campaign, more than 80% of respondents in Nigeria couldn't provide an answer. In Mali and Guinea, 59.3% and 67% of respondents, respectively, indicated dates that likely correspond to the campaign periods (July and November). This suggests that the minimum four-month timeline between doses is generally being followed. Nevertheless, further analysis of the data is needed, and the questionnaires may have to be revised to obtain more accurate responses.

Figure 17. Routine coverage only



Finally, results shown in **Figure 17** from the coverage surveys are instrumental in estimating what the coverage of routine services could be in the absence of campaigns. In most cases, results are consistently ranging between 10 to 30%, which is consistent with results from the literature. These results highlight the ongoing challenges of relying solely on routine services to reach children, reinforcing the need for continued support and potential enhancements to routine delivery systems to improve overall coverage rates.

7. Research Overview: July 1, 2023 – June 30, 2024

During the past year, Helen Keller Intl's Vitamin A Supplementation (VAS) program undertook multiple research initiatives to enhance the integration of VAS into national routine health systems while maintaining cost-effectiveness and high coverage.

7.1. Completed studies

Côte d'Ivoire (December 2023 – June 2024): Helen Keller Intl conducted a cost-effectiveness study of VAS delivery approaches in the Ferkessedougou and Niakaramandougou districts. The total expenditure for both districts was approx. USD 25,250, with rural areas incurring higher costs. The VAS coverage reached 59.8%, with an average cost per child of USD 0.96. Notably, routine strategies proved the most cost-effective, and 75% of the total costs were attributed to personnel. Moreover, 72% of Community Health Workers received a daily wage higher than their potential earnings from alternative activities, demonstrating favorable opportunity costs.

Madagascar (January – May 2024): Helen Keller Intl partnered with the Ministry of Public Health (MSANP) to conduct a baseline "Scoping Study" combining a household representative cross-sectional survey and a qualitative assessment of the health system in Menabe and Sava regions. This study assessed VAS coverage for children aged 6–59 months, as well as Iron Folic Acid (IFA) and prenatal consultation coverage among women. The findings revealed that the overall VAS coverage was 58.4%. In both regions, 57.5% of pregnant women received prenatal care; however, only 13.8% received the recommended number of prenatal consultations based on the stage of their pregnancy. Additionally, less than half (48.2%) of pregnant women received or purchased iron-containing tablets or syrup

during their current pregnancy. These findings will inform a pilot study integrating VAS into routine maternal and child health services.

7.1. Ongoing research

Kenya (December 2023 – Ongoing): A formative assessment is being conducted to enhance data use for planning and resource allocation for maternal and child health (MCH) services in Narok North Sub-County. The project assesses the availability and use of MCH-related Geographic Information Systems (GIS) and data for planning and resource allocation. A situational and gap analysis have been completed, and participatory mapping training sessions for community health assistants are underway. The final output will be a GIS-integrated health readiness and implementation plan, guiding a three-year quasi-experimental study to pilot GIS data in routine health system planning in Narok County.

Tanzania (December 2023 – Ongoing): Helen Keller Intl launched a bottleneck study in Tanzania to assess challenges and opportunities for improving maternal and child nutrition services. Data was collected in the Mara Region, with national-level interviews in Dodoma and Dar es Salaam. This cross-sectional study will provide evidence to inform ongoing interventions and guide a three-year quasi-experimental study on integrating VAS with other maternal and child health services in Tanzania.

7.2. Knowledge Mobilization Activities

Workshops and Conferences: Helen Keller Intl actively participated in several workshops and conferences to share findings and engage stakeholders. Key events included participation at the Micronutrient Forum in the Netherlands (October 2023), where we presented poster and oral presentations, facilitated discussions, and engaged in networking. Additionally, we presented at the Federation of African Nutrition Societies conference (November 2023), furthering our commitment to strengthening partnerships and advancing nutritional programs across Africa.

