HELEN KELLER INTL

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

**31 October 2023**

## Contents

# 1. Introduction

Helen Keller triumphed over significant health challenges and inspired millions to do the same. Guided by her enduring legacy, Helen Keller Intl partners with communities that are striving to break free persistent cycles of poverty. Through the delivery of fundamental elements such as good health, sound nutrition and clear vision, we empower millions of people create lasting positive change in their lives. Together with a global community of supporters, we are committed to ensuring that every person, just as Helen did, has the opportunity to reach their full potential.

In our commitment to advancing global nutrition, Helen Keller Intl provides technical and financial assistance to Ministries of Health in 14 countries across Sub-Saharan Africa aimed at implementing and strengthening vitamin A supplementation (VAS) services targeting children aged 6 to 59 months. Helen Keller supports the design, implementation and monitoring of VAS mass distribution campaigns, which can efficiently reach all children in our supported areas in a short timeframe. Recognizing the continuous development and improvement of health systems, we also facilitate the integration of VAS into routine health systems, contributing to the enhancement of health system performance.

Between January 2022 and June 2023, we meticulously documented our progress, challenges, and successes. This report serves as a testament to our collective efforts and our unwavering determination to make a meaningful difference.

# 2. Brief overview of Helen Keller Vitamin A supplementation program strategy plan

Helen Keller International ‘s strategic plan for 2022-2027 builds upon a history of impactful initiatives. Helen Keller International remains steadfast in its commitment to support 14 sub-Saharan African countries in sustaining their VAS programs. Over the next five years, Helen Keller’s strategic plan focuses on overcoming obstacles and expanding the reach of this life-saving intervention to ensure the well-being of children in the region.

Helen Keller actively collaborates with governments and partners to navigate the evolving landscape of VAS delivery. Our three main goals are:

- Promote cost-effective delivery mechanisms for VAS.
- Enhance the sustainability of VAS services by increasing the proportion of these services funded by local government budgets.
- Ensure that no children are left unprotected.

Our strategic objectives for the next five years include:

- A sustainable and cost-effective delivery model for VAS is identified, tested, documented and fully integrated into the health system in each country.
- Transition plan toward a cost-effective and sustainable model for VAS developed and being rolled out in each country.
- Global evidence produced on cost effective and sustainable delivery models for VAS.
- Proportion of VAS services costs covered by domestic funding increased.

We also consider the following sub-objectives in specific countries as appropriate:

- Developing solutions to maximize campaign cost-effectiveness by integrating them into health systems, reducing campaign costs and extendingt service reach.
- Providing technical and financial support to countries transitioning to cost-effective VAS delivery models while maintaining coverage at 80% during the transition .
- Leveraging VAS as a catalyst to strengthen health systems.
- Developing and promoting a VAS learning agenda, including knowledge and evidence-building for VAS programming.
- Evaluating and increasing domestic resource mobilization for VAS through advocacy.

To achieve its objectives, Helen Keller Intl provides support to the governments of 14 countries in Sub-Saharan Africa for Vitamin A supplementation. These countries are Burkina Faso, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo (DRC), Guinea, Kenya, Madagascar, Mali, Mozambique, Niger, Nigeria, Tanzania, Senegal, Sierra Leone (figure 1).

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

# 3. Vitamin A Supplementation program

## 3.1. Vitamin A capsules distribution main strategies

In the 1980s, HKI played a significant role in generating groundbreaking evidence highlighting the potential of biannual VAS to reduce child mortality by up to 24% if delivered to at least 80% of children aged 6 to 59 months every 6 months in areas with high under-five mortality and high prevalence of vitamin A deficiency. This compelling evidence received strong support from the World Health Organization (WHO), leading to its robust recommendation for universal VAS in appropriate contexts.

Initially, VAS coverage rapidly reached more than 80% of children aged 6 to 59 months in sub-Saharan Africa through its integration in door-to-door polio vaccination campaigns. However, as these campaigns began to phase out following progress in the eradication of polio in Africa in the 2010's, VAS coverage started to decline. Helen Keller continued to support campaigns for VAS without polio where needed, and started to work towards integrating VAS into routine facility-based services. However, routine health systems services continue to pose numerous challenges, especially when targeting children over 12 months of age. While continuing to support mass campaigns in most countries, Helen Keller Intl is supporting the governments of 14 sub-Saharan African countries in this integration process. Our collaborative approach therefore involves working closely with governments and various partners to implement VAS through two primary models: campaign and routine.

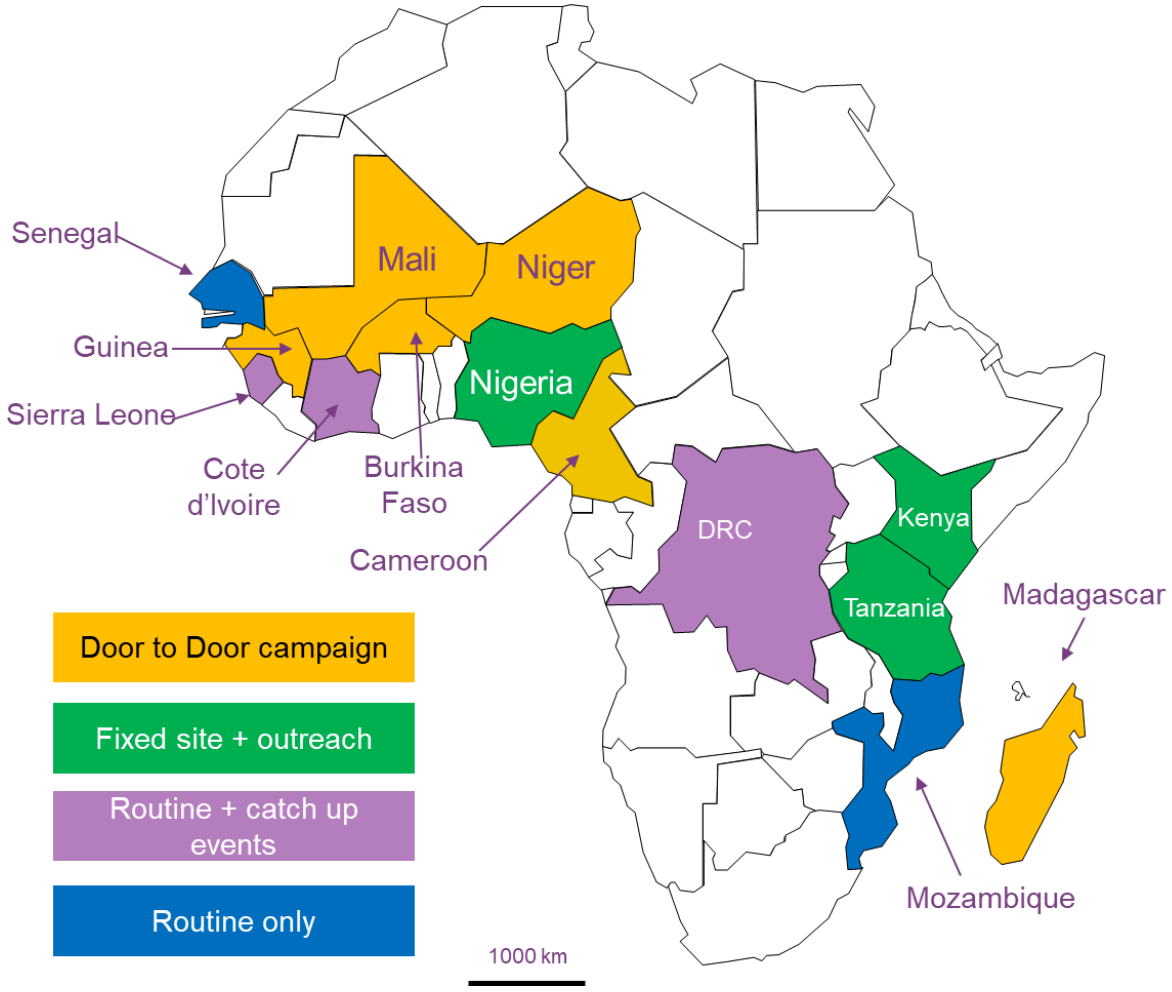
### Campaign delivery model

This model involves the rapid delivery of vitamin A Supplements to children over a short period, typically lasting 5 days to 2 weeks, usually in May and October each year. Distribution occurs through either door-to-door approaches or fixed sites such as health facilities and outreach stations in remote locations. These campaigns often include additional services like deworming, acute malnutrition screening, promotion of health and nutrition best practices, and even birth registration to enhance cost-effectiveness.

### Routine delivery model

This model comprises two approaches: delivery through facility-based services and routine outreach sessions as in Senegal and Mozambique and a combination of routine activities with mop-up campaigns at the end of each semester in DRC, Sierra Leone and part of Côte d'Ivoire. In these three countries, Helen Keller actively supports the transition towards full integration of VAS into facility-based routine service delivery. This often involves establishing a network of community-based volunteers to inform communities about opportunities and to support distribution activities in remote areas.

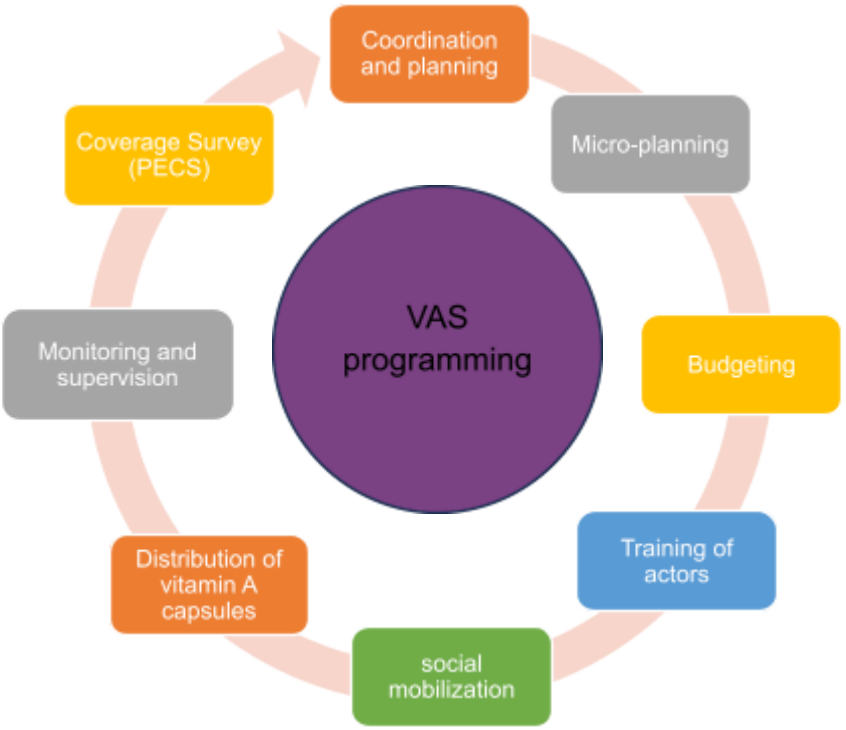
*Figure 2. Vitamin A Supplementation implementation strategies per country*



## 3.2. Program cycle management for VAS

Implementing vitamin A supplementation services implies following a sequence of essential steps. This cycle is illustrated in figure 3 below.

*Figure 3: Project cycle management for the implementation of Vitamin A supplementation services*




### Coordination and planning

Helen Keller Intl is an active member of the national Technical Working Group and Coordinating Committees in each country. Coordination meetings serve as key forums for shaping VAS activity planning, implementation and monitoring. For the organization of campaigns, technical working groups begin planning three months before the date of the upcoming campaign. They discuss previous results, challenges encountered, and appropriate corrective measures. They also define essential campaigns features such as the package of services to be delivered alongside VAS, timelines, target populations, coverage targets, resources needed, communication strategies and logistical arrangements. Helen Keller developed a comprehensive planning and process monitoring tool for its teams to enhance the effectiveness of this coordination processes. The timing of the previous campaign is integrated in the tool and sets the timing of all planning steps for the next campaign. We also work with partners and ministry officials to establish sub-groups to oversee campaign preparations, covering areas such as communications, data management and financial planning. At the sub-national level, Helen Keller supports local partners to organize coordination meetings at least three weeks prior to the start of each VAS campaign. This proactive approach greatly improves the management of all aspects of campaigns preparation at the local level.

### Micro-planning

Helen Keller supports governments in developing microplans for both routine and campaigns. For routine, the process takes place at the beginning of every year with the government and partners. For campaigns, micro-planning begins approximately six weeks prior to the campaign (or routine mop up) activities and is characterized by several key inputs:

- Standardized micro-planning: Helen Keller has developed standardized guidelines to support governments to conduct this process, with daily objectives for distribution teams in both urban and rural areas of each supported region. These guidelines serve as a basic framework for accurately calculating the number of distributors, supervisors and social mobilisers needed. Implementing these standards ensures that the workload for each category of actor remains manageable, significantly increasing the campaign's chances of success.
- Comprehensive micro-plans: based on these standards, comprehensive micro-plans are developed with budgeted activities at all levels, from national level to health facilities. In addition defining the target populations and staffing requirements, these micro-plans specify supplies needs, address logistics processes, and create structured monitoring circuits.

### Budgeting and fund transfer

Helen Keller plays an important role in the financial planning and resource allocation process for vitamin A supplementation.

