Helen Keller Intl's Review of GiveWell's Updated Cost-effectiveness Analysis – 31st October 2024

1. Overview of Cost-Effectiveness Analysis

In 2024, GiveWell updated its cost-effectiveness analysis for vitamin A supplementation across ten countries supported by Helen Keller Intl: Burkina Faso, Cameroon, Cote d'Ivoire, DRC, Guinea, Kenya, Madagascar, Mali, Niger, and Nigeria. The update was shared through two key documents:

- HKI review_GiveWell's CEA of vitamin A supplementation
- HKI review_Helen Keller International cost per supplement (2024)

GiveWell's cost-effectiveness threshold is set at 8, meaning VAS programs should demonstrate at least 8 times the benefit on child mortality compared to unconditional cash transfer to qualify for GiveWell support.

Table 1 below summarizes GiveWell's 2024 analysis, showing that multiple countries (Burkina Faso, Cameroon, Cote d'Ivoire, Guinea, Kenya) and states in Nigeria (Akwa Ibom, Benue, Ebonyi) where Helen Keller Intl supports VAS programs no longer meet GiveWell's threshold for funding eligibility.

Table 1. GiveWell calculated cost-effectiveness in terms of multiples of GiveDirectly's unconditional cash transfer program, after all adjustments, Helen Keller Intl VAS program, 2024

Country	States/regions	Cost-effectiveness[1]
Burkina Faso		5.97
Cameroon		5.16
Côte d'Ivoire		4.36
DRC		12.90
Guinea		6.25
Kenya		2.61
Madagascar		8.47
Mali		12.50
Niger		44.81
Nigeria	Adamawa	11.42
	Akwa Ibom	3.40
	Anambra	1.91
	Benue	5.52
	Delta	2.45
	Ebonyi	5.10
	Edo	2.78
	Ekiti	2.86
	Imo	2.55
	Kogi	2.75
	Nasarawa	6.78
	Ogun	2.62
	Osun	1.41
	Rivers	4.17
	Taraba	14.59
	Kaduna	11.73
	Niger	12.43
	Plateau	3.73
	Sokoto	48.10
	Kebbi	22.66
	FCT (Abuja)	2.21

[1] in terms of multiples of GiveDirectly's unconditional cash transfer

GiveWell's CEA relies on a variety of indicators and assumptions, which are summarized below.

1.1. Cost per supplement

The cost per supplement metric considers the financial resources required to deliver VAS, incorporating expenditures from Helen Keller Intl, UNICEF, Nutrition International, and the Ministry of Health.

Figure 1 in the report illustrates GiveWell's methodology for calculating the cost per supplement, which uses a combination of population data, financial records, and VAS coverage estimates. Details on these calculations are further provided in Section 2 of this report.

Figure 1. Indicators and calculations from GiveWell CEA for the cost per supplement delivered

Main calculations	unit	type	Overall	Burkina Faso	Cameroon
Final cost-effectiveness estimate (pulled from below for visibility)	**xcash**	**feed**	-	**6.0**	**5.2**
GiveWell costs					
Grant size	$	input	$1,000,000	-	-
Cost breakdown					
Percentage of total costs covered by the grantee	%	input	-	41%	64%
Percentage of total costs covered by Nutrition International (vitamin A capsule	%	input	-	4%	6%
Percentage of total costs covered by other philanthropic actors	%	input	-	7%	0%
Percentage of total costs covered by domestic governments (financial contribut	%	input	-	18%	0%
Percentage of total costs covered by domestic governments (in-kind contributic	%	input	-	30%	30%
Total costs					
Total spending by all contributors	$	calc	-	$2,452,342	$1,555,867
Total spending attributable to different actors					
Total spending contributed by grantee	$	calc	-	$1,000,000	$1,000,000
procurement)	$	calc	-	$102,225	$89,107
Total spending contributed by other philanthropic actors	$	calc	-	$166,418	$0
Total spending contributed by domestic governments (financial contributions)	$	calc	-	$447,997	$0
Total spending contributed by domestic governments (in-kind contributions)	$	calc	-	$735,703	$466,760
Upstream / downstream spending					
Total spending causally upstream of donations to grantee	$	calc	-	$1,614,415	$1,000,000
Total spending causally downstream of donations to grantee	$	calc	-	$837,927	$555,867
Cost per child covered					
Cost per vitamin A supplement delivered	$	input	-	$2.02	$1.28
Supplementation rounds delivered per year	#	input	2	-	-
Total cost per child receiving a year of vitamin A supplementation (VAS)	$	calc	-	$4.04	$2.56
Upstream costs per child receiving a year of VAS	$	calc	-	$2.66	$1.65