Publications: Several key research findings were published in international peer-reviewed journals, making significant contributions to the global body of knowledge on nutrition and public health:

Several studies were published in peer-reviewed journals, contributing to the global understanding of VAS and nutrition:

- February 2024: "*Feasibility of delivering vitamin A supplementation (VAS) and deworming through routine community health services in Siaya County, Kenya: A cross-sectional study*" Published in Maternal & Child Nutrition.
- July 2023: *"COVID-19 concerns among caregivers and vitamin A supplementation coverage in four sub-Saharan African countries."* Published in Public Health Nutrition.
- April 2024: *"Vitamin A supplementation coverage and associated factors for children aged 6 to 59 months in integrated and campaign-based delivery systems in four sub-Saharan African countries."* Published in BMC Public Health.
- June 2024: *"Dietary diversity among infants and young children in West Africa."* Published in Frontiers in Public Health.
- April 2024: *"Dietary Quality among Women of Reproductive Age in Sub-Saharan Africa."* Published in Nutrients.

Three additional manuscripts have been submitted for consideration to the following journals:

- *"The Cost and Cost-Effectiveness of Vitamin A Supplementation: An Assessment of a Vitamin A Days-Plus Event in Burkina Faso."* Submitted to Maternal & Child Health.
- *"The Cost-Effectiveness of Vitamin A Supplementation Services in Kenya."* Submitted to the Annals of the NYAS.
- *"Using the Global Diet Quality Score to assess women's dietary intake in three sub-Saharan African countries."* Submitted to Food and Nutrition Bulletin.

7.3. Proposed research for FY25 to FY29 (July 2024 – June 2028)

In the upcoming three years, Helen Keller Intl will focus its research on:

- Identifying and documenting sustainable, cost-effective VAS delivery models to maximize coverage and reduce costs.
- Supporting the transition from campaign-based to routine VAS delivery systems integrated into existing health structures.
- Leveraging VAS initiatives to strengthen overall health systems.

Table 9. Proposed research for FY25 to FY29

Country	Study Timeframe	Study Focus	Type of study	Delivery Models
Cote d'Ivoire	June – December 2026	Cost-effectiveness study	Prospective study	This study will assess coverage, cost, and cost-effectiveness of four VAS delivery methods across three health districts: - Routine Delivery 'As Is' - Routine Delivery with Support (operational and financial) - Routine Delivery with Self-Monitoring - Once-a-Semester Catch-Up Events
Democratic Republic of Congo	July 2025 – January 2027	Routine VAS pilot & Cost-effectiveness analysis	Randomized controlled trial	A matched cluster randomized trial in Kongo Central Province (12 communities: 6 intervention, 6 control) will evaluate health system strengthening interventions for improving VAS coverage. Monitoring and qualitative research will track implementation and the pathways through which change occurs.
Madagascar	July 2025 – January 2027	Routine VAS & Health System Strengthening	Operational / Implementation study	Conducted in two regions, this study will track monthly supplementation data from community health centers, compare it to the District Health Information Software 2 (DHIS2), and monitor vitamin A stock levels. Triangulating these data will provide insights into system gaps and the effectiveness of health system-strengthening activities.
Kenya	January 2025 – June 2027	Routine VAS & Health System Strengthening	Quasi-experimental	This study will utilize GIS data to optimize decision-making for routine maternal and child health (MCH) services in Narok County, Kenya. GIS will help provide spatial insights to improve planning, prioritization and resource allocation to targeted populations who are underserved. The study will operate at multiple levels, from health facilities to household outreach programs, aiming to enhance service coverage and MCH outcomes.
Tanzania	July 2025 – January 2028	Routine VAS & Cost-effectiveness study	Quasi-experimental	Focusing on the Mara region, this quasi-experimental study will evaluate the impact of health system strengthening interventions on the routine health system and VAS coverage. The research will compare intervention and control groups, adjust for confounding factors, and use a mixed methods approach to examine the mechanisms through which improvements occur.
Regional	October 2024 – December 2025	Various	Retrospective analysis	This analysis will investigate factors influencing access to VAS, exploring whether investments in planning, training, social mobilization, distribution, and supervision activities correspond with VAS coverage. Results will be disaggregated by setting, country and VAS distribution approaches.