- Budgeting support: Using the microplans developed, Helen Keller works with government teams to develop activities budgets. These budgets include specific areas to be supported by Helen Keller and, in some cases, cover the entire country. The resulting budget, along with the detailed information from the microplans, form the basis for sub-agreements signed with government entities.
- These sub-agreements define in detail the roles and responsibilities of Helen Keller and the governments in the implementation of VAS activities and are mainly used for campaigns. Sub-agreement funds for government activities and staff represent approximately 70% of the total implementation costs and are established with local administrative entities. They describe the legal obligations of the government and all aspects of campaign implementation such as staff training, social mobilization, distribution, and data management. Sub-agreements also describe payment terms, milestones and deliverables associated with each payment.
- Helen Keller also provides direct financial support to other activities such as micro-planning workshops, supervision by national ministry teams, communication activities and production of materials, independent monitoring of the campaign and coverage surveys. The proportion of funding through sub-agreements and through direct funding may varies between countries.

### Training

Helen Keller is involved in coordinating and supporting training for all actors engaged in vitamin A supplementation at all levels of the health system. Our involvement includes the comprehensive review and improvement of training tools to capitalize on lessons learned from previous campaigns and the rollout of training tools. We work closely with Ministries of Health to facilitate training at all levels, usually training trainers ourselves at national level

and supporting these trainers cascade the training down to the field level. This cascading approach ensures that health workers at facility level are trained by the district management teams, while community health workers are equipped with the necessary skills through training by health workers.

### Communication/ Social mobilization

The success of VAS activities depends heavily on effective communication strategies and channels to create widespread awareness among the population on the importance of VAS and the organization of an upcoming campaign. Coverage surveys have shown that one of the main reasons for children not to receive VAS is that caregivers were not aware of the campaign taking place around them. Helen Keller supports the development of communication plans and communication tools and the roll out of the communication campaign. This includes:

- Advocacy: Working with political and community leaders to ensure engagement at all levels of society in support of supplementation.
- Social mobilization: Promoting participation and buy-in from different social groups and local actors is critical to the success of the campaign. To inform communities about VAS campaigns and other related activities, we build the capacity of communication focal points and community mobilisers. Social mobilization activities, carried out by well-trained mobilisers from neighborhoods, villages, or communities, play a key role in behavior change. For campaigns, these mobilisers carry out door-to-door communication working closely with distribution teams, identify children, address possible refusals, and use their community connections to increase the effectiveness of distribution. These communication activities last for five days, starting three days before the start of the campaign and continuing for the first two days of campaign implementation. Helen Keller promotes the use of pre-identified mobilization channels tailored to specific environments. Local radio stations, administrators, health workers, educators, traditional and religious leaders, and town criers are used to disseminate information effectively. Banners and posters are used for visibility. Local radios are used to announce campaign dates and provide information on the benefits of vitamin A, the target age groups, administration methods, and other related activities.

### Vitamin A capsule distribution

Health workers distribute vitamin A capsules at health facility level, and community health workers are responsible for vitamin A distribution in communities, using either door-to-door visits or outreach distribution stations. Community distributors are usually organized in pairs and are equipped with tally sheets to record each capsule they distribute, indicating the age group and the sex of the child receiving it. Every morning, they visit their supervising health facility to collect tally sheets and vitamin A capsules and deworming tablets. Before the campaign starts, they go through a careful mapping of their catchment area to plan for the distribution and ensure no household is missed. This mapping also helps identify the target number of children they are expected to reach. These morning visits also allow them to report any challenge encountered and allow the facility workers to identify which teams need more support and will require supervision during that day.

### Monitoring and supervision

Helen Keller supports monitoring and supervision of campaigns through three main activities: independent monitoring, supportive supervision and coverage surveys.

- Independent monitoring: Throughout the distribution process, Helen Keller establishes a robust independent monitoring system that follows a WHO-approved method to ensure equitable access to vitamin A capsules for all children. [1] Carefully trained independent monitors with no affiliations to the health system are contracted to assess the coverage of localities previously visited by distributors, and monitoring visits are conducted to ensure the effective execution of campaign activities. Independent monitoring is conducted in areas with low coverage based on the administrative and coverage data from previous campaigns. Additionally, it is conducted in hard-to-reach areas suspected to not have been reached (or at risk of not being reached) by distributors.
- Supervision: Supervision of distribution activities is a joint endeavor by supervisors from Ministries of Health (central, regional, district, and health facility levels) and Helen Keller teams. During campaign implementation, supervisors follow predefined circuits with districts and health facilities to monitor the campaign implementation. Daily synthesis meetings are conducted at each level during the campaign to assess its strengths and weaknesses, identify areas for improvement, and address any urgent challenge.
- Coverage survey: Because administrative data extracted from the compilation of distributors tally sheets often provide inaccurate estimates of coverage, Helen Keller conducts at least one post-event coverage survey per year in each country it supports. These surveys serve several purposes, including evaluating program performance, assessing the effectiveness of efforts to increase coverage, and identifying program weaknesses. A notable benefit of conducting such surveys is the transparency they bring, providing concrete evidence of program performance and impact. They also represent unique opportunities for collecting additional data useful to health system strengthening and nutrition.

Note. Helen Keller continues to extend its use of digital technologies for surveys, independent monitoring and supervision. Teams use electronic forms configured with ODK and upload them to ONA, using tablets. The benefits of digitalization in independent monitoring and surveillance are multiple. It facilitates efficient, real-time data collection and transmission, reducing the time lag between data collection and decision making. This not only improves the accuracy and timeliness of monitoring, but also enables quick responses to coverage gaps and campaign-related issues. Digitalization also enhances data security, ensuring the integrity and confidentiality of the information collected. It also offers a more streamlined and cost-effective approach than traditional paper-based methods. Overall, the integration of digital technology into independent monitoring significantly improves the quality and effectiveness of VAS campaigns.

[1] https://polioeradication.org/polio-campaign-monitoring/#:~:text=The%20basic%20elements%20of%20monitoring,the%20proportion%20of%20districts%20monitored.

## 4. Program impact from 1st January 2022 to 30th June 2023

Between January 1, 2022 and June 30, 2023, Helen Keller supported the distribution of 100,789,181 capsules over three rounds of distribution, a substantial increase compared to the 45,193,768 capsules distributed in the two rounds of distribution in 2021.


This important increase in the number of capsules distributed is due to the extension of our support to all regions of Cameroon, Côte d'Ivoire, and Niger, following requests from the Ministry of Health and UNICEF. In addition, expansion continued as planned in the Democratic Republic of the Congo (DRC) from 3 to 6 provinces for the second semester of 2022 and the first semester of 2023.

Table 1 provides a summary of achievements per country and per round of distribution over the reported period. Details of implementation of VAS services are then provided for each country.

More details are also available in the attached program excel sheet (Program report to Givewell, VAS delivery, Helen Keller, 2022 – 2023).

Table 1. Summary of 2022 and first semester 2023 VAS campaigns

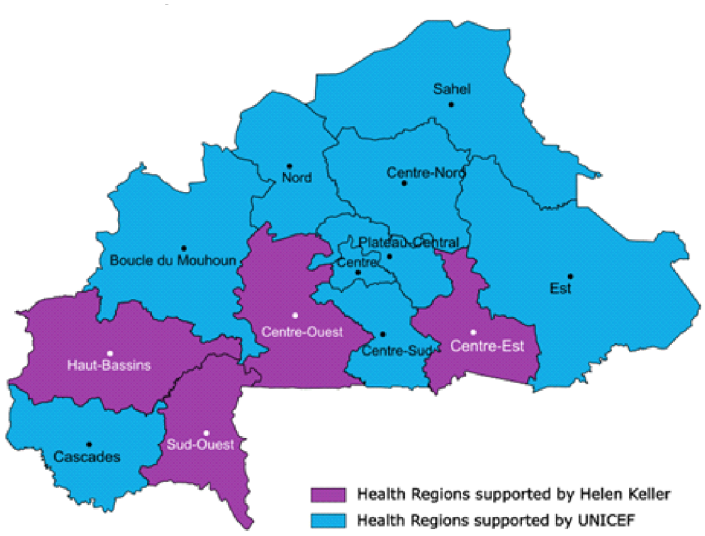
| | Round | Nb. Of target areas in the country | Nb. Of regions targeted | Geographic Coverage | Target Population | Administrative Coverage | Number of capsules distributed |
|---|---|---|---|---|---|---|---|
| Burkina Faso | 2022 R1 | 13 | 5 | 38% | 1,202,566 | 103% | 1,237,303 |
| | 2022 R2 | | 4 | 31% | 1,073,705 | 100% | 1,069,675 |
| | 2023 R1 | | 4 | 31% | 1,093,488 | 98% | 1,071,195 |
| Cameroon campaign | 2022 R1 | 10 | 6 | 60% | 2,772,587 | 97% | 2,678,590 |
| | 2022 R2 | | 6 | 60% | 2,772,589 | 91% | 2,530,509 |
| | 2023 R1 | | 10 | 100% | 5,697,035 | 96% | 5,491,942 |
| Cameroon routine | 2022 R1 & R2 | | 2 | | 90,389 | 99% | 89,485 |
| | 2023 R1 | | 2 | | 83,292 | 21% | 17,491 |
| Côte d'Ivoire campaign | 2022 R1 | 72 | 63 | 88% | 5,728,033 | 99% | 5,688,707 |
| | 2022 R2 | 40 | 40 | 100% | 2,287,614 | 100% | 2,295,628 |
| | 2023 R1 | 40 | 40 | 100% | 2,353,955 | 100% | 2,351,272 |
| Côte d'Ivoire Routine | 2022 R1 | 41 | 14 | 34% | 484,743 | 59% | 285,433 |
| | 2022 R2 | 73 | 54 | 74% | 1,708,884 | 50% | 846,325 |
| | 2023 R1 | 73 | 60 | 82% | 2,051,754 | 77% | 1,579,851 |
| DRC | 2022 R1 | 26 | 3 | 12% | 3,691,960 | 98% | 3,624,982 |
| | 2022 R2 | | 6 | 23% | 6,421,306 | 92% | 5,899,440 |
| | 2023 R1 | | 6 | 23% | 6,604,767 | 99% | 6,536,344 |
| Guinea | 2022 R1 | 8 | 5 | 63% | 1,686,668 | 100% | 1,688,218 |
| | 2022 R2 | | 5 | 63% | 1,708,655 | 95% | 1,624,444 |
| | 2023 R1 | | 5 | 63% | 1,704,853 | 100% | 1,705,786 |
| Kenya | 2022 R1 | 47 | 24 | 51% | 3,476,491 | 104% | 3,624,454 |
| | 2022 R2 | | 25 | 53% | 4,644,268 | 93% | 3,379,383 |
| | 2023 R1 | | 25 | 53% | 3,716,143 | 92% | 3,420,933 |
| Mali | 2022 R1 | 11 | 3 | 27% | 2,835,460 | 94% | 2,670,423 |
| | 2022 R2 | | 3 | 27% | 2,835,460 | 87% | 2,476,988 |
| | 2023 R1 | | 3 | 27% | 1,994,626 | 120% | 2,390,591 |
| Niger | 2022 R1 | 8 | 6 | 75% | 5,211,589 | 101% | 5,254,636 |
| | 2022 R2 | | 8 | 100% | 6,755,553 | 87% | 5,843,553 |
| | 2023 R1 | | 8 | 100% | 6,361,641 | 107% | 6,821,808 |
| Nigeria | 2022 R1 | 36 | 6 | 17% | 5,821,464 | 92% | 5,342,384 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 2022 R2 | | 7 | 19% | 6,430,050 | 94% | 6,020,193 |
| | 2023 R1 | | 6 | 17% | 5,791,271 | 90% | 5,231,215 |
| Totals | | | | | 107,092,859 | | 100,789,181 |

## Burkina Faso

In 2022, campaign rounds took place in June and December, adhering to the recommended 4-to-6-month interval between two rounds. The campaigns followed the established mixed model, which included five weeks of distribution by community workers in rural areas and a five days of door-to-door distribution in urban settings, delivering VAS and screening for acute malnutrition for children 6 to 59 months and deworming tablets for children 12 to 59 months. In the initial round of 2022, Helen Keller extended its support to all thirteen regions of the country. This assistance was provided to five regions through funding from Givewell. UNICEF provided funds to Helen Keller to support the other 8 regions they usually manage, due to administrative constraints that prevented them from supporting the regions directly for that round.

*Figure 4. VAS geographic coverage per Partner in Burkina Faso during second round 2022 and the first semester 2023*




In the second round of 2022 and the first round of 2023, Helen Keller support focused on four regions, while the remaining regions continued to receive direct assistance from UNICEF (figure 4). The targeted population supported by Helen Keller for the three rounds with Givewell funds amounted to 1,202,566, 1,073,705, and 1,092,488 children respectively.

The Ministry of Health partnered with Helen Keller to implement a communication strategy that combined mass media and community engagement. This strategy operated on two levels: national and local. National-level activities involved using television spots, radio spots, and announcements for social mobilization, while at the local level town criers were employed to raise awareness. Helen Keller's support facilitated the creation and dissemination of seven television spots and 875 radio spots for each round in 2022 and 15 radio broadcasts in 2023 to ensure reach of these messages to the target audience. This dual approach, integrating mass media and community mobilization, significantly increased awareness and encouraged active community involvement in the campaign.

For the first round in 2023, independent monitoring was organized to ensure the effectiveness of implementation. A total of 4,693 households were visited in 53 hard-to-reach localities to verify that targeted children had received vitamin A capsules. Data showed that 7.55% of these localities were not covered. The independent monitors were able to provide children surveyed in these areas with vitamin A capsules, as they were equipped with a kit

containing capsules. The non-covered areas were then reported to the health authorities at the district level, so that the distributors could return the same day or the next day to ensure that all children not yet supplemented received supplementation.