1.2. VAS Impact on Child Mortality

The second set of indicators considered calculates **VAS's impact on reducing child mortality** (**Figure 2**)

- In the "external validity adjustment" section, GiveWell reduces VAS impact by 66% based on factors such as vitamin A deficiency prevalence, stunting and wasting rates, under-five mortality, and prevalence of other morbidities.
- The "internal validity adjustment" reduces the impact of VAS by an additional 20% to address the perceived inflation of results in the Cochrane meta-analysis, citing potential weaknesses in underlying trials. Using these adjusted mortality rates and data from the Global Burden of Disease (GBD) group, GiveWell calculates the total number of averted deaths per country (e.g., 162 deaths averted in Burkina Faso).

Figure 2. Indicators estimating VAS impact on mortality reduction

Mortality reduction among people under age 5				
Reduction in all-cause mortality for children under age 5 participating in VAS programs found in GiveWell's meta-analysis	%	input	19%	-
Proportion of participating children that received VAS in the trials from GiveWell's meta-analysis	%	input	88%	-
Implied reduction in all-cause mortality for children under age 5 receiving vitamin A supplementation	%	calc	22%	-
Internal validity adjustment	%	input	-20%	-
External validity adjustment	%	supp	-	-66%
Adjustment for supplementation frequency in VAS trials vs. current contexts	%	input	-17%	-
Expected reduction in all-cause mortality among 6-59-month-olds receiving vitamin A supplementation	%	calc	-	4.9%
Annual all-cause mortality rate among 6-59-month-olds in areas targeted for VAS	%	supp	-	1.24%
Proportion of people under age 5 represented in GBD 2019 disease burden estimates who received VAS	%	input	-	38%
All-cause mortality rate among 6-59-month-olds in the absence of VAS	%	calc	-	1.26%
Total deaths averted among people under age 5	#	calc	-	162

1.3. Adjustments for Helen Keller Intl Program Practices

The third component of the CEA includes adjustments based on program-specific assumptions. These adjustments, unlike other metrics, are not based on empirical data but rather on GiveWell's assumptions regarding the reliability of Helen Keller's data **(Figure 3)**:

- A 15% reduction due to perceived insufficiencies in Helen Keller's monitoring budget.
- A 2% reduction based on an assumption of limited reliability in coverage survey data.
- A 5% reduction due to the belief that Helen Keller may be less incentivized to fundraise for VAS given GiveWell support.

Figure 3. Adjustments to VAS cost-effectiveness based on assumptions on Helen Keller Intl program and practice

Main calculations	unit	type	Overall	Burkina Faso
Final cost-effectiveness estimate (pulled from below for visibility)	**xcash**	**feed**	**-**	**6.0**
Adjustments				
Supplemental grantee-level adjustments				
Risk of wastage				
Double treatment	%	input	0%	-
Ineffective goods	%	input	0%	-
Goods purchased and left in storage until they expire / cash doesn't receive recipients or is taken back from them inappropriately	%	input	0%	-
Quality of monitoring and evaluation				
Misappropriation without monitoring results	%	input	-	-15%
False monitoring results	%	input	-	-2%
Confidence in funds being used for intended purpose				
Change of priorities	%	input	-	0%
Non-funding bottlenecks	%	input	-	0%
Within-org fungibility	%	input	-	-5%
Total supplemental grantee-level adjustment	%	calc	-	-22%

1.4. Additional Benefits and Funding Adjustments

Additional benefits, such as reduced anemia and morbidity, are integrated to enhance cost-effectiveness by 57%. For instance, the co-delivery of deworming tablets and other services alongside VAS amplifies the impact. Conversely, GiveWell reduces cost-effectiveness by 31% under the assumption that Helen Keller funding may displace contributions from other donors and that, in Helen Keller's absence, local governments would provide VAS effectively.
Figure 4 displays how these additional benefits and "funding displacement" adjustments contribute to the overall cost-effectiveness ratio.