8. Financial report

Table 10 summarizes the funds pledged or received by Helen Keller between 2018 and June 2024.

Table 10. Funds received and pledged by Helen Keller International for VAS since 2018

Donor	Amount (USD)	
Givewell	$	172,733,283
Small Donations	$	7,697,361
UNICEF	$	2,585,008
Three Graces	$	3,250,000
Noorda	$	5,500,000
Centre for Effective Altruism	$	443,365
Effective Altruism Foundation	$	135,471
Effective Altruism Australia	$	896,203
Ayuda Effectiva	$	466,009
Effective Spenden Germany	$	662,346
Effective Spenden Schweiz	$	151,721
Effective Ventures	$	122,872
Founders for Good	$	5,828,477
Stichting Effectief Doneren	$	229,666
Effect hope	$	1,907,033
Topsoe Holding	$	149,204
Gimble Foundation	$	20,000
The Prism Charitable Trust	$	12,700
Effective Altruism Poland	$	10,978
Effective Altruism New Zealand	$	1,074
VAS Optiver	$	8,208
Total		$202,810,979

Table 11 shows the funds already used for VAS by Helen Keller for VAS campaigns in countries recommended by GiveWell. Helen Keller has received USD M.202.8 over the last 5 years, from which USD M.106.9 has been spent on delivering VAS capsules (**tables 11 & 12**).

Table 11. Summary of spending on VAS campaigns per country per year

Country	2018	2019	2020	2021	2022-2023	FY24	Total
Burkina Faso	$497,352	$565,043	$794,145	$1,212,264	$1,611,953	$1,250,152	$5,930,910
Cameroon	$0	$0	$0	$1,540,474	$5,307,568	$6,813,006	$13,661,047
Cote d'Ivoire	$472,416	$1,173,552	$1,015,906	$2,202,689	$4,108,860	$3,805,351	$12,778,774
DRC	$0	$0	$32,476	$1,525,242	$4,940,514	$4,692,206	$11,190,438
Guinea	$832,259	$819,744	$1,274,493	$846,207	$2,699,361	$3,348,142	$9,820,206
Kenya	$0	$482,683	$631,162	$1,069,217	$4,412,767	$2,791,779	$9,387,608
Madagascar	$0	$0	$0	$0	$9,014	$1,113,163	$1,122,177
Mali	$464,032	$574,136	$1,088,508	$1,670,132	$2,209,646	$2,086,671	$8,093,126
Niger	$58	$864,667	$1,036,925	$2,113,725	$3,458,351	$2,533,343	$10,007,070
Nigeria	$0	$0	$493,003	$1,927,803	$7,113,154	$3,173,446	$12,707,406
Management	$748,548	$1,204,792	$1,259,157	$1,020,569	$4,096,487	$3,967,874	$12,297,427
Total	$3,014,666	$5,684,617	$7,625,777	$15,128,322	$39,967,674	$35,575,133	$106,996,189

Table 12 highlights the funds used for non-campaign activities in other countries under separate grants received essentially from the 3 Graces and the Ray and Tye Noorda Foundations.

Table 12. Non-campaign expenditures, per country, 2018-2024

Country	2018	2019	2020	2021	2022-2023	FY24	Total
Cameroon	$0	$0	$75,052	$121,565			$196,617
Mozambique					$1,593,800	$1,578,937	$3,172,736
Senegal	$0	$0	$134,466	$201,214	$672,909	$532,259	$1,540,849
Sierra Leone	$17,774	$156,655	$103,367	$176,779	$507,138	$364,111	$1,325,824
Tanzania					$407,837	$683,326	$1,091,163
Total	$17,774	$156,655	$312,884	$499,558	$3,181,684	$3,158,633	$7,327,189

Tables 13 and 14 provide details of expenditures for the 12-month period covered by this report for GiveWell-supported campaign countries and non-supported countries.