After the campaign, Helen Keller, in collaboration with various partners, contributed to funding a data validation workshop convened in Ouagadougou. This workshop allowed representatives from all regions to come together and ensure the accuracy and reliability of the data collected and to analyze the performance of the campaigns.

A detailed breakdown of the personnel trained and involved in campaign implementation in the supported regions is provided in table 2.

*Table 2: Number of supervisors, distributors, social mobilizers, independent monitors trained and employed per round in Burkina Faso for VAS campaigns.*

| Number of people trained | Round 1 2022 | Round 2 2022 | Round 1 2023 |
|---|---|---|---|
| Supervisor at national level * | | 26 | 22 |
| Supervisors at regional level | 1,227 | 1,104 | 1,040 |
| Number of distributors | 1,414 | 2,372 | 3,660 |
| Social mobilizers | 1,414 | 2,372 | 2,843 |
| Independent Monitors | N/A | N/A | 104 |

** In the first semester of 2022, the expenses for national-level supervision were covered by UNICEF*

### Cameroon

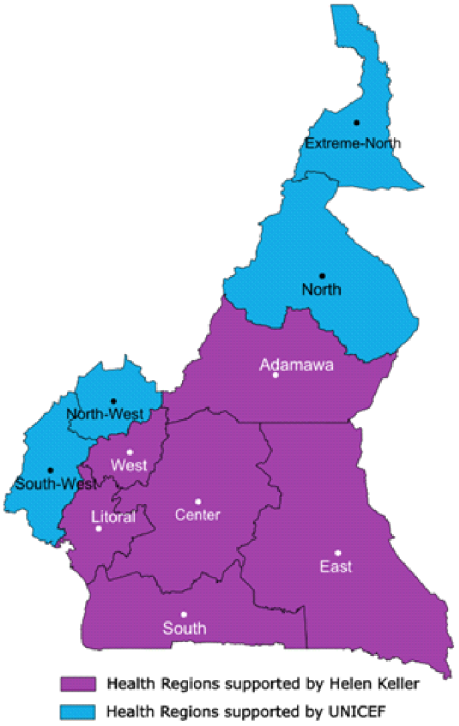
In Cameroon, Helen Keller Intl provided support to six regions during both rounds in 2022, targeting 2,772,587 children aged 6 to 59 months for each round, with UNICEF covering the four other regions. These campaigns were conducted in May and December.

In 2023, UNICEF faced funding gaps and approached Helen Keller to extend our support to all ten regions, with a total population of 5,697,035 children. The first round occurred in June.

During the first rounds, VAS was piggy-backed on polio campaigns that covered all 10 regions of Cameroon in 2022, and four regions (East, Adamawa, North, and Far North) in 2023.

Additional services delivered included deworming for children aged 12 to 59 months with Albendazole/Mebendazole, routine immunization for children not up to date with their vaccination calendar, reporting and investigating vaccine-preventable diseases within communities, promoting awareness of hygiene and sanitation practices, and encouraging enrollment in Universal Health Coverage (UHC).

*Figure 5. VAS geographic coverage per Partner in Cameroon during the first and second round 2022*




Helen Keller teams worked directly with regional and district teams to plan campaign activities in detail, using established criteria and benchmarks. These criteria included ensuring that distribution teams reached at least 150 children per day, and that each supervisor covered at least 5 teams. This extensive planning process informed the budget for the contractual agreement between Helen Keller and the regions.

To raise awareness among the population at various levels, several materials were developed and printed. Radio messages and spots in multiple languages (French, English, Fulfulde, etc.) were created and broadcast, alongside the use of sound-equipped vehicles in areas supported by Helen Keller.

Independent monitoring was conducted during all three rounds of the campaigns. This monitoring helped identify areas not reached. Whenever these monitors identify areas where at least 3 children out of 10 did not receive Vitamin A capsules, they inform Helen Keller and local authorities to send distributors back to these areas to ensure that no child was left behind.

In addition to campaigns, Helen Keller supported routine activities through an operational study in two health districts, Guidiguis and Kaele targeting 90,389 and 83,292 children aged 6 to 59 months, respectively.

Table 3 outlines the roles of the personnel who received training and were involved in campaign implementation. In addition, in 2022, 146 community health workers were trained to carry out research activities.

*Table 3: Number of supervisors, distributors, social mobilizers trained per semester in Cameroon.*

| Number of people trained | Round 1 2022 | Round 2 2022 | Round 1 2023 |
|---|---|---|---|
| Supervisor at national level | 6 | 12 | 18 |
| Supervisors at regional level | 560 | 81 | 53 |
| Supervisors at district level | 208 | 444 | 764 |
| Supervisors at Health facility level | 1,107 | 1,454 | 5,772 |
| Number of distributors | 1,354 | 6,328 | 13,586 |
| Social mobilizers | 6,237 | 15,889 | 13,523 |
| Independent Monitors | 80 | 133 | 156 |

### Côte d'Ivoire

Since 2016, Côte d'Ivoire has been working to integrate VAS and deworming into routine health service delivery. Initially, the plan was for health districts to gradually shift to a routine delivery model, covering all districts by 2020. However, due to delays in implementation, the PNN (National Nutrition Program), with support from its partners, revised the plan in 2021, with the expectation that all districts will transitioned to routine delivery by 2023.

In the first semester of 2022, out of the 113 health districts, 72 implemented VAS through campaign activities, while 41 adopted routine delivery models. In the second semester of 2022 and the first semester of 2023, the number of health districts conducting campaigns decreased from 72 to 40, with routine health districts increasing to 73.

During the first semester of 2022, Helen Keller supported 63 out of the 72 campaign districts and 14 out of 41 routine districts. In the second semester, we provided support to all 40 campaign health districts and 54 out of 73 routine.

In the first semester of 2023, Helen Keller supported 100 out of 113 health districts, 40 for campaigns and 60 for routine. The remaining 13 health district were supported by UNICEF.

VAS campaigns were coupled with deworming for children aged 12 to 59 months and community awareness activities promoting good nutritional and hygiene practices. Unfortunately, due to a shortage of tablets, deworming was not included in the second round of 2023.

Communication activities were carried out to increase the visibility of these campaigns, including radio spots, two in French and two in the most widely spoken local languages in the country; a television spot; 1,870 posters; 12,963 T-shirts; 400 caps; and 19 polo shirts. Digital communication was also intensified on the website https://www.educarriere.ci/, where an article on the campaign was posted for 11 days. In addition, communication efforts extended to social media platforms such as Facebook and LinkedIn, with a half-page banner on the homepage and the activation of 10 posts on Facebook and 5 on LinkedIn. Similar posts were published on the UNICEF website, Facebook, Instagram, and Twitter.

Independent monitoring was conducted during the first round 2023, covering 160 localities and identifying 41 areas where children had been missed. These areas were revisited to ensure that all children received supplements.

*Figure 6. VAS geographic coverage per partner in Côte d'Ivoire during second round 2022 and first round 2023*

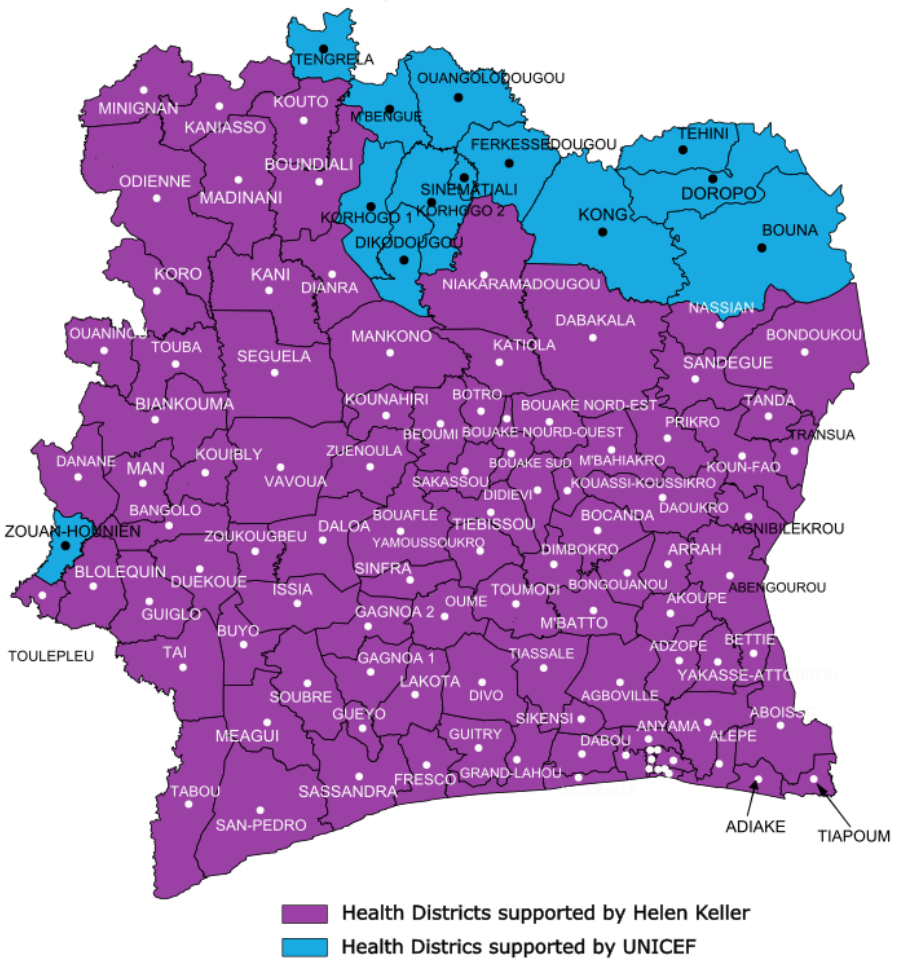



Table 4 presents all the individuals who received training and were engaged in the distribution of VAS for each round.

*Table 4: Number of supervisors, distributors, social mobilizers trained per semester in Côte d'Ivoire.*

| Number of people trained | Round 1 2022 | Round2 2022 | Round 1 2023 |
|---|---|---|---|
| Coordinator at national level | 10 | 10 | 19 |
| Supervisor at national level | 57 | 50 | 50 |
| Supervisors at regional / district level | 387 | 213 | 213 |
| Social mobilization focal points | 72 | 40 | 40 |
| Supervisors at Health facility level | 2,597 | 1,355 | 1,497 |
| Distributors (first round 2023) | 19,578 | 8,638 | 8,974 |
| Social mobilizers | 1,958 | 864 | 1,022 |
| Griots | 1,972 | 1,053 | 1,104 |
| Independent Monitor's | N/A | N/A | 20 |

## Democratic Republic of Congo (DRC)

From 2015 to 2018, DRC's National Nutrition Program (PRONANUT) used two delivery strategies: (i) Child Health Days (CHD), through which a package of activities including vitamin A was offered to children aged 6-59 months at fixed and outreach sites over the course of one week and (ii) Integration of VAS into routine vaccination.

Since 2019, faced with reduced resources for implementing CHD, the Ministry of Health has implemented the "Routinization" approach, which consists of integrating VAS for children aged 6-59 months and deworming with mebendazole/ albendazole for children aged 12-59 months into the services offered in health facilities: routine immunization and Preschool Consultation (PC). These services are promoted twice a year over the course of 30 days, using awareness-raising activities and the mobilization of parents and communities through community outreach committees (CACs), community relays and community-based organizations.

These two platforms are proving insufficient. Although "routinization" has reduced the cost of VAS nationwide, administrative coverage has fallen dramatically and is not reaching the ≥80% coverage target recommended by WHO. The government is also failing to ensure these events occur every 4 to 6 months. To address these weaknesses and at the request of PRONANUT, Helen Keller proposed an "Intensive Community-Based Routinization" approach, or a catch-up activity to reach children over a period of 4 to 7 days, twice a year. The approach is implemented by CACs, supported by health facilities, and under the supervision of the health zone, the health directorate, and PRONANUT. Awareness-raising campaigns are carried out before distribution, over at least seven days. A VAS register and tally sheets are given to each CAC, which are later compiled by health facilities and sent to the health zone (district), which then compile data from all health facilities in their catchment area, and send these to the province. The province aggregates the health zone data before transmitting these to the national level.

Helen Keller provided support to three out of the country's 26 provinces during the first round of 2022, expanding to six provinces during the second round of 2022 and the first round of 2023. The combined target population for these provinces was 3,691,960 children aged 6 to 59 months during the first semester of 2022. This number almost doubled, to 6,421,306 and 6,604,707 children, respectively, for the second round of 2022 and the first round of 2023.

*Figure 7. VAS geographic coverage per Partner in DRC during the second round 2022 and first round 2023*


During the first semester of 2022, independent monitoring was organized in the hard-to-reach areas of three provinces: Kinshasa, Kongo Central and Kasaï Oriental, with 13, 7, and 7 health zones, respectively. In the second semester of 2022, this was extended to 18 of the 66 health zones in the provinces of Kinshasa and Kongo Central, and in the first round of 2023, covering 29 health zones in the provinces of Kasai, Kwilu and Lomami. A total of 2,912 households with eligible children were surveyed during the distribution of VAS and deworming tablets.

Independent monitoring identified children who had not been reached, while also flagging localities with insufficient coverage, which were revisited by the Central Health Zone Offices.