Figure 4. Additional benefits of VAS and impact of the Helen Keller VAS program on other sources of funding for VAS

Supplemental intervention-level adjustments				
Adjustments not affecting cost per life saved				
Short-term consequences of reduced infectious disease morbidity	%	input	6%	-
Short-term anemia effects	%	input	9%	-
Investment of income increases	%	input	3%	-
Vision benefits	%	input	9%	-
Benefits from other programs supported by our funding (e.g. deworming, immunizations)	%	input	18%	-
Treatment costs averted from prevention	%	input	20%	-
Adjustments affecting cost per life saved				
Interaction between VAS and vaccines	%	input	2%	-
Children reached by VAS campaigns may have lower than average baseline mortality rates	%	input	-10%	
Marginal funding going to lower priority areas	%	input	-	0%
Total supplemental intervention-level adjustment	%	calc	-	57%
Leverage and funging adjustment				
Adjustment for the possibility of crowding funding into the program (leverage)	%	supp	-	-5%
Adjustment for the possibility of crowding funding out of the program (funging)	%	supp	-	-26%
Overall adjustment for leverage and funging	%	calc	-	-31%

2. Summary of Helen Keller Intl's Review

Helen Keller Intl values GiveWell's thorough analysis of VAS program cost-effectiveness and the ongoing partnership that supports these life-saving interventions. We also recognize that, as child mortality and morbidity indicators improve over time, the direct impact of VAS may appear to decline in some areas. However, we have identified several aspects of GiveWell's analysis where additional programmatic insights may clarify and improve the cost-effectiveness assessment and where certain assumptions warrant further review.
Key Concerns and Recommendations:

- **Use of Prospective Data:** GiveWell's use of prospective rather than retrospective data to calculate the cost per supplement may not accurately reflect real program expenses.
- **Ministry of Health Contribution Factor**: The 30% increment added to the cost per supplement to account for Ministry of Health expenses appears overestimated relative to the actual contributions seen in program delivery.
- **Application of Coverage Rates Across Regions**: Applying survey-based coverage rates from specific regions to other areas, especially using older survey data, may inaccurately estimate current reach and effectiveness.
- **VAS Impact Reduction by 66%:** The 66% reduction in cost-effectiveness to account for updated epidemiological indicators may not fully capture the continued relevance and impact of VAS across diverse contexts.
- **Adjustment for Monitoring Reliability**: Reducing the program's cost-effectiveness by 22% based on assumptions regarding Helen Keller's monitoring practices does not align with recent monitoring investments and improvements.
- **Likelihood of Alternative Funding:** Reducing cost-effectiveness by 31% on the assumption that other actors would step in to fund VAS in the absence of Helen Keller support contradicts our experience, where program support typically discontinues without Helen Keller funding.

Helen Keller Intl looks forward to further dialogue with GiveWell to ensure these programmatic insights inform future cost-effectiveness analyses, supporting the accurate representation of VAS program impact and sustainability.

2.1. Cost Per Supplement Analysis

One of the first key indicators in the Cost-Effectiveness Analysis (CEA) is the expense of delivering vitamin A supplements, calculated based on data from the "HKI Review_Helen Keller International Cost per Supplement (2024)" spreadsheet.

Forecasted Costs and Targeted vs. Actual Beneficiaries and Expenditures

Historically, GiveWell has updated the cost per supplement for vitamin A supplementation (VAS) annually, using actual program data from the previous year. Recently, however, there has been a shift towards using forecasted budgets and population estimates rather than real program population and expenditure data in calculating this metric. The rationale behind this transition remains unclear, especially given that forecasted budgets often differ from actual costs incurred. Budget estimates, which serve as the numerator in this calculation, are inherently approximations and may not align with the actual program expenditures, which can vary significantly due to various factors (see **Table 1**).

In Table 1, we compare forecasts shared with GiveWell in July 2023 for the Room for More Funding proposal against the actual implementation data reported to GiveWell in the October 31, 2024, annual report. Generally, the achieved cost per supplement tends to be lower than forecasted, reflecting

Helen Keller Intl's continued efforts to reduce campaign costs, leading to gradual but consistent cost savings.

The only countries where the cost per supplement increased are Niger and Guinea. In Niger, the first-semester campaign of 2024 was rescheduled from June to September 2024. Although non-direct campaign support continued, only half the targeted children were reached. In Guinea, a similar delay in the campaign from the first semester of 2023 led to campaign costs being charged in July 2023, during the fiscal year reported in Table 1, meaning that the costs represent three campaigns within 12 months instead of two. Not accounting for this additional campaign, the real cost per supplement is approximately $0.54—significantly lower than forecasted.