Table 13. Detailed expenditures, July 2023 to June 2024, Helen Keller campaign countries

2023 - 2024		Burkina Faso	Cameroon	Cote d'Ivoire	DRC	Guinea	Kenya	Madagascar	Mali	Niger	Nigeria	Regional & Global Support	Total
Personnel		$257,301	$751,482	$828,309	$812,150	$364,636	$529,053	$193,489	$417,047	$417,132	$487,228	$1,852,688	$6,910,515
Travel		$29,876	$44,265	$27,692	$26,903	$45,366	$914	$20,590	$28,087	$31,833	$40,643	$217,418	$513,586
Equipment and supplies		$2,444	$106,378	$124,511	$120,780	$25,339	$108,052	$62,075	$57,328	$100,610	$160,629	$17,779	$885,925
Other Direct Costs		$55,228	$263,147	$149,437	$212,259	$153,178	$146,598	$118,436	$93,755	$120,673	-$225,851	$143,591	$1,230,452
Activities	Planning	$16,594	$492,249	$335,091	$259,954	$88,386	$292,296	$149,173	$46,284	$69,264	$217,599	$574,380	$2,541,271
	Policy	$0	$0	$0	$19,793	$1,604	$14,159	$0	$0	$0	$0	$6,008	$41,565
	Training	$6,213	$119,232	$0	$11	$501	$718,317	$0	$0	$9,627	$551,436	$78,524	$1,483,861
	Distribution	$0	$28,828	$2,617	$0	$25,315	$374,407	$0	$226	$91,824	$260,107	$0	$783,325
	Mobilization	$39,207	$578,196	$205,769	$0	$0	$22,740	$0	$4,401	$0	$124,820	$299	$975,433
	Research	$0	$0	$84,957	$0	$0	$60,786	$0	$0	$0	$852	$408,326	$554,920
	Monitoring	$158,832	$130,570	$182,444	$446,409	$357,156	$135,735	$65,582	$226,789	$122,105	$1,111,444	$107,630	$3,044,694
Sub Agreements	Planning	$0	$0	$0	$0	$0	$927	$3,670	$157,733	$0			$162,330
	Policy	$0	$0	$0	$0	$0	$0	$0	$0	$0			$0
	Training	$0	$0	$0	$0	$258,580	$1,292	$20,548	$96,992	$0			$377,412
	Distribution	$509,361	$3,360,614	$1,331,545	$2,147,649	$688,731	$0	$304,322	$665,767	$1,215,453			$10,223,442
	Mobilization	$0	$0	$0	$0	$440,423	$0	$0	$0	$0			$440,423
	Research	$0	$0	$0	$0	$0	$0	$0	$0	$0			$0
	Monitoring	$0	$0	$0	$0	$429,984	$0	$19,368	$0	$0			$449,352
Total direct costs		$1,075,055	$5,874,961	$3,272,371	$4,045,909	$2,879,199	$2,405,277	$957,252	$1,794,410	$2,178,521	$2,728,907	$3,406,643	$30,618,506
Indirect Costs		$175,097	$938,045	$532,980	$646,296	$468,943	$386,503	$155,910	$292,261	$354,822	$444,539	$561,231	$4,956,627
Total		$1,250,152	$6,813,006	$3,805,351	$4,692,206	$3,348,142	$2,791,779	$1,113,163	$2,086,671	$2,533,343	$3,173,446	$3,967,874	$35,575,133

Table 14. Detailed expenditures, July 2023 to June 2024, Helen Keller non-campaign countries

2023-2024		Mozambique	Senegal	Sierra Leone	Tanzania	Total
Personnel		$606,138	$208,929	$69,827	$262,081	$1,146,975
Travel		$22,554	$13,682	$19,840	-$155	$55,921
Equipment and supplies		$31,996	$13,056	$1,315	-$1,964	$44,403
Other Direct Costs		$111,538	$53,908	$41,844	$28,146	$235,436
Activities	Planning	$119,440	$40,255	$29,584	$35,928	$225,208
	Policy	$250	$57,290	$0	$12,797	$70,338
	Training	$223,015	$6,379	$7,956	$111,333	$348,683
	Distribution	$62,508	$639	$0	$88,933	$152,080
	Mobilization	$60,693	$8,066	$0	$1,887	$70,647
	Research	$0	$332	$0	$45,931	$46,263
	Monitoring	$108,983	$46,265	$2,441	$2,227	$159,917
Sub Agreements	Planning		$5,898	$0	$0	$5,898
	Policy		$2,966	$0	$0	$2,966
	Training		$0	$0	$0	$0
	Distribution		$0	$140,306	$0	$140,306
	Mobilization		$0	$0	$0	$0
	Research		$0	$0	$0	$0
	Monitoring		$0	$0	$0	$0
Total direct costs		$1,347,116	$457,664	$313,114	$587,145	$2,705,040
Indirect Costs		$231,820	$74,595	$50,998	$96,181	$453,594
Total		$1,578,937	$532,259	$364,111	$683,326	$3,158,633