Table 5. Number of supervisors, distributors, social mobilizers trained per semester in DRC.

| Number of people trained | Round 1 2022 | Round2 2022 | Round 1 2023 |
|---|---|---|---|
| Supervisor at national level | 15 | 28 | 32 |
| Supervisors at Health facility level | 2,657 | 5,700 | 3,562 |
| Number of distributors | 20,822 | 43,532 | 36,724 |
| Social mobilizers | 1,658 | 4,446 | 4,149 |
| Independent Monitor's | 37 | 50 | 52 |

## Guinea

Helen Keller supported campaigns in five regions of Guinea in 2022 and 2023. The first round of 2022 took place from June 24-27, the second from December 15-18, and the first round in 2023 from July 28-31. In 2022 these four-day campaigns involved door-to-door activities that included VAS and deworming. In 2023 there was a shortage of deworming tablets.

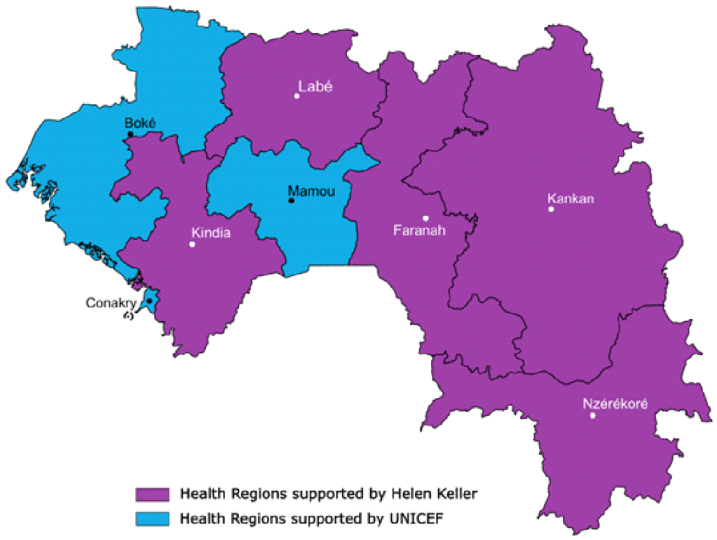
At the national level, planning was organized through a series of coordination meetings involving the Direction Nationale de la Santé Familiale et de la Nutrition (DNSFN) and the Division Alimentation et Nutrition (DAN) of the Ministry of Health, the Office National de l'État Civil et de l'Identification (ONECI), and various partners including WHO, UNICEF, WFP, ChildFund, Plan International and Nutrition International.

Helen Keller worked closely with DAN to review data collection and social mobilization tools, and to enable digitalized monitoring using smartphones, with real-time data transmission through ONA. These tools greatly facilitated decision making during the implementation of the campaign.

In the two rounds of 2022, independent monitoring was conducted in a total of 38 and 32 health districts, respectively. In the first semester, 23.9% of localities were initially reported as not covered, but these issues were promptly addressed by interactions between distributors and monitors. In the second semester, monitoring found that all localities achieved satisfactory coverage.

The total target population for these three campaigns was 1,686,668, 1,708,655, and 1,704,853 children aged 6 to 59 months, respectively.

Figure 8. VAS geographic coverage per Partner in Guinea during both rounds 2022 and the first round 2023




The numbers of supervisors, distributors and social mobilisers are outlined below. To reduce the workload of distributors and improve the quality of vitamin A supplementation, the number of health facility supervisors and distributors was increased.

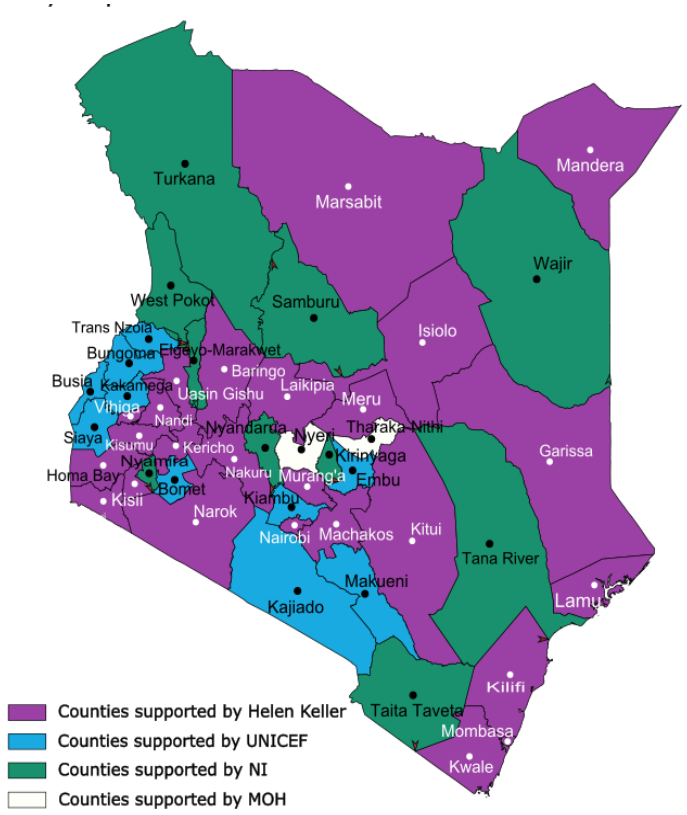
Table 6: Number of supervisors, distributors, social mobilizers trained per semester in Guinea.

| Number of people trained | Round 1 2022 | Round 2 2022 | Round 1 2023 |
|---|---|---|---|
| Supervisor at national level | 8 | 8 | 8 |
| Supervisors at Health facility level | 842 | 856 | 1,241 |
| Number of distributors | 7,030 | 7,066 | 11,264 |
| Social mobilizers | 6,270 | 6,420 | 5,616 |

### Kenya

Helen Keller provided support to 24 counties during the first round of campaign of 2022, and extended it support to 25 counties for the second round of 2022 and the first round of 2023. Various delivery models were employed across counties, including routine distribution at health facilities, integration into community health units' door-to-door visits during *Malezi Bora* mop up campaigns, and distribution at Early Childhood Development Centers and other outreach distribution stations. VAS was combined with deworming (VAS+D) for children aged 12-59 months and included health talks for caregivers of children aged 6-59 months. Additional activities encompassed advocacy, communication, and social mobilization, the updating of household registers, nutritional screening of children under five years of age, and monitoring by Community Health Volunteers (CHV) of various health indicators during household visits, such as Family middle-upper arm circumference (MUAC) measures in Kisumu, malnutrition screening coverage, and immunization defaulters. The total target population in Helen Keller-supported counties in the three rounds was 3,476,491, 3,644,268, and 3,716,143 children, respectively.

Figure 9. VAS geographic coverage per Partner in Kenya during the second round 2022 and the first round 2023




The number of healthcare providers (health workers and CHVs) sensitized on VAS+D administration across the counties supported by Helen Keller Intl is presented in Table 7.

Table 7: Number of supervisors, health workers, Community health worker trained per semester in Kenya.

| Number of people trained | Round 1 2022 | Round 2 2022 | Round 1 2023 |
|---|---|---|---|
| Health worker | 2,912 | 2,809 | 3,977 |
| Community health workers | 16,724 | 19,509 | 21,286 |
| Support Supervisors | 524 | 171 | 326 |
| Data reviews attendees | 825 | 246 | 850 |

## Mali

In Mali, Helen Keller supported three regions in both rounds of 2022 and the first round of 2023 through a four day, door-to-door campaign. The total target population for these campaigns was 2,835,460, 2,835,460, and 1,994,626 children, respectively.

The decrease in the target population in 2023 is attributed to a change in the data source used for population estimates. Until 2022, the VAS campaign utilized data from the previous year's campaign to update estimates. However, in 2023, with the support of Helen Keller, the Ministry of Health decided to use population data from its national health information system platform. These data sources are derived from the General Population and Housing Census (RGPH) of 2009, which has been updated.

Planning at national level was organized through a coordination committee composed of representatives from the Ministry of Health, Helen Keller, UNICEF, World Vision, Nutrition International, and USAID. Its main role was to ensure the availability of essential inputs and to oversee the campaign implementation process, from micro-planning to evaluation.

With the support of Helen Keller, social mobilization strategies have been implemented, including the dissemination of campaign information through local radio broadcasts and the use of community mobilisers. Given the growing challenges of insecurity, special emphasis was placed on social mobilization through local radio stations to reduce the reliance on community mobilisers. Close monitoring of all areas remains a challenge in insecure areas; Helen Keller covers the cost of monitoring in accessible areas only. Independent monitoring is also carried out in these regions.

Within the three regions supported by Helen Keller, a significant percentage of localities were initially declared as not covered in the first round of 2022 (38.6%), the second round of 2022 (40%) and the first half of 2023 (25%). These localities were subsequently revisited to ensure full coverage.

Figure 10. VAS geographic coverage per partner in Mali during both rounds 2022 and the first round 2023

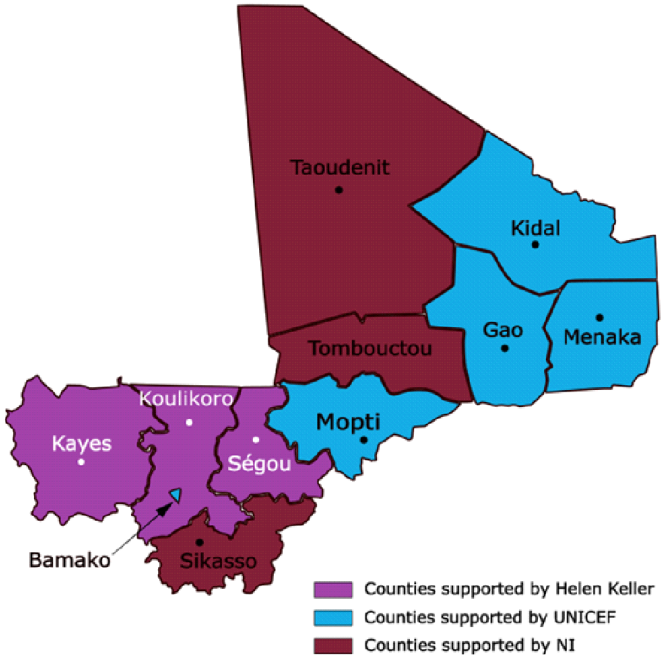



Table 8. Number of supervisors, health workers, Community health worker trained per semester in Mali.

| Number of people trained | Round 1 2022 | Round 2 2022 | Round 1 2023 |
|---|---|---|---|
| Supervisor at national level | 53 | 50 | 24 |
| Supervisors at subnational level | 3,164 | 3,180 | 1,524 |
| Number of distributors | 8,818 | 8,818 | 6,972 |
| Social mobilizers | 6,643 | 6,643 | 54 |
| Independent Monitor’s | 20 | 23 | 26 |

## Mozambique

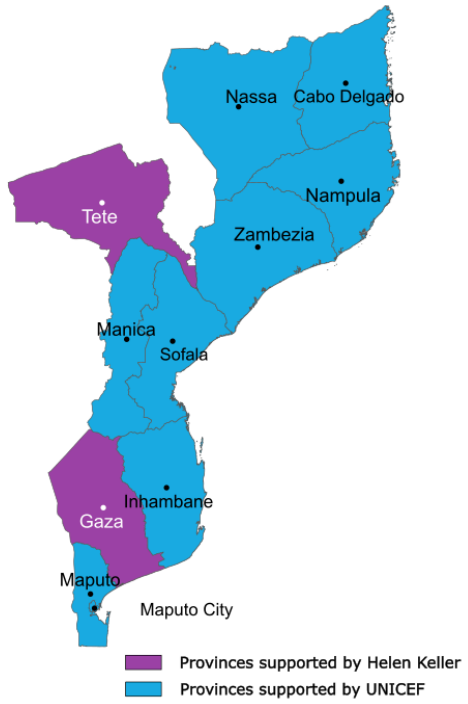
In Mozambique, delivery of VAS is conducted through three platforms: routine service in health facilities for population living within five kilometers of these facilities; outreach visits by Mobile Brigades for communities located 5 - 8 kilometers from facilities; and by community health workers (CHWs) who go door to door in communities >8 kilometers from facilities.

Delivery through each of these methods faces various challenges including the limited capacity of the service providers, inaccurate and incomplete reporting, stock outs of vitamin A capsules, and insufficient funding, all contributing to low coverage.

Helen Keller conducted a survey for the period January to June 2022 which revealed a coverage of ~40%.

Since July 2022, Helen Keller has provided technical and financial support to enable the government to plan, implement and monitor routine delivery of VAS through these three platforms. We provide financial support to organize outreach sessions and we support the training of health workers and community health workers to improve their skills and knowledge on the importance of VAS, its dosage, eligible children, and procedures for accurate reporting.

Figure 11. VAS geographic coverage per partner in Mozambique during both rounds 2022 and the first round 2023




In the province of Tete we supported a micro-planning workshop for officers from the Ministry of Health at the national, provincial, and district levels to identify numbers for every district and how to reach all children using the three platforms. Then, in the first semester of 2023, we supported the province to deliver VAS and deworming services routinely. A total of two coordination meetings were held during the semester to plan and ensure coordinated implementation. Helen Keller also supported improvement of data quality and developed a

tool to assess data quality in health facilities. Training was provided to seven national and provincial supervisors, 30 district supervisors, and five distributors.

Administrative coverage for the second semester of 2022 in Tete reached 83%. Helen Keller continues to conduct data quality audits and training on reporting to improve quality of data. For second semester 2023, we provided support to the province of Gaza. Coverage for the second semester 2022 and the first semester 2023 are presented in Table 9.