Table 1. Targets and budgets vs. reached (administrative data) and expenditures

Country	Nb supplements initially targeted (RFMF 23)	Budget for FY24 (RFMF 23)	cost per supplement	Nb supplements distributed	Spent on FY24	cost per supplement
Burkina Faso	2,578,316	1,794,821	0.70	2,436,311	1,250,152	0.51
Cameroon	11,648,940	7,121,667	0.61	12,016,287	6,813,006	0.57
Cote d'Ivoire	9,308,650	4,964,169	0.53	8,384,293	3,805,351	0.45
DRC	18,758,834	5,720,527	0.30	18,606,501	4,692,206	0.25
Guinea	3,558,556	2,510,065	0.71	4,105,330	3,348,142	0.82
Mali	4,107,796	2,975,617	0.72	4,044,984	2,086,671	0.52
Niger	13,219,490	4,533,528	0.34	5,438,281	2,533,343	0.47
Nigeria	9,604,036	5,861,235	0.61	11,184,556	3,180,052	0.28
Overall	72,784,618	35,481,629	0.49	66,216,543	27,708,923	0.42

Factors Contributing to Variations in Forecasted vs. Real Costs

Significant fluctuations in currency exchange rates, rising fuel costs, and inflation have led to notable discrepancies between forecasted and real expenditures over the last 24 months. Additionally, program-specific factors, such as the need for Helen Keller to adjust regional support based on funding from other partners, play a role. In Cameroon, Côte d'Ivoire, and Guinea, for example, Helen Keller expanded support due to reduced contributions from other partners, increasing the direct campaign support costs while keeping certain fixed expenditures constant, thereby lowering the achieved cost per supplement.

Integration with Other Health Campaigns

Integrating VAS with other health campaigns (e.g., polio vaccination) can reduce total program costs by sharing resources, logistics, and personnel costs, frequently resulting in actual expenditures that are lower than budget estimates.

Target Population Estimates

Population estimates serve as the denominator in the cost per supplement calculation. GiveWell's practice of reducing Helen Keller's population estimates by 10% could artificially increase the calculated cost per supplement, potentially skewing cost-effectiveness results. Helen Keller's estimates are based on official Ministry of Health and UNICEF data, generally reflecting recent population growth trends. For example, the Siguiri district in Guinea has experienced rapid population growth due to mining, a factor not accounted for in static population reduction estimates.

Similar discrepancies in population estimates have emerged in Cameroon and Côte d'Ivoire, where Helen Keller's data aligns more closely with field needs and recent surveys. GiveWell's reduced estimates do not reflect these increases, potentially underestimating the program's reach and overstating per-supplement costs.

Recommendation

To ensure accurate cost-per-supplement calculations, we recommend basing this metric on actual expenditures and the number of children reached. A two-year average may also help to capture delayed campaign expenses that extend beyond the fiscal year.

2.2. Cost of Ministry of Health Contribution

GiveWell currently assumes that the Ministry of Health (MoH) contributes 30% of the funding Helen Keller Intl provides for Vitamin A Supplementation (VAS) campaigns in each country. However, this calculation, based on Helen Keller's total expenditure budgets, does not fully capture the realities of MoH involvement. Helen Keller's expenditures include costs beyond direct campaign support, such as personnel, administration, operations, and indirect expenses, which differ significantly from MoH's scope and structure. A more accurate calculation would focus exclusively on MoH's contributions towards campaign activities and sub-agreements, as the types and proportions of costs incurred by the MoH and Helen Keller differ.

Additionally, we believe the 30% assumption significantly overstates the MoH's in-kind contribution to VAS campaigns. Leslie et al.'s findings indicate that government contributions generally amount to only 18% of total campaign costs. Based on our programmatic experience and literature, a more accurate contribution rate would fall below 30%.

- **Tanzania** (Foster et al., 2008): Government contributions were only 16%, as international donors covered most logistics, supplies, and operational costs.
- **Uganda** (Brooker et al., 2008): Government contributions were higher, between 30-40%, in a context where local government

provided substantial support for logistics and community mobilization.

In VAS campaigns, where external partners bear the brunt of logistical and community mobilization costs, MoH contributions tend to be on the lower end. Based on our experience, a realistic estimate of MoH's contribution for VAS campaigns would range from 15-20%, primarily consisting of existing infrastructure and human resources.