Table 15 shows the expenditures against the budget submitted to GiveWell in July 2023 for the fiscal year 2024 (July 2023 to June 2024). The rate of expenditure shown in the table is significantly lower than expected, leading to a USD M.8.5 underspending.

Explanations for the underspending include:

- The difference in Burkina Faso is that the campaign expenditures were rolled over to July 2024 for the first semester of the campaign.
- In DRC, campaigns have been integrated with polio campaign systematically, leading to significant savings.
- In Cote d'Ivoire, a large proportion of the campaign expenditures were also charged in July 2024.
- In Guinea, expenditures are higher than expected because the campaign for the first semester of 2023 was partly spent in July 2023. Hence, three campaigns are accounted for instead of 2 in the expenditures.
- In Kenya, the remaining budget is expected to be spent in the second semester of 2024 as part of the program's closure.
- In Madagascar, delays in obtaining the official agreement from the government did not allow for two campaigns to be implemented.
- In Mali, the campaign was delayed to August 2024, so it does not appear in the report
- In Niger, the campaign was delayed to September 2024, so it does not appear in the report.

- In Nigeria, a significant proportion of the campaign was paid in July. In addition, a massive devaluation of the local currency led to a reduction of costs against US dollars.
- The increased amount spent on management includes the funding of several research initiatives and the organization of a regional workshop dedicated to

Table 15. Detailed expenditures, July 2023 to June 2024, Helen Keller non-campaign countries

	FY24 budget	FY24 spending	difference	%
Burkina Faso	$1,794,821	$1,250,152	544,669	70%
Cameroon	$7,121,667	$6,813,006	308,661	96%
Cote D'Ivoire	$4,964,169	$3,805,351	1,158,818	77%
DRC	$5,720,527	$4,692,206	1,028,321	82%
Guinea	$2,510,065	$3,348,142	$(838,077)	133%
Kenya	$3,956,730	$2,791,779	1,164,951	71%
Madagascar	$1,500,000	$1,113,163	386,837	74%
Mali	$2,975,617	$2,086,671	888,946	70%
Niger	$4,533,528	$2,533,343	2,000,185	56%
Nigeria	$5,861,235	$3,173,446	2,687,789	54%
Management	$3,148,703	$3,967,874	$(819,171)	126%
Total	$44,087,062	$35,575,133	$8,511,929	81%

Funds not used as per the project budget will be used for the upcoming fiscal year.

Table 16 shows the budgets for the coming 3 years for VAS campaigns.

Table 16. Budget for fiscal year 2025 to fiscal year 2027

	FY25	FY26	FY27	Total
Burkina Faso	1,867,231	1,792,574	1,843,038	5,502,843
Cameroon	6,556,781	6,720,489	6,874,430	20,151,699
Cote D'Ivoire	4,182,066	4,601,612	4,790,069	13,573,747
DRC	6,393,220	7,183,205	7,243,497	20,819,921
Guinea	2,536,381	2,520,402	2,615,088	7,671,871
Madagascar	805,212	481,995	558,820	1,846,027
Mali	1,500,000	1,500,000	1,500,000	4,500,000
Niger	2,364,438	2,390,663	2,456,545	7,211,645
Nigeria	4,455,645	4,830,889	3,907,550	13,194,084
Management	5,376,550	5,664,790	5,065,043	16,106,384
Total	2,584,404	2,772,071	2,787,399	8,143,874

More detailed financial reports are available in the Excel sheet attached to this report.