Table 9. Children targeted and reached in Helen Keller supported health district of Tete in Mozambique per round.

| Year and semester | Children targeted | Children reached |
|---|---|---|
| 2nd Semester, 2022 | 505,193 | 394,247 (78%) |
| 1st Semester, 2023 | 509,186 | 447,424 (88%) |

### Niger

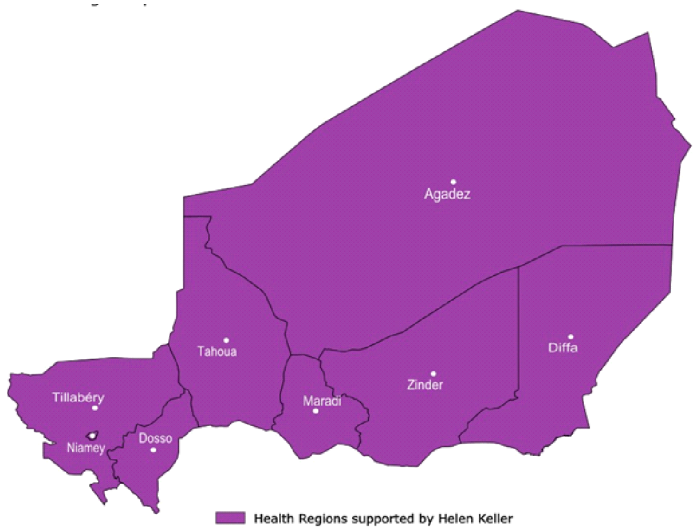
Helen Keller provided support to Niger for both campaign rounds in 2022. The first round took place from June 2 - 5, 2022, and the second round from December 22 - 28, 2022. The first round was conducted alongside deworming with Albendazole, polio vaccination, and community awareness campaigns to emphasize the importance of vaccinations, VAS, and deworming. The second round was linked with deworming using Albendazole, measles vaccination, and community awareness campaigns. This awareness campaign included: radio messages and broadcasts, town criers, social mobilisers; involvement of opinion leaders, including administrative, religious and traditional authorities. These activities are implemented through the communication guideline validated by all stakeholders.

National coordination involves the Ministry of Health, WHO, UNICEF, GAVI and the USAID Advancing Nutrition program in Niger. Coordination meetings are also held with the departments of nutrition, immunization and the national programme for the control of schistosomiasis and soil-transmitted helminths. These meetings serve to streamline all campaign activities and ensure that there is no duplication of funding for activities at either national or local levels.

Monitoring of areas supported by Helen Keller is carried out by a multidisciplinary team using digital tools that incorporate elements of independent monitoring. When the VAS campaign is coupled with the polio campaign, independent monitoring is supported by WHO.

During the first round in 2022, Helen Keller provided support to 6 out of 8 regions, while for the second round, assistance was extended to all 8 regions. The total target population for these campaigns was 5,211,589, 6,755,553, and 6,361,641, respectively.

Figure 12. VAS geographic coverage per partner in Niger during both rounds 2022 and the first round 2023




In the 2022 campaign, UNICEF provided funding for communication activities. Table 9 provides details of personnel supported by Helen Keller to implement VAS in both 2022 and 2023.

Table 9: Number of supervisors, distributors, social mobilizers trained per semester in Niger.

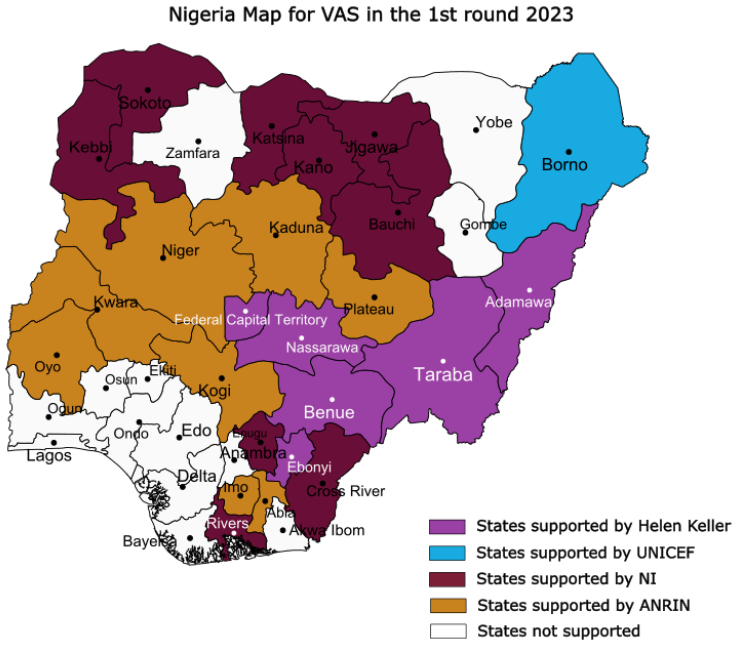
| Number of people trained | Round 1 2022 | Round 2 2022 | Round 1 2023 |
|---|---|---|---|
| Supervisor at national level | 14 | 18 | 415 |
| Supervisors at subnational level | 1,151 | 4,500 | 2,655 |
| Number of distributors | 7,512 | 9,025 | 13,063 |
| Social mobilizers | | | 10,478 |
| Griots | | | 6,818 |
| Briefing for members of the audiovisual media | | | 464 |

## Nigeria

Helen Keller Intl supported six, seven, and six states out of 36 in total for the two rounds of 2022 and the first round of 2023, respectively. This support was carried out using a fixed + outreach strategy. A wide range of services were included in the program, such as routine immunization (for children aged 0 – 12 months), nutrition screening using MUAC tapes (for children aged 6 – 59 months), birth registration, family planning, health & nutrition education (covering topics like handwashing, early initiation of breastfeeding, exclusive breastfeeding, adequate complementary feeding, hygiene promotion, and sanitation), provision of Sulfadoxine Pyrimethamine preventive tablets and iron-folic acid supplementation for pregnant women, HIV / AIDS testing and counselling, among others.

The total target population for these three campaigns was 5,821,464, 6,430,050, and 5,791,271 children aged 6 -59 months, respectively.

Figure 13. VAS geographic coverage per partner in Nigeria during the first round 2023




In Nigeria, health workers are responsible for administering VAS, while community health workers handle social mobilization. Table 9 presents the summary of the supervisors, independent monitor and social mobilizers trained.

Table 10. Number of supervisors, social mobilizers trained per semester in Nigeria.

| Number of people trained | Round 1 2022 | Round 2 2022 | Round 1 2023 |
|---|---|---|---|
| Supervisor at national level | 1582 | 1910 | 396 |
| Supervisors at subnational level | 23,913 | 33,422 | 26,395 |
| Independent monitors | 167 | 216 | 178 |
| Social mobilizers | 3,802 | 5,555 | 3,846 |

## Senegal

Helen Keller supports the Department of Mother and Child Health (DSME) of the Ministry of Health in Senegal at the national level to coordinate VAS programming, develop strategies and tools, and monitor coverage through the national health information system. Some key achievements include:

- Development of the national reference guide for implementing VAS through the routine healthcare system.
- Development of the operational guide and training materials for the integrated package of attentive care to ensure continuity of care.
- Furnishing health facilities with guides for monthly VAS performance monitoring.
- Supporting refresher training for regional nutrition/child survival supervisors on the DHIS2 platform.

Helen Keller is implementing a project aimed at supporting the sustainable improvement of VAS coverage through the routine healthcare system. Helen Keller conducted a study that

showed that monthly target-setting and self-monitoring of performance by health facilities, combined with support for joint decision-making by the head of the health post and community stakeholders and improved monitoring and coordination at all levels, can significantly increase coverage. The initial four districts targeted included Saint-Louis, Podor, Pete (Saint-Louis region), and Kanel. At the end of 2022 this support was extended to the Regional Health Directorates in following 3 health regions:

- Saint Louis (Podor, Pété, Saint Louis, Dagana, Richard Toll districts)
- Louga (Sakal, Louga, Keur Momar Sarr, Kebemer, Darou Mousty, Koki, Linguère districts) and
- Matam (Ranerou, Matam, Thilogne, Kanel districts)

VAS is delivered together with other essential health interventions, including deworming, prevention and management of acute malnutrition, counseling on infant and young child feeding, promotion of exclusive breastfeeding, and immunization.

The target population within the regions supported by Helen Keller amounts to 452,735 children aged 6 to 59 months. Data are collected through the Ministry of Health's health information system. However, due to healthcare worker strikes, data for the second semester of 2022 and the first semester of 2023 are not yet available. Table 11 presents coverage achieved in the four districts supported in the first round of 2022.

*Figure 14. VAS geographic coverage per partner in Senegal during the first round 2022*

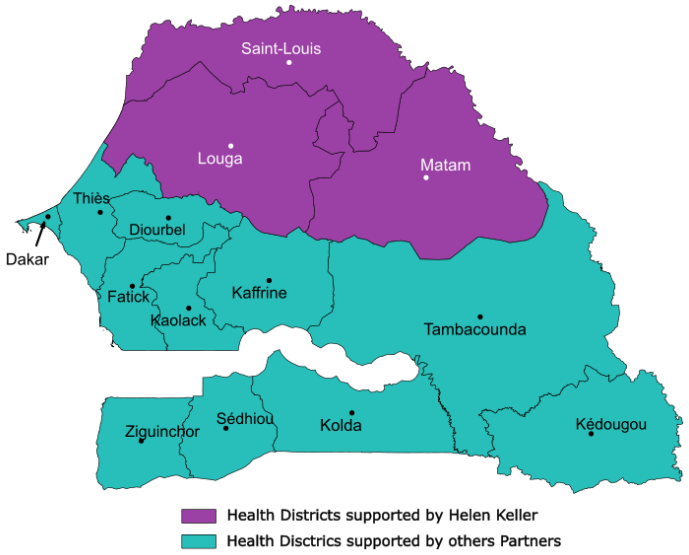



Table 11. VAS coverage in Helen Keller supported district during the first semester 2022 in Senegal

| District | Saint Louis | Podor | Pété | Kanel |
|---|---|---|---|---|
| R1 2022 | 76% | 66% | 76% | 54% |

In Senegal's routine health system, there is no regional breakdown by partner. Operational support from Helen Keller, Nutrition International and UNICEF is all channeled through DSME according to specific needs. Helen Keller's project covers seventeen districts, while UNICEF and NI provide ad hoc support to 33 and 30 districts, respectively, for VAS

intensification activities). Additional support to the remaining districts is provided by USAID/OWOD and the World Bank supported ISMEA project through an integrated package.

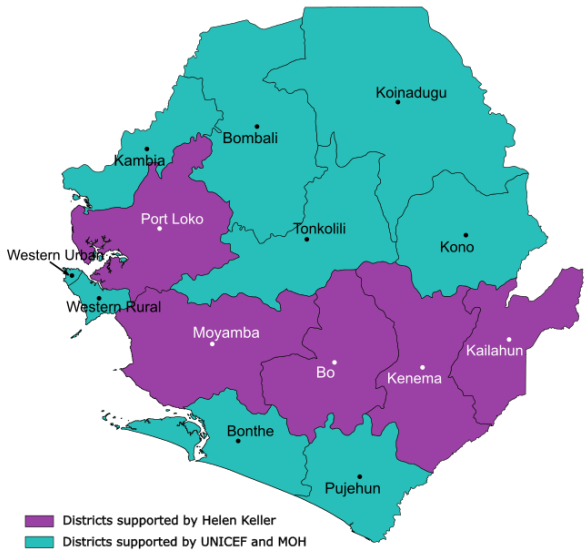
### Sierra Leone

In Sierra Leone, VAS is delivered through routine health services, with Periodic Intensification of Vitamin A Supplementation Activities (PIRVAS) catch-up events organized at the end of each semester for areas with low coverage. As children beyond one year of age rarely attend health facilities, coverage for children 12-59 with VAS is low. To improve this coverage, Helen Keller supports the Ministry of Health at both national and subnational levels in planning, training, mobilization and awareness creation; coordination, supervision, outreach and defaulter tracing; improved reporting; and supply chain strengthening.

During the first semester of 2023, Helen Keller supported 5 districts (Kailahun, Kenema, Bo, Moyamba, and Port Loko) out of Sierra Leone's 16 districts, targeting a total of 495,467 children aged 6-59 months. Helen Keller supported the Ministry of Health to conduct two meetings to strengthen VAS delivery. The meetings were attended by various stakeholders including NGOs and UN bodies. Key discussion points involved data quality management, planning for effective routine VAS, outreach and defaulter tracing, and acceleration of PIRVAS. Helen Keller supported training for 30 national supervisors, 20 district supervisors and 16 administrators to support continuous quality improvement of VAS routine delivery.

In the five districts supported by Helen Keller, administrative coverage reached 84% of targeted children.