Adjustment in Reporting for 2023 Campaigns in Burkina Faso

An error in our 2023 reporting for Burkina Faso miscalculated MoH contributions using an inflated salary rate of 30,000 XOF for community health volunteers instead of the correct 20,000 XOF. This resulted in an overestimated MoH contribution, reported at USD $860,593 instead of the actual USD $573,918. Including this adjustment within the cost per supplement would avoid the risk of double-counting the MoH contribution.

Recommendation

Rather than applying a blanket 30% assumption, we recommend a more context-sensitive approach that reflects the actual MoH contribution level in each country. A 15-20% range would better represent VAS campaigns, where international partners cover most logistics and operational expenses. Additionally, MoH contributions should be calculated based on direct campaign funding and sub-agreements rather than overall expenditures by Helen Keller. Alternatively, using a 100% ratio for direct campaign funding and 50% for non-direct funding could account for structural differences between MoH and Helen Keller.

2.3. Coverage and Target Population Estimates

Up to 2024, Helen Keller Intl has proactively monitored VAS coverage, conducting annual surveys with a particular focus on regions where contextual challenges might lower coverage rates. This strategy aims to identify program weaknesses and implement corrective actions. As a result, this adaptive approach has successfully raised coverage in areas with initially lower performance, such as Guinea, Cameroon, and Côte d'Ivoire.

While we recognize that GiveWell requires reliable coverage data to determine the actual number of children reached, using data from previous surveys to extrapolate coverage estimates across broader regions or at different times may lead to inaccuracies. Many of these surveys reflect low coverage rates that have since been addressed through targeted program improvements. Relying on these historical figures risks underestimating the current coverage in regions that have seen increased performance due to these adjustments. Such underestimation could misrepresent the cost-effectiveness of the VAS program, inaccurately reflecting the true reach of VAS campaigns.

Table 3 shows the coverage figures GiveWell currently uses in their cost-per-supplement model. Notably, a survey conducted in Guinea in July 2024 indicated a campaign coverage of 84.6%, demonstrating the positive impact of program improvements based on findings from the 2022 survey (used in Table 3).

Table 3. Proposed coverage estimates

Country	Coverage used for cost per supplement calculation	Estimates for calculation moving forward
Burkina Faso	87%	87%
Cameroon	74%	75%
Cote d'Ivoire	78%	78%
DRC	89%	91%
Guinea	69%	72%
Kenya	81%	81%
Mali	78%	82%
Niger	91%	91%
Nigeria	94%	94%

Recommendation

We recommend that GiveWell calculate an average coverage rate by combining data from recently surveyed regions with administrative coverage estimates for regions not recently surveyed. Additionally, as Helen Keller completes surveys across all countries and regions in both semesters of 2024, we suggest updating the cost-effectiveness denominator based on these new results. This approach will provide a more accurate and current reflection of the program's true reach and impact.

2.4. Distribution of Helen Keller management costs

Currently, management cost forecasts are distributed according to the relative budget weight of each country within the overall program. While this approach may be logical from a financial standpoint, it does not accurately reflect how management resources are actually allocated across different countries and regions.

In practice, management support from our teams is more closely aligned with the number of districts or regions supported in each country and the population size served. Management efforts—including coordination, oversight, reporting, and logistical support—naturally scale with the program's scope and reach. This is especially true in countries with a higher number of supported districts and larger populations, where the demand for management resources is greater.

Recommendation

Rather than basing management cost distribution solely on each country's budget, we propose that these costs be allocated according to the