Figure 18 shows the cost per supplement achieved in each country. Note that management costs have been added to each country based on the proportion of the target population of each country. As management costs consist primarily in personnel and travel (70%), their proportion weighs heavier on support costs than other costs. Overall, most countries' costs turn around $0.5 per supplement distributed (administrative data for the number of children

reached is used). Except for DRC and Nigeria, which have turned around $0.3 USD due to lower campaign and support costs, Guinea is the most expensive at $ 0.87 USD per supplement. This high cost for Guinea is because the campaign for the first semester 2023 was delayed to July. Therefore, it was partly funded during this fiscal year, but the number of children reached is not accounted for in Figure 18. Adjusting for this, the cost per supplement in Guinea would turn around $0.51 USD

Looking at **Figure 19**, we can see that all country's cost categories weigh reasonably similarly, with support costs around 40% and activities costs around 60%. Overall, around 10% of expenditures are linked with monitoring activities.

Figure 18. Cost per supplement per budget category, expenditure FY24

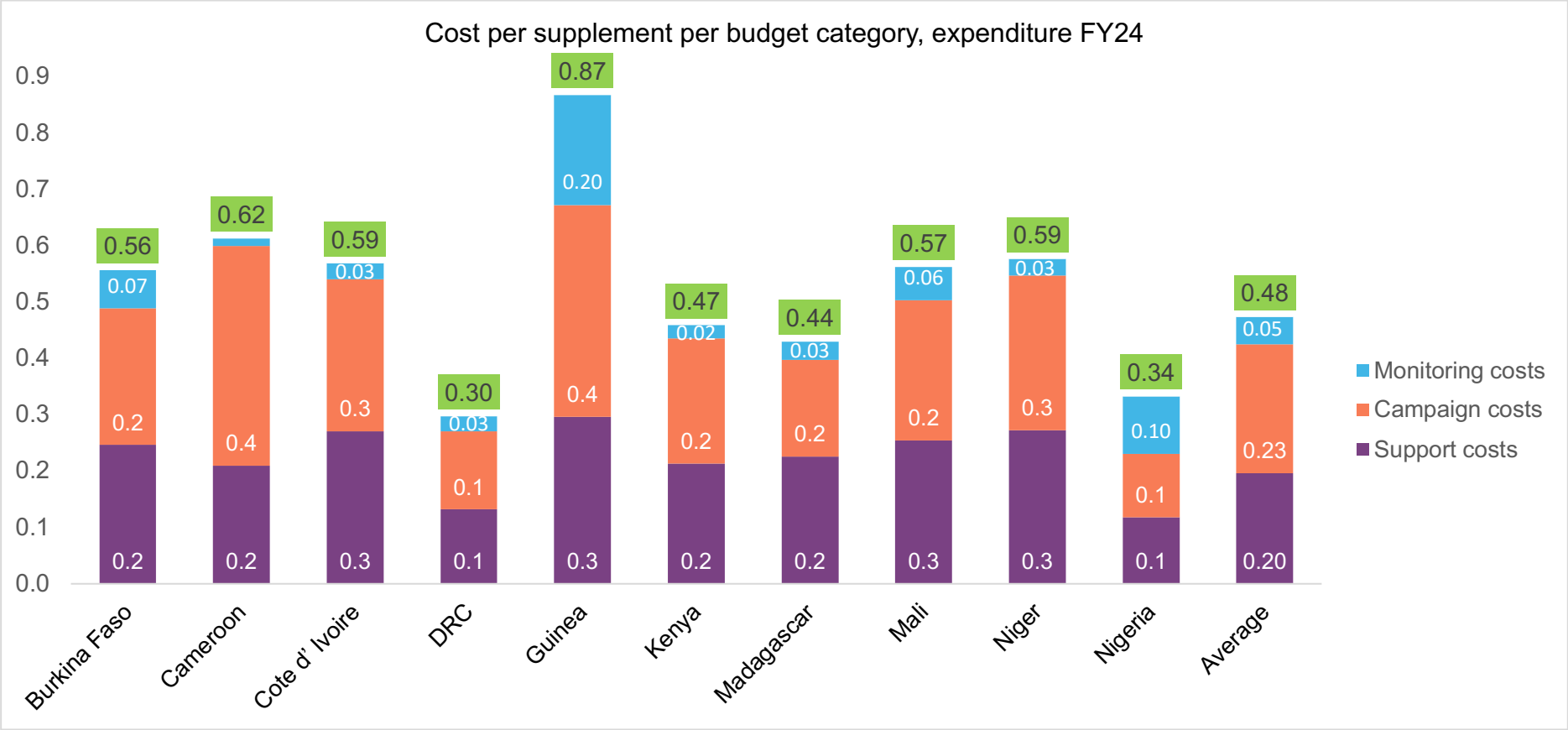
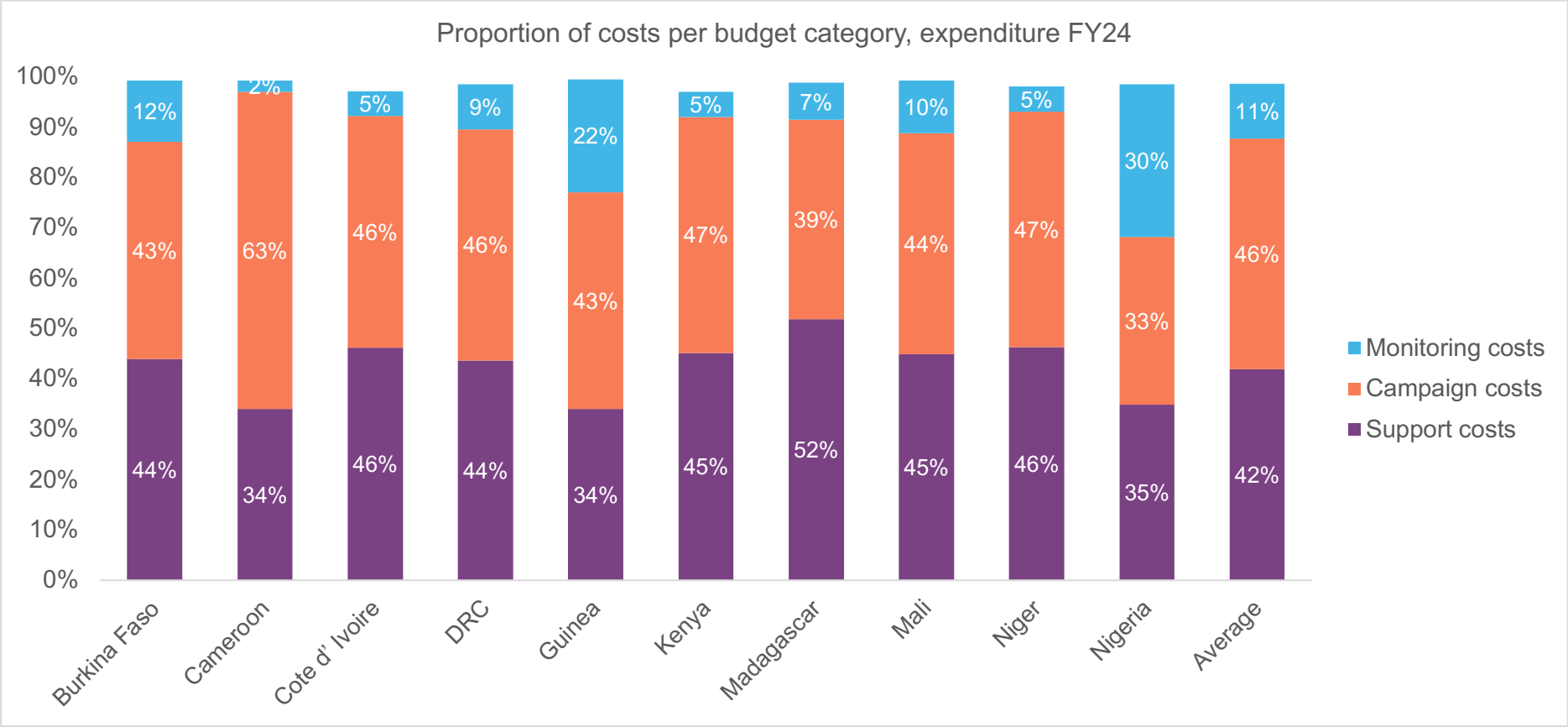