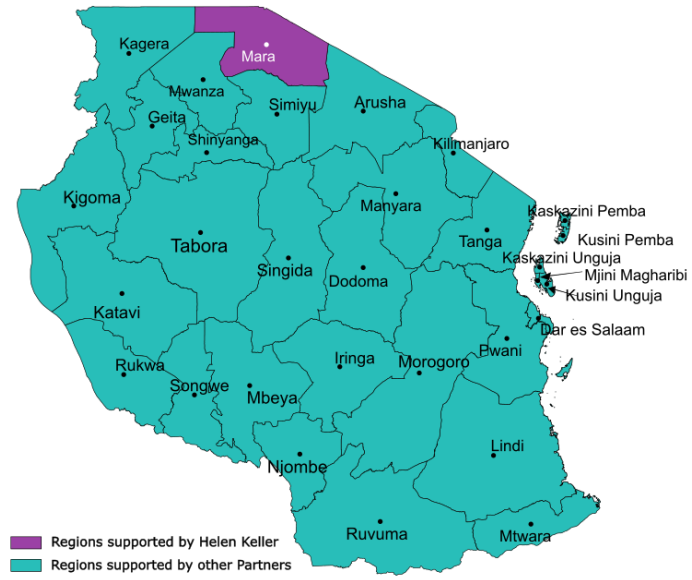
*Figure 16. VAS geographic coverage per partner in Sierra Leone during the first round 2023*




### Tanzania

In Tanzania, Helen Keller provides technical expertise both at national and subnational levels. At the national level, Helen Keller participates in all technical sessions to review policy and strategies for VAS and plan VAS campaigns. Helen Keller also conducts advocacy and evidence generation for VAS.

*Figure 17. VAS geographic coverage per partner in Tanzania during the first round 2023*




At the subnational level, Helen Keller builds capacities through training and mentorship of the regional health management teams, community health management teams, health care workers, and community health workers on the importance of good nutrition and VAS, joint planning for VAS campaigns, and strengthened reporting. Helen Keller attends planning meetings and ensures plans are aligned to the approved budget, supports distribution, facilitates monitoring of campaigns and training, and facilitates supportive supervision. Helen Keller supported the Ministry of Health to deliver VAS through campaigns in the Mara region in the first semester of 2023 targeting 490,500 children. The campaigns took place in June. Eleven microplanning and coordination meetings were held at both regional and national levels to ensure effective planning of the campaigns and timely availability of VAS capsules.

Table 12. Number of supervisors, administrators and social mobilizers trained per semester in Tanzania.

| Number of people trained | Round 1 2023 |
|---|---|
| Supervisor at national level | 2 |
| Supervisors at subnational level | 162 |
| Administrators | 25 |
| Social mobilizers | 1,656 |

Campaign distribution took place in health facilities and through outreach stations for hard-to-reach communities. Prior to distribution, caregivers were mobilized via radio and town criers. A total of 828 town criers were engaged and two community radio programs were broadcast. With this support the Mara region achieved administrative coverage of 105%.

### Number of deworming tablets distributed alongside VAS

VAS is integrated with different activities depending on the country context. A common approach is the simultaneous distribution of deworming tablets to children between the ages of 12 and 59 months. A total of 24,702,741 children have received deworming tablets through Helen Keller support in nine countries. It's worth noting that there was a temporary shortage of tablets in Côte d'Ivoire during the second round of 2022 and in Guinea during the first round of 2023.

This integration not only improves the cost-effectiveness of VAS activities, but also helps to reduce the risk of anemia and promote the health and overall well-being of these children. Table 13 presents the number of children reached per country and per semester.

Table 13. Summary deworming tablets distributed by Helen Keller between January 2022 and June 2023

| | 2022 | | | | 2023 | |
|---|---|---|---|---|---|---|
| Countries | Target population in the areas supported by Helen Keller | Number of children reached by Helen Keller | | | Target population in the areas supported by Helen Keller | Number of children reached by Helen Keller |
| | | Round 1 | Round 2 | Total | | Round 1 |
| Burkina Faso | 1,092,480 | 849,429 | 952,072 | 1,801,501 | 970,070 | 952,524 |
| Cameroun | 2,397,976 | 2,003,706 | 2,150,034 | 4,153,740 | 5,082,715 | 3,625,704 |
| Côte d'Ivoire | 2,583,252 | 2,369,669 | No deworming | 2,369,669 | 3,679,127 | 1,966,646 |
| Guinée | 1,441,237 | 1,407,167 | 1,245,366 | 2,652,533 | No deworming | |
| DRC | 3,255,042 | 3,175,044 | 5,865,771 | 9,040,815 | 5,823,138 | 5,243,940 |
| Kenya | 3,034,508 | 2,046,973 | 2,188,356 | 4,235,329 | 3,279,755 | 2,285,171 |
| Mali | 2,539,179 | 2,385,534 | 2,180,696 | 4,566,230 | 1,240,976 | 1,528,513 |
| Niger | 4,815,101 | 4,734,013 | 5,042,043 | 9,776,056 | 5,795,022 | 6,278,863 |
| Nigeria | 5,722,874 | 3,158,416 | 3,409,645 | 6,568,061 | 5,150,235 | 2,821,379 |
| TOTAL | **26,881,648** | **22,129,951** | **23,033,983** | **45,163,934** | **31,021,038** | **24,702,741** |

# 5. Monitoring, Evaluation, Accountability and Learning for VAS program.

Helen Keller International conducts at least one Post-Event Coverage Survey (PECS) in each of the countries it targets. The surveys are designed to evaluate the effectiveness and quality of our VAS programs. Between 2022 and July 2023, a total of 16 PECS were conducted across 9 countries.

## Methodology

A two-stage cluster survey design is used to select the sample of households, in accordance with WHO guidelines (2018). These surveys are conducted in nine African countries and specific regions where Helen Keller International is active: Burkina Faso, Côte d'Ivoire, Cameroon, Democratic Republic of Congo, Guinea, Kenya, Mali, Niger and Nigeria. The target households are those with at least one child aged between 6 and 59 months, and a random selection process is used to select 10-12 eligible households per cluster for the survey.

Household interviews are conducted using structured questionnaires covering a range of topics including household characteristics, access to health services, communication, knowledge of vitamin A and deworming, and vitamin supplementation.

Ethical approval was obtained from the relevant institutions in each country, and informed consent was sought and obtained from all survey participants. Enumerators were trained by Helen Keller in the methodology for administering the tailored questionnaire. Health workers (HWs) and community health workers (CHWs) were systematically selected from health centers in the selected clusters, particularly those who had participated in vitamin A supplementation and deworming (VASD) community distribution activities. One health center and one community health worker were selected per cluster. Data analyses included both univariate and bivariate analyses, with a significance level of 5% ($p < 0.05$). STATA software was used for these analyses.

To maintain data integrity, a team of supervisors appointed by a steering committee conducted daily field monitoring. During data collection, survey teams used mobile data collection tools that allowed for real-time data monitoring, enabling observation of data collection in progress and facilitating tracking of key indicators by geographic region. Data visualization was used to ensure clarity of survey questions and desired data quality.

Quality control was overseen by supervisors who checked 10% of the data collected by interviewers. This 10% was randomly selected from households within each cluster and sent daily to the ONA database. To streamline this process, a short questionnaire focusing on key questions was used and adapted for double interviews. These double interviews were used to assess the coverage of services provided by the households surveyed by comparing the responses from the first and second interviews. Any differences identified were addressed through feedback to the enumerators.

Helen Keller has fully digitalized its coverage surveys. This involves the systematic use of mobile devices, including tablets and smartphones, for data collection, facilitating the efficient and accurate collection of data. One significant advantage is the real-time analysis of data as it is collected, made possible by platforms such as ONA.IO, which are accessible via the internet. These platforms are specifically designed for mobile data collection, making it user-friendly and efficient.

By adopting this digital approach, Helen Keller has achieved faster results generation compared to traditional paper-based surveys. Each team member, team leader, and supervisor now utilize Android phones to streamline data collection. The process for conducting a vitamin A coverage survey through digitalization encompasses several key steps:

- XLSForm Questionnaire: An XLSForm questionnaire, following widely accepted standards, is designed to gather data relevant to vitamin A coverage. This digital form includes structured questions and response options to ensure accurate and efficient data entry.
- Data Collection through ODK: Open Data Kit (ODK), a mobile data collection platform, is employed for data gathering. Enumerators use the ODK Collect app on their mobile devices to access the XLSForm questionnaire and directly input survey responses.
- Transmission to ONA Platform: After completing data collection, the collected information is transmitted electronically to a central data repository, the ONA platform. ONA, a cloud-based data management system, offers secure storage and organized data aggregation. This platform enables easy data sharing and subsequent analysis.

Throughout the entire survey process, real-time monitoring is in place, ensuring data quality and completeness. This digitalized approach not only streamlines data collection but also minimizes errors. It facilitates efficient data management and analysis, ultimately contributing to the production of insightful reports crucial for informed decision-making and program enhancements.

### Main results

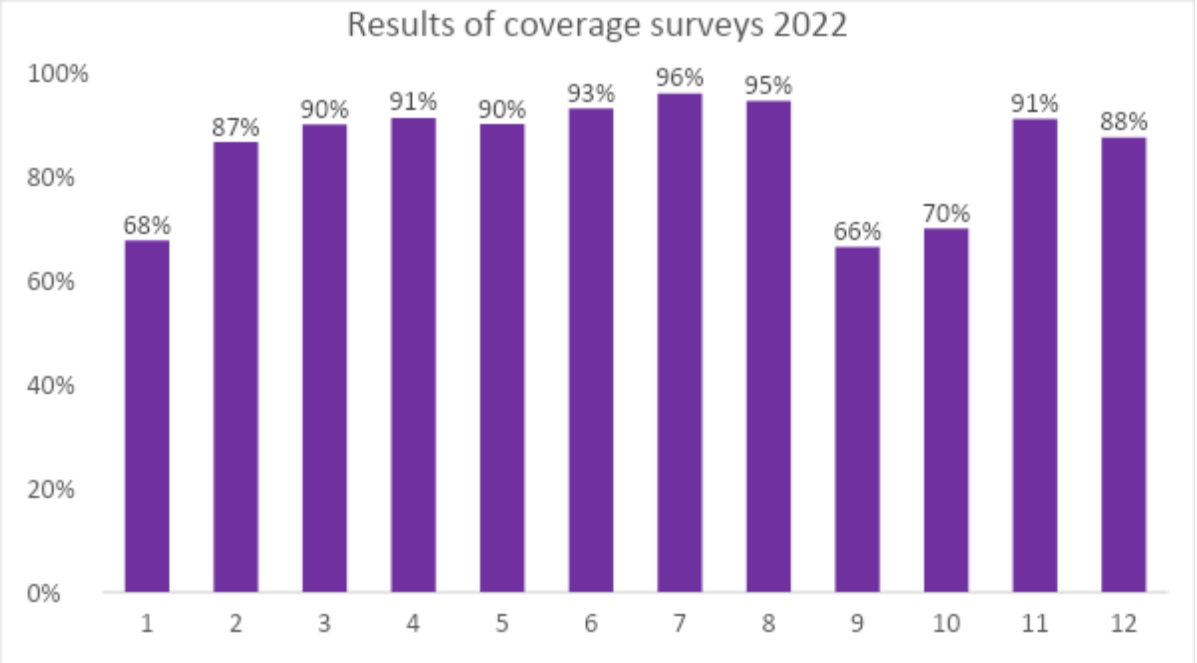
In 2022, coverage surveys were conducted in eight countries.

- **Cameroon:** In 2022, two coverage surveys were conducted in two different regions supported by Helen Keller. The surveys covered the Centre and Littoral regions in the first semester, and the Adamawa, West and Far North regions in the second semester. In addition, the first-round survey in Cameroon was complemented by a bottleneck analysis aimed at addressing issues related to the quality of implementation of the VAS campaign. This effort resulted in the formulation of an action plan that outlined specific activities for each phase of implementation. Thanks to this plan, coverage increased from 67.7% in the first semester to 86.6% in the second semester.
- **DRC:** In 2022, two coverage surveys were conducted. The first semester surveys covered two provinces, Kasai Oriental and Kongo Central, estimating coverage rates of 91.1% and 87.5% respectively.
- **Guinea:** the first round of 2022 was followed by a nationwide coverage survey disaggregated in three strata: urban, rural and the capital, Conakry. The results showed a low coverage rate of 66.4%. This survey was simultaneously integrated into a national SMART (Standardised Monitoring and Assessment in Relief and Transitions) nutrition survey. The overall objective of this survey was to assess the nutritional status of children under five, adolescents and women of reproductive age and the factors contributing to malnutrition. Indicators included VAS coverage,

deworming, morbidity (diarrhea, fever, and acute respiratory infections), measles vaccination, infant and young child feeding practices, and access to water, sanitation and hygiene infrastructure.