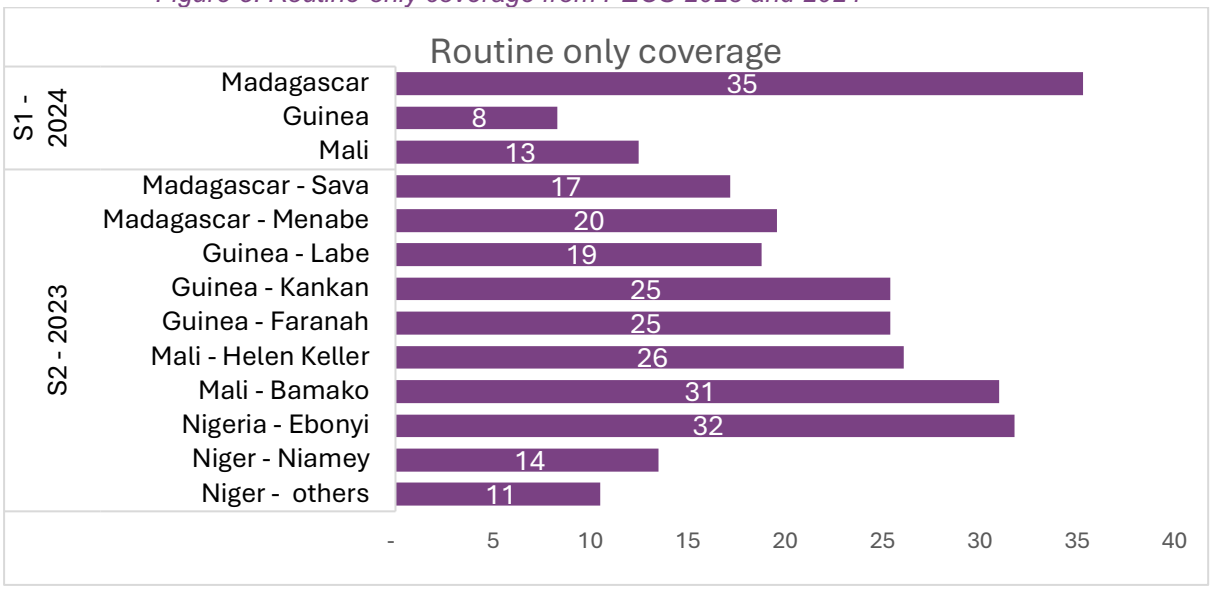
proportion of the population served in each country. This approach would more accurately reflect the actual demand for management support, ensuring that resources are distributed in line with program needs across countries.

3. Cost-effectiveness analysis

3.1. Baseline proportion of people under age 5 who receive VAS in the absence of GiveWell support

GiveWell currently estimates that countries would have a baseline VAS coverage of 30% without Helen Keller's support. However, this estimate may be overly optimistic compared to recent evidence from coverage surveys conducted in multiple countries in 2023 and 2024. These surveys indicate significant variations in VAS coverage between countries, with potentially lower coverage rates without organized campaign delivery, as indicated in **Figure 4.**

Figure 5. Routine-only coverage from PECS 2023 and 2024



3.2. Internal validity adjustment

GiveWell applies a 20% reduction to the impact of VAS on child mortality, indicating: "*We apply a -20% internal validity adjustment to account for the risk that the main finding from the Cochrane meta-analysis is inflated because of weaknesses in the underlying trials*". We are, however, unclear on how such a large reduction was calculated, as the quality and reliability of Cochrane reviews are well accepted. We believe that this adjustment may lead to an underestimation of the true impact on child mortality.

3.3. External validity adjustment

We are unclear on how the calculation is made, but we feel such a high reduction of effect (-66%) does not adequately reflect the reality of the

contexts we support. The model seems to suggest a linear cumulative effect of VAS's impact on mortality. However, there is no empirical evidence to support this assumption.

For example, the calculation applies a -62% adjustment for deaths not attributed to measles or diarrhea, which underplays VAS's broader impact on other infectious diseases common in Africa. Research indicates that VAS not only reduces mortality from specific diseases but also strengthens the immune system, thereby mitigating the severity of illnesses like malaria and respiratory infections (Michaelsen et al., 2011; Imdad et al., 2017). This adjustment misses VAS's broader protective effects.

VAS effects on non-infectious causes of mortality—such as malnutrition, anaemia, and birth complications—are less direct and not well-documented in the literature. Thus, the claim that VAS "significantly impacts non-infectious causes of mortality" appears overstated based on current evidence. VAS is indeed crucial in reducing mortality, but its primary impact is through the prevention of infectious diseases.

While VAS does provide a broader protective effect by enhancing immune function, which may help mitigate both infectious and non-infectious health burdens, quantifying its impact on health challenges beyond infectious diseases remains speculative.

Recommendation

We recommend taking a more nuanced approach that considers the broader impacts of VAS on both infectious and non-infectious mortality, ensuring the cost-effectiveness calculations more accurately reflect the program's true benefits.

3.4. Adjustment for supplementation frequency in VAS trials vs. current contexts

GiveWell applies a -17% reduction in the estimated effectiveness of VAS, citing concerns that the protective effects of vitamin A may diminish with longer intervals between doses, particularly among children with low vitamin A stores. While these concerns are valid, we believe this adjustment is overly conservative for several reasons.

First, clinical trials have consistently demonstrated that the protective effects of vitamin A can last up to six months, which is why the World Health Organization (WHO) recommends biannual supplementation for children 6 to 59 months (WHO, 2011; Rojas et al., 2014). There is limited evidence to support a precise 17% reduction, especially given the variability in the timing of VAS campaigns in different contexts.