Figure 19. Proportion of costs per budget category, expenditure FY24



Annex 1. Campaign implementation checklist

		Days for activities start & end		Dates for activities start & end		Roles & responsibilities		Reminders		
		start	end	start	end					
Campaign date	reference for count down	0	5	1-Jun	6-Jun	Assigned to	Reviewer	at start date	at mid point	at end date
Campaign preparation										
Decision on all campaign modalities (target, area, model, package, mobilization)	start date	-90	-60	3-Mar	2-Apr	PM	CD	3-Mar	18-Mar	2-Apr
Availability of VAS capsules confirmed in all supported regions	start date	-90	-60	3-Mar	2-Apr	PM	CD	3-Mar	18-Mar	2-Apr
Microplans completed for all supported regions	start date	-60	-30	2-Apr	2-May	PM	CD	2-Apr	17-Apr	2-May
Availability of other supplies confirmed in all supported regions	start date	-30	-5	2-May	27-May	PM	CD	2-May	14-May	27-May
FAA Preparation										
FAA submitted to the country Director for all regions	start date	-40	-30	22-Apr	2-May	PM	CD	22-Apr	27-Apr	2-May
FAA submitted to the regional team for all regions	start date	-35	-21	27-Apr	11-May	PM	CD	27-Apr	4-May	11-May
FAA approved by G&C for all regions	start date	-21	-7	11-May	25-May	PM	CD	11-May	18-May	25-May
Funds transferred to the supported regions	start date	-14	-7	18-May	25-May	PM	CD	18-May	21-May	25-May
Independent Monitoring										
Independent monitors recruited	start date	-60	-14	2-Apr	18-May	M&E, PM	CD	2-Apr	25-Apr	18-May
Independent monitoring sampling developped	start date	-60	-30	2-Apr	2-May	M&E, PM	CD	2-Apr	17-Apr	2-May
Independent monitors training completed	start date	-14	-5	18-May	27-May	M&E, PM	CD	18-May	22-May	27-May
independent monitoring report completed	End date	6	12	12-Jun	18-Jun	M&E, PM	CD	12-Jun	15-Jun	18-Jun
PECS										
PECS Consultants recruited	End date	-90	-30	8-Mar	7-May	M&E, PM	CD	8-Mar	7-Apr	7-May
PECS stratification approved by VAS AFRO	End date	-90	-60	8-Mar	7-Apr	M&E, PM	CD	8-Mar	23-Mar	7-Apr
PECS protocols and tools submitted to IRB	End date	-60	-30	7-Apr	7-May	M&E, PM	CD	7-Apr	22-Apr	7-May
PECS sampling completed	End date	-60	-30	7-Apr	7-May	M&E, PM	CD	7-Apr	22-Apr	7-May
PECS training completed	End date	1	7	7-Jun	13-Jun	M&E, PM	CD	7-Jun	10-Jun	13-Jun
PECS data collection completed	End date	7	28	13-Jun	4-Jul	M&E, PM	CD	13-Jun	23-Jun	4-Jul
PECS data analysis and report writting	End date	28	61	4-Jul	6-Aug	M&E, PM	CD	4-Jul	20-Jul	6-Aug
PECS report submitted to Regional team	End date	61	75	6-Aug	20-Aug	M&E, PM	CD	6-Aug	13-Aug	20-Aug
PECS report submitted to Givewell	End date	61	75	6-Aug	20-Aug	M&E, PM	CD	6-Aug	13-Aug	20-Aug
Campaign report completed		1	14	7-Jun	20-Jun	M&E, PM	CD	7-Jun	13-Jun	20-Jun