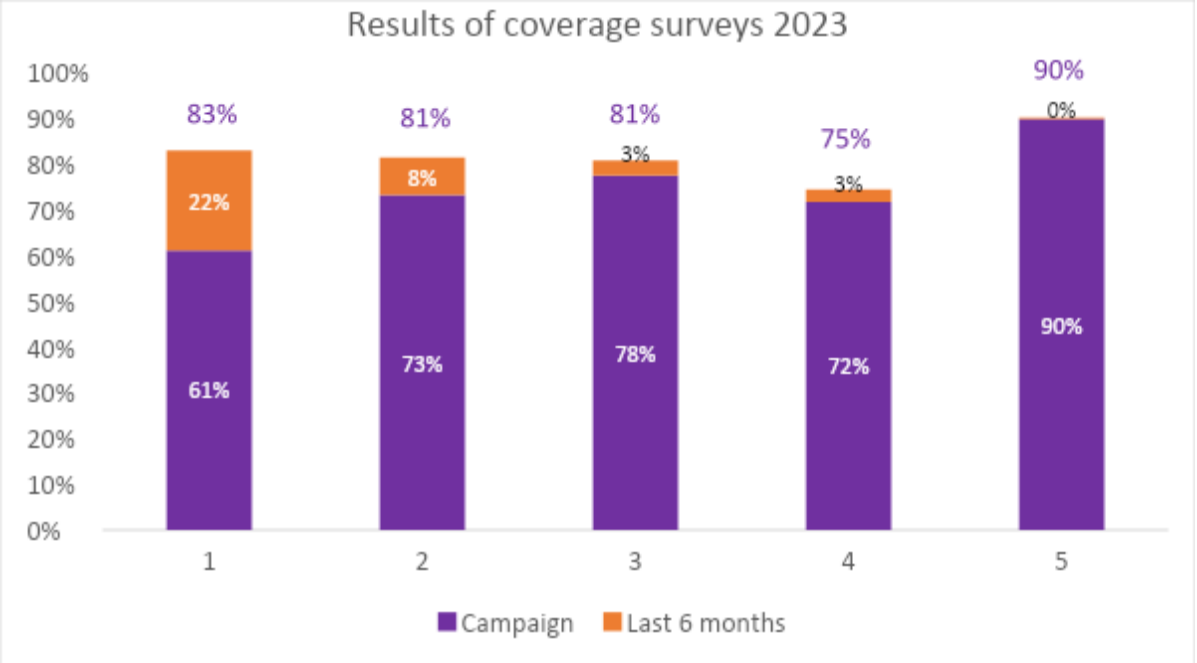
- **Kenya**: A coverage survey was carried out in the first semester of 2022 in one county, estimated a coverage rate of 90%.
- **Mali**: A coverage survey was conducted after the second round in the Helen Keller supported regions (Kayes, Koulikoro and Ségou) as well as two regions (Sikasso and Bamako District) supported by other partners. Coverage in all regions was low (70%).
- **Niger**: A coverage survey after the second round of 2022 included all regions targeted except some areas with security issues. The results showed coverage of 91.3%.
- **Nigeria**: Surveys were conducted in the states of Adamawa, Benue and Nasarawa after the first round, and in Taraba state after the second round. Results showed coverage of >80%.
- **Senegal:** An endline coverage survey was conducted in the three districts supported by Helen Keller for a routine delivery study. The results showed a significant increase in VAS coverage from 42% to 67% between 2020 and 2022. The survey provided insights on remaining weaknesses such as information and awareness gaps, highlighting the need to improve service quality and knowledge about vitamin A supplementation.

Figure 18. PECS coverage by country for 2022




Starting 2023, coverage survey investigated coverage for both the recent campaign and the receipt of VAS throughout the semester, as more and more children are reached through health facilities as efforts to integrate VAS into health systems continue.

Figure 19. PECS coverage by country for 2023




## 6. Update on research January 2022 – July 2023

Several VAS-related research projects took place between January 2022 and June 2023.

### Burkina Faso

In collaboration with the Burkina Faso Ministry of Health and Public Hygiene and the University of California, Davis (UC Davis), Helen Keller completed a cost-effectiveness study on the Vitamin A Days Plus (JVA+) campaign that took place in Yako and Kombissiri health districts from December 2021 to January 2022. Overall, approximately 88% of the targeted children between 6-59 months of age were supplemented during the JVA+ campaign. Coverage did not differ across health districts but was lower in urban than in rural areas. Coverage among children 6-11 months of age was lower than that for other age cohorts, particularly in urban areas. The VAS event cost approximately 138,000 USD. The cost composition varied substantially across districts, especially as regards monthly administrative expenses and community health worker (CHW) operational expenses. Regarding cost burdens, national costs (with international support) were substantial and mainly covered vitamin A capsules and CHW salaries. Community-level stakeholders incurred monthly administrative expenses and transportation/communications costs; regional and district-level stakeholders contributed minimally. Caregivers in rural areas contributed significantly to the program costs, mostly in terms of their time; the value of caregiver time was ~20% of total program costs. Overall, the cost per child reached was 1.34 USD, ranging from 1.45 USD in one rural area to 0.93 USD in one urban area.

The findings from this study are available in a draft paper that is currently being finalized and will be submitted to an international journal for consideration for publication.

### Cameroon

Two studies were conducted in Cameroon from January 2022 to July 2023. A bottleneck study of the twice-yearly VAS delivery through campaign took place from September to October 2022. Results from this study were crafted into actions to improve the SASNIM that took place in December 2022.

From February 2022 to February 2023, Helen Keller supported the Ministry of Health in a project that implemented a self-monitoring approach in the routine health system. This approach aimed to strengthen the routine delivery of VAS in health facilities and increase caregiver uptake of VAS at health facilities in the health districts of Kaele and Guidiguis. In this project, administrative service utilization data were analyzed and compared to the census population data of target children who are due for VAS. If children were identified as nearing their due date for supplementation, the community health volunteers visited, reminded, and referred caregivers to the nearest health facility so that their child could receive VAS. If the child did not receive VAS within the month following the reminder/referral, a second visit was made to the household during the following month. During the review of administrative coverage data the end of every month, health workers organized and the community health workers would go to a targeted fixed point within the catchment areas with highest default rate (or, in other words, lowest VAS coverage of targeted children for that month). Community mobilization activities such as radio and community leadership announcements would promote/advertise that parents take their children to these fixed points if they were due or overdue for VAS. Using this approach for routine VAS distribution, Guidiguis and Kaele were successful in achieving high VAS coverage on a monthly basis throughout the pilot study (overall coverage throughout the study period: 87.6% in Guidiguis and 89.11% in Kaele). The cost per child supplemented with vitamin A in Kaele and Guidiguis was an estimated 497.11 FCFA (approximately 0.75 USD). The results from this study are available in a report and will be further developed into a paper for submission to an international journal for consideration for publication. These results are also currently being considered by the Ministry of Health and partners to inform the scale up of routine VAS delivery in Cameroon.

### Côte d'Ivoire

The government of Côte d'Ivoire began transitioning VAS from a campaign to routine delivery model in 2016. The aim of this research was to identify barriers related to this transition. Quantitative surveys were conducted among households (N=1,826), facility managers (N=76); health workers (N=96); community health workers (N=112). In addition, 52 qualitative interviews were carried out. Four major constraints were identified:

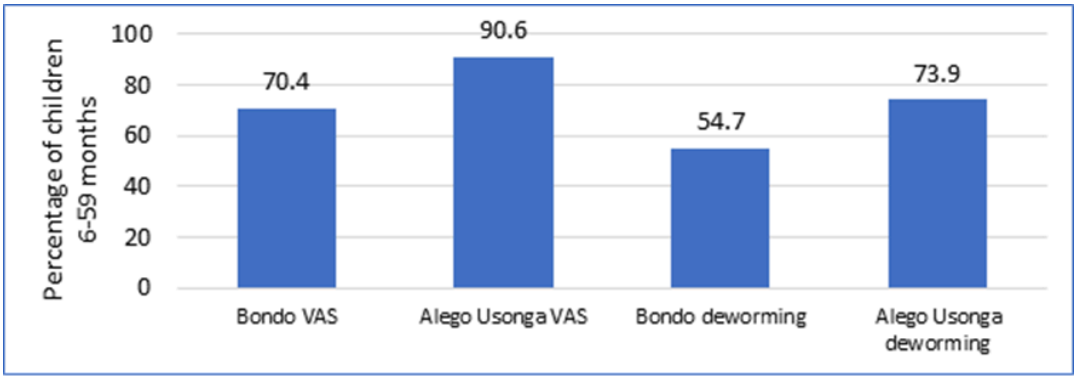
- The target number of children are determined at the district level; however, at the health post level, many lack information to adequately estimate the number of children who need VAS within their catchment areas.
- Supply stock outs are widespread.
- Caregivers are not aware of the availability of routine VAS.
- Constructive feedback and community appreciation contribute significantly to community health worker motivation, though this is hampered by lack of remuneration and high perceived workload.

The detailed results from this study are available in a report

## Kenya

From June 2021 to June 2022, Helen Keller conducted a pilot study to compare the feasibility and coverage of VAS and deworming (VASD) locally delivered through Kenya's Community Health Services (CHS) to that achieved by the bi-annual Malezi Bora campaign events. VASD were offered through the CHS in Alego Usonga Sub-County from September to December 2021, and through the Malezi Bora in Bondo Sub-County in December 2021. Coverage in the two arms was assessed by a post-event coverage survey among caregivers of children aged 6-59 months (N=307 intervention; N=318 control). A total of 46 key informant interviews were conducted with members of the sub-county health management teams, nutrition coordinators, health workers, community health assistants, and community health volunteers for their assessments of the two delivery modalities. Ten focus group discussions were conducted among caregivers of children aged 6-59 months to gain insights into knowledge, perceptions, and attitudes regarding the delivery of VASD through the CHS and the Malezi Bora. The VAS coverage by community health volunteers through the distribution of VAS during their routine health service delivery through the CHS was 90.6% [95% CI: 87.3-93.9] compared to 70.4% [95% CI: 65.4-75.4] through the Malezi Bora and 'standard' VAS distribution activities that are routinely offered at health facilities (with no additional supports or intervention from the study), while deworming coverage was 73.9% [95% CI: 69.0-78.7] and 54.7% [95% CI: 49.2-60.2], respectively (Figure 20).

Figure 20. VAS coverage through the community health service (Alego Usonga) and the Malezi Bora (Bondo Sub-County)




The study findings are presented in a paper entitled Feasibility of delivering Vitamin A Supplementation (VAS) and Deworming through Routine Community Health Services in Siaya County, Kenya: A Cross-Sectional Study. This paper has been submitted for review and consideration for publication in the Journal of Maternal & Child Nutrition.

## Senegal

In response to low routine VAS coverage, in 2020 the Ministry of Health and Helen Keller introduced a monthly monitoring approach in the routine delivery model. This approach established a monthly target for children ages 6-59 months for each health post. An analysis of the administrative data on the number of children supplemented compared to the expected number of eligible children was done by the head of the health post and the community health workers each month in a coordination meeting. If a child did not receive VAS during

the required timeframe, a community health worker would visit the household of the child to supplement him/her and subsequently reports back to the head of health post.

A baseline and an endline survey were conducted to measure coverage and identify the barriers and enablers to VAS status in the selected/studied (4) heath districts. After two years of implementation (2020-2022) there was an overall increase of approximately 25% (P-value <0,001) from baseline to endline in the health districts where the self-monitoring approach was implemented.

### Regional

From July 2022 to January 2023, scoping studies were conducted in four countries in Africa – Tanzania, Senegal, Sierra Leone and Mozambique to assess VAS coverage through routine delivery and explore the effects of key socio-demographic factors on VAS uptake among children aged 6-59 months in four Sub-Saharan African countries.

We found routine VAS coverage to be 42.8% (95% CI: 40.2, 45.6) in Mozambique, 46.7% (95% CI: 45.5, 48.0) in Senegal, 89.3% (95% CI: 88.3, 90.2) in Sierra Leone and 43.8% (95% CI: 41.5, 46.0) in Tanzania.

Urban vs. rural children had a higher likelihood of VAS in Mozambique (aOR=1.80; 95% CI: 1.31, 2.47) and Senegal (aOR=1.32; 95% CI: 1.14, 1.53).

Children 6-23 months had a higher likelihood of VAS, compared to those 24-59 months, in Mozambique (aOR=2.11; 95% CI: 1.67, 2.66), Senegal (aOR=2.37; 95% CI: 2.12, 2.64) and Tanzania (aOR=1.77; 95% CI: 1.46, 2.15).

Increased household wealth was associated with higher VAS uptake in Mozambique (aOR=1.39; 95% CI: 1.07, 1.79) and Senegal (aOR=1.38; 95% CI: 1.22, 1.57).

In Sierra Leone, VAS coverage was 20% higher for home vs. facility-based distribution.

A paper entitled, Factors associated with vitamin A supplementation coverage through routine delivery systems in four Sub-Saharan African countries, is currently being finalized and will be submitted for consideration for publication in an international journal.

In addition, throughout 2022, several analyses were conducted using data from PECS, including:

- **COVID-19 concerns among caregivers and VAS coverage among children aged 6-59 months in four countries in Western Sub-Saharan Africa**. Data from eight representative household surveys were used to assess VAS coverage in nine (2019) and 12 (2020) districts in Burkina Faso, Côte d'Ivoire, Guinea and Mali. Multivariable logistic regression models examined the effect of rural/urban residence, child sex and age, caregiver education, COVID-19 concern and household wealth on VAS status. Between 2019 and 2020, VAS coverage increased in Burkina Faso (82.2% to 93.1%), Côte d'Ivoire (90.3% to 93.3%) and Mali (76.1% to 79.3%) and decreased in Guinea (86.0% to 81.7%). Rural children had a higher likelihood of VAS uptake compared to urban children in Burkina Faso (aOR = 4.22; 95% CI: 3.11, 5.72), Côte d'Ivoire (aOR = 5.19; 95% CI: 3.10, 8.70) and Mali (aOR = 1.41; 95% CI: 1.15, 1.74). Children aged 12-59 months had a higher likelihood of VAS uptake compared to children 6-11 months in Côte d'Ivoire (aOR = 1.67; 95% CI: 1.12, 2.48) and Mali (aOR = 1.74; 95% CI: 1.34, 2.26). Moderate to high COVID-19 concern was associated with a lower likelihood of VAS uptake in Côte d'Ivoire (aOR = 0.55; 95% CI: 0.37, 0.80). The findings from this study are available in a paper published in the Journal of Public Health Nutrition (https://doi.org/10.1017/S1368980023001258).