Moreover, the timeline between campaigns can vary significantly across contexts, and some campaigns may occur at shorter intervals, maintaining adequate vitamin A levels in children. For instance, a study in Ghana

showed that timely administration of VAS can effectively maintain serum retinol levels in children under five (Adu-Afarwuah et al., 2008). It is important to consider this variability when assessing the potential impact of VAS across different settings.

Additionally, data from the Global Burden of Diseases (GBD) 2019 study indicate that a significant proportion of children under the age of five received VAS, further underscoring the importance of timely and effective delivery of supplementation programs (GBD 2019 Diseases and Injuries Collaborators, 2020). However, we are unclear about how the rates are calculated, and this would encourage further transparency and clarity in the methodology.

3.5. Supplemental grantee-level adjustments

GiveWell comment	Helen Keller Intl response
Misappropriation without monitoring results : -15% to the cost effectiveness of VAS services Scenario: Grantee sends money/goods to a country/partner and the country/partner reports back that they carried out the program and reached a certain number of people, but these results are partially or fully fabricated and we do not have monitoring results from those locations. The monitoring results we have seen from Helen Keller are less comprehensive than those from GiveWell's other top charities. We have seen monitoring results for campaigns representing 64% of Helen Keller's VAS spending in 2019, 52% in 2020 and 29% in 2021. In part, our understanding is that this fall has been because of temporary disruption resulting from the coronavirus pandemic.	We have consistently ensured that the activities supported by Helen Keller take place as planned and funded, with independent monitoring, participation by Helen Keller teams in activities, and supervision during the campaign. Thus, we are confident that results are not fabricated, even if we acknowledge that administrative data is often inaccurate. In addition, Helen Keller has a clear system of control called the "Sub award Management System" to ensure that instead of only sending money to grantees, all interventions are well implemented with high quality. Moreover, since 2019, our organization has spent between 5 and 10% on coverage surveys (11% for the period July 2023 to June 2023), but we do not believe that the additions per country (64%, 52%, 29%) truly depict the evolution of our monitoring approach. In the first years, we conducted surveys to target new regions supported and regions where we assumed coverage would be lower, essentially to ensure that funds donated by GiveWell are used with the highest cost-effectiveness rate. As the program continued and expanded, the weight of surveys on overall spending was reduced due to economies of scale. Surveys were also not systematically re-conducted in regions that consistently showed high coverage. Finally, we note that other top charities supported by GiveWell spend between 5 and 10% of their funding on monitoring, which is consistent with Helen Keller's practice. Moreover, it should be noted that Helen Keller's reach is far greater than that of other top charities, with 35 million children reached per semester against a maximum of 5 million for other top charities. Such a large reach creates cost efficiencies that tend to lower the proportion of funds spent on monitoring by Helen Keller.

GiveWell comment	Helen Keller Intl response
Misappropriation without monitoring results: -15% to the cost effectiveness of VAS services We also have a concern that the monitoring results we see may not be fully reflective of the results achieved across Helen Keller's VAS campaigns. That is because Helen Keller usually conducts monitoring for only one of the two campaign rounds it delivers per country per year, and in some cases only some regions or districts are surveyed. If VAS implementers know in advance which rounds and locations will be surveyed, they may have less incentive to ensure high coverage in other rounds and locations, as these have less oversight.	We are only conducting a campaign for one round in each country based on GiveWell's recommendation, so we are unclear why this recommendation would lead to a reduction of cost-effectiveness. In terms of the risk that Ministry managers knowing that a survey will be conducted after the campaign influences coverage, we see this as very unlikely, essentially because in each administrative unit surveyed, sub-agreements are signed with the Ministry that represent more than 5,000 distributors and hundreds of supervisor, and they have no flexibility to add workload to these campaign workforce. Starting in 2024, we are also conducting independent monitoring during the campaign for all countries and all rounds of the campaign, reinforcing the reliability of the results.
Misappropriation without monitoring results: -15% to the cost effectiveness of VAS services Finally, we have heard feedback from Helen Keller that its monitoring surveys tend to take place in the non-rainy season. This raises a concern that, if coverage is lower during campaigns conducted in the rainy season, the results we see may be systematically overestimating coverage.	Out of 47 surveys conducted in the last five years, 21 took place after the first semester and 26 after the second one, providing a reasonable estimate of coverage in both types of seasons, including during rainy seasons. We have seen from the data that there is no seasonal coverage variation, so we do not believe this concern to be confirmed.
Misappropriation without monitoring results: -15% to the cost effectiveness of VAS services	We do not understand the high value of -15%. While we appreciate GiveWell's concerns, we have implemented all of GiveWell's recommendations since the beginning of 2024, so we are unclear why our cost-effectiveness should be affected to such a large extent.

These concerns mean that we use a relatively high value for this parameter compared to GiveWell's other top charities	The use of previous coverage survey figures in the cost per supplement model for the regions surveyed as well as the others, knowing that we were targeting our surveys in regions we assumed needed more support, already reduces the cost-effectiveness of VAS significantly, so adding another reduction factor seems to double the negative effect of one aspect that has already been addressed.
False monitoring results : -2% to the cost effectiveness of VAS services Overall, we believe that Helen Keller's coverage surveys are designed to measure key indicators of the success of VAS campaigns and to achieve samples that are generally representative of target populations. Helen Keller's surveys use an audit procedure whereby supervisors re-survey a random sample of participants, and Helen Keller has increasingly begun to report the results from this procedure. This alleviates some of our initial concerns about the quality of Helen Keller's auditing procedure and gives us more confidence in the accuracy of the monitoring data. However, we note that the caregiver-reported nature of responses may produce bias in results.	We acknowledge the risk of bias linked with the caregiver's recall. However, the restructuring of the VAS questionnaire, the addition of multiple triangulation questions, and quality control measures should be sufficient to address these concerns.
Within-org fungibility: -5% to the cost effectiveness of VAS services Scenario: Grantee runs multiple programs and shifts funds from non-GiveWell sources or fundraising	As indicated in the GiveWell comment ("*Helen Keller has consistently used GiveWell grants to support VAS campaigns*"), we have always used donations received from GiveWell to support VAS campaigns in the recommended countries and have actively sought additional funding from various sources to support the VAS

effort out of the program that we want to fund as a result of receiving GiveWell-directed funding. Helen Keller has limited unrestricted funding relative to the size of this program. Fundraising efforts may be redirected to other programs as a result of more funding being available for this program.	programs, succeeding in some instances through funding from UNICEF or philanthropies such as Effect: Hope, the 3 Graces Foundation or the Ray and Tye Noorda Foundation. However, funding for VAS among other donors remains very limited, so we are unclear why this should lead to a 5% reduction in the program's cost-effectiveness.

Recommendation

GiveWell recommended in 2024 that coverage surveys should only be conducted for all regions once a year, as the cost would otherwise be very high due to the large footprint of the VAS programs supported by Helen Keller compared with other top charities. Past practices tend to underestimate coverage as we targeted regions we identified as having more challenges, so we believe that using those coverages to calculate the cost per supplement already accounts for the bias that the impossibility may create to conduct surveys every semester for all regions. We recommend revisiting the -15% adjustment, given our consistent implementation of GiveWell's guidelines, improved monitoring practices, and transparent targeting of high-need regions. Adjusting this reduction to 5% would prevent redundant adjustments for monitoring impact.

3.6. Supplemental intervention-level adjustments

The calculation methodology for these percentage adjustments remains unclear, particularly concerning how they interact with previously discussed reduction indicators. Additionally, the 10% reduction applied due to "lower-than-average baseline mortality rates" seems overly conservative, as coverage surveys consistently indicate that we reach between 80% and 90% of the target children.

Table 4. Supplemental intervention-level adjustments on the cost-effectiveness of the VAS program

Short-term consequences of reduced infectious disease morbidity	%	input	6%
Short-term anemia effects	%	input	9%
Investment of income increases	%	input	3%
Vision benefits	%	input	9%
Benefits from other programs supported by our funding (e.g. deworming, immunizations)	%	input	18%
Treatment costs averted from prevention	%	input	20%
Interaction between VAS and vaccines	%	input	2%
Children reached by VAS campaigns may have lower-than-average baseline mortality rates	%	input	-10%

3.7. Counterfactual Funding Scenarios

The assumption that "other philanthropic actors would replace Helen Keller's costs" carries an estimated likelihood of 20-45%, which seems high based on our experience. When Helen Keller lacked funding for VAS campaigns, support was almost universally discontinued, making it unlikely that other actors would consistently fill this gap.
Furthermore, it's unclear how this assumption impacts the cost-effectiveness analysis, as it appears to be an independent consideration rather than an indicator directly influencing VAS program outcomes.

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