- **Adherence to COVID-19 movement restrictions is associated with income loss and meal restriction in households with children under 5 in Guinea, Mali, Cote d'Ivoire and Burkina Faso**. Four nationally representative cross sectorial clusters surveys of caregivers of children 6–59 months of age (n= approximately 13,500) were conducted between March and November 2020 in Guinea, Burkina Faso, Mali and Cote d'Ivoire. The surveys aimed to capture VAS coverage and assessed reported adherence to COVID-19 restrictions on travel, mass gathering, and social distancing, loss of income, meal cutting and skipping. Adjusted multivariate logistic regression was used to assess adherence to restrictions, household wealth, and urban/rural split against meal restriction and income loss. Households that reported refraining from mass gatherings were more likely to report a reduction in the quantity of food consumed in the past week (BF OR:1.85 [1.30-2.63]; CI OR: 1.88 [1.49-2.37]; Guinea OR 1.66[1.16-2.36], Mali OR1.34 (1.05-1.72) and a reduction in the types of food consumed. In Burkina Faso, Cote d'Ivoire and Guinea, households were more likely to skip a meal entirely (BF OR:1.85 [1.21-2.81]; CI OR: 1.76 [1.38-1.58]; Guinea OR 1.71 [1.23-2.40]). Similarly, households that reported limiting travel due to COVID-19 were more likely to report loss of income since the start of the pandemic (BF OR:1.96 [1.45-2.65]; CI OR: 1.33 [1.11-1.58]; Mali OR 1.57 [1.31-1.87]). Income impacts were strongest in Guinea, where odds of income loss were over twice as high among those adhering to restrictions. These findings will be developed into a paper that will be submitted to an international peer-reviewed journal for consideration for publication.

- **Dietary diversity among infants and young children in three West African countries**. Diet Quality Questionnaires from the Global Diet Quality Project https://www.dietquality.org/) administered to caregivers were analyzed to obtain children's consumption of breast milk, grains, roots and tubers, legumes and nuts, dairy products, flesh foods, eggs, vitamin A-rich fruits and vegetables and other fruits and vegetables. MDD for children aged 6-23 months was estimated based on consumption of ≥ 5 food groups the previous day (Côte d'Ivoire: N = 110; Niger: N = 763; Senegal: N = 987). We found the prevalence of minimum dietary diversity (MDD) as per WHO recommendations to be 48.2% (95% CI: 38.7, 57.7) in Côte d'Ivoire, 24.2% (95% CI: 21.2, 27.3) in Niger and 31.8% (95% CI: 28.9, 34.7) in Senegal, with respective average food group consumption scores of 4.29 (95% CI: 3.92, 4.66), 3.36 (95% CI: 3.25, 3.48) and 3.64 (95% CI: 3.54, 3.73). Grains, roots and tubers were most commonly consumed (75.2 - 87.2%), with lower flesh food (24.2 - 54.4%) and vitamin A-rich food (9.4 - 48.8%) consumption. In Côte d'Ivoire, the proportions achieving MDD were 35.3% and 59.3% for children 6-11 and 12-23 months, respectively ($p = 0.012$). In Niger, these proportions were 13.7% (6-11 months) and 29.1% (12-23 months) ($p < 0.001$). And in Senegal, the proportions were 16.4% (6-11 months) and 39.5% (12-23 months), respectively ($p < 0.001$). These findings are currently being developed into a paper that will be submitted to an international peer-reviewed journal for consideration for publication.

- **Dietary quality among women of reproductive age in six Sub-Saharan African countries**. The standardized, locally-adapted Diet Quality Questionnaire (DQQ) tool were used to collect representative food group consumption data from women 15-49 years in Cameroon (N=3,264), Côte d'Ivoire (N=310), Kenya (N=864), Nigeria (N=4,238 in 3 states), Senegal (N=2,616), and Tanzania (N=2,701) in 2022. Consumption of ≥ 5 out of 10 specific food groups (MDD), consumption of starchy staples, vegetables, fruits, pulses/nuts/seeds, and animal-source foods (All-5), and average (0-10) food group consumption (FGDS) were estimated based on categories of foods consumed the previous day or night. We found the proportion of women achieving the MDD recommendations was 47.8% in Cameroon, 81.6% in Côte

d'Ivoire, 59.6% in Kenya, 56.8% in Senegal, 42.9% in Tanzania, and 58.5%, 61.1%, and 70.5% in the Nigerian states of Adamawa, Benue, and Nasarawa, respectively. All-5 consumption was 24.0% in Cameroon, 48.1% in Côte d'Ivoire, 28.7% in Kenya, 33.0%, 41.2%, and 45.3% in Nigeria, 18.0% in Senegal, and 19.5% in Tanzania. FGDS ranged from 4.4 (95% CI: 4.3, 4.5) in Tanzania to 6.2 (95% CI: 6.0, 6.5) in Côte d'Ivoire. These findings are currently being developed into a paper that will be submitted to an international peer-reviewed journal for consideration for publication.

In addition to the research that was underway in 2023, the regional VAS team at Helen Keller, in collaboration with UC Davis, finalized a **cost-effectiveness toolkit** for the VAS program. The toolkit consists of study guidance documents, concept note, study protocol, data analysis plan, final report templates, pseudo code for data analysis using Stata statistical analysis software, data collection tools, and all training materials for a cost-effectiveness training workshop and practical field exercise. The toolkit will be piloted in Cote d'Ivoire in the second semester of 2023.

## 7. Financial report

Table 14 summarizes the funds pledged or received by Helen Keller between 2018 and June 2023.

Table 14. Funds received and pledged by Helen Keller International for VAS since 2018

| Donor | Amount (USD) |
|---|---|
| Givewell | $171,026,221 |
| Small Donations | 7,199,509 |
| UNICEF | 1,378,256 |
| Three Graces | $3,250,000 |
| Noorda | $6,000,000 |
| Centre for Effective Altruism | $443,366 |
| Effective Altruism Foundation | $135,471 |
| Effective Altruism Australia | $775,236 |
| Ayuda Effectiva | $193,850 |
| Effective Spenden Germany | $421,811 |
| Effective Spenden Schweiz | $66,435 |
| Founders Pledge | $2,557,337 |
| Stichting Effectief Doneren | $48,903 |
| Effect hope | $1,907,033 |
| Topsoe | $105,000 |
| Total | $195,508,428 |

Table 15 shows the funds already used for VAS by Helen Keller for VAS campaigns in countries recommended by Givewell. Helen Keller has received USD M.195.5 over the last 5 years, from which USD M.75.5 have been spent on delivering VAS capsules (tables 15 & 16). Remaining funds have been budgeted as shown by table 19 to cover gaps for Vas campaign delivery.

Table 15. Summary of spending on VAS campaigns, per country per year

| Country | 2018 | 2019 | 2020 | 2021 | 2022-2023 | Total |
|---|---|---|---|---|---|---|
| Guinea | $832,259 | $819,744 | $1,274,493 | $846,207 | $2,699,361 | $6,472,064 |
| Mali | $464,032 | $574,136 | $1,088,508 | $1,670,132 | $2,209,646 | $6,006,455 |
| Burkina Faso | $497,352 | $565,043 | $794,145 | $1,212,264 | $1,611,953 | $4,680,758 |
| Côte d'Ivoire | $472,416 | $1,173,552 | $1,015,906 | $2,202,689 | $4,108,860 | $8,973,423 |
| Kenya | $0 | $482,683 | $631,162 | $1,069,217 | $4,412,767 | $6,595,829 |
| Niger | $58 | $864,667 | $1,036,925 | $2,113,725 | $3,458,351 | $7,473,727 |
| Nigeria | $0 | $0 | $493,003 | $1,927,803 | $7,113,154 | $9,533,961 |
| DRC | $0 | $0 | $32,476 | $1,525,242 | $4,940,514 | $6,498,232 |
| Cameroon | $0 | $0 | $0 | $1,540,474 | $5,307,568 | $6,848,041 |
| Madagascar | | | | | $9,014 | $9,014 |
| Management | $748,548 | $1,204,792 | $1,259,157 | $1,020,569 | $4,096,487 | $8,329,553 |
| | $3,014,666 | $5,684,617 | $7,625,777 | $15,128,322 | $39,967,674 | $71,421,056 |

Table 16 highlights the funds used for non-campaign activities in other countries, under separate grants received essentially from the 3 Graces and the Noorda Foundations.

Table 16. Non campaign expenditures, per country, 2018-2021

| Country | 2018 | 2019 | 2020 | 2021 | 2022-2023 | Total |
|---|---|---|---|---|---|---|
| Cameroon | $0 | $0 | $75,052 | $121,565 | $0 | $196,617 |
| Senegal | $0 | $0 | $134,466 | $201,214 | $672,909 | $1,008,589 |
| Sierra Leone | $17,774 | $156,655 | $103,367 | $176,779 | $507,138 | $961,712 |
| Tanzania | | | | | $407,837 | $407,837 |
| Mozambique | | | | | $1,593,800 | $1,593,800 |
| | $17,774 | $156,655 | $312,884 | $499,558 | $3,181,684 | $4,168,555 |

Table 17 and 18 provide details of expenditures for the 18 months period covered by this report.

Table 17. Detailed expenditures, January 2022 to June 2023, Helen Keller campaign countries

| Jan. 2022 - June 2023 | | Guinea | Mali | Burkina Faso | Cote d'Ivoire | Kenya | Niger | Nigeria | DRC | Cameroon | Management | Madagascar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personnel | | $399,351 | $410,196 | $371,060 | $865,270 | $1,199,493 | $483,668 | $1,150,548 | $781,362 | $722,381 | $2,216,088 | $3,072 | $8,602,490 |
| Travel | | $12,661 | $17,544 | $13,928 | $33,855 | $47,180 | $12,475 | $20,554 | $58,005 | $38,980 | $498,534 | $1,014 | $754,729 |
| Equipment and supplies | | $80,296 | $40,676 | $13,877 | $219,000 | $281,380 | $94,852 | $587,688 | $149,006 | $274,715 | $69,532 | $45 | $1,811,068 |
| Other Direct Costs | | $131,424 | $118,995 | $136,458 | $327,613 | $221,129 | $213,768 | $165,703 | $186,286 | $294,400 | $155,416 | $1,106 | $1,952,298 |
| Activities | Planning | $11,917 | $102,173 | $5,243 | $121,440 | $644,408 | $116,447 | $383,415 | $535,801 | $442,787 | $271,483 | $2,659 | $2,637,773 |
| | Policy | $35,552 | $0 | $6,330 | $0 | $12,695 | $0 | $2,121 | $0 | $0 | $7,009 | $0 | $63,708 |
| | Training | $4,257 | $251 | $25,567 | $4,420 | $572,345 | $0 | $1,087,636 | $0 | $76,267 | $3,922 | $0 | $1,774,667 |
| | Distribution | $35,297 | $136,085 | $80 | $160,982 | $645,576 | $58,584 | $577,080 | $0 | $105,109 | $8 | $0 | $1,718,802 |
| | Mobilization | $0 | $6,485 | $8,055 | $26,912 | $7,118 | $14,938 | $290,551 | $0 | $623,362 | $0 | $0 | $977,421 |
| | Research | $338,179 | $32,929 | $87,314 | $205,209 | $2,603 | $319 | $6,628 | $558 | $68,357 | $210,345 | $0 | $952,441 |
| | Monitoring | $0 | $0 | $637 | | $187,377 | $499 | $2,014,205 | $428,620 | $79,002 | $119,089 | $0 | $2,829,428 |
| Sub Agreements | Planning | $0 | $125,316 | $0 | $2,937 | $47,352 | $0 | $0 | $267,200 | $0 | $0 | $0 | $442,805 |
| | Policy | $0 | $0 | $0 | $0 | $0 | $0 | $0 | | $0 | $0 | $0 | $0 |
| | Training | $172,274 | $174,744 | $0 | $7,537 | $0 | $99,164 | $0 | | $0 | $0 | $0 | $453,719 |
| | Distribution | $302,976 | $764,172 | $369,900 | $1,554,413 | $5,785 | $1,914,729 | $0 | $1,928,434 | $1,822,581 | $0 | $0 | $8,662,990 |
| | Mobilization | $387,688 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $49,276 | $0 | $0 | $436,963 |
| | Research | $16,173 | $0 | $0 | $29,100 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $45,272 |
| | Monitoring | $443,719 | $0 | $417,518 | $0 | $0 | $0 | $0 | $6,088 | $0 | $0 | $0 | $867,324 |
| Total direct costs | | $2,371,762 | $1,929,566 | $1,455,967 | $3,558,689 | $3,874,441 | $3,009,443 | $6,286,130 | $4,341,359 | $4,597,218 | $3,551,426 | $7,896 | $34,983,898 |
| Indirect Costs | | $327,599 | $280,080 | $155,987 | $550,171 | $538,326 | $448,908 | $827,024 | $599,155 | $710,350 | $545,061 | $1,117 | $4,983,777 |
| Total | | $2,699,361 | $2,209,646 | $1,611,953 | $4,108,860 | $4,412,767 | $3,458,351 | $7,113,154 | $4,940,514 | $5,307,568 | $4,096,487 | $9,014 | $39,967,674 |

Table 18. Detailed expenditures, January 2022 to June 2023, Helen Keller non-campaign countries

| 2022 - 2023 | | Senegal | Sierra Leone | Mozambique | Tanzania | Total |
|---|---|---|---|---|---|---|
| Personnel | | $187,969 | $154,578 | $897,425 | $88,979 | 1,328,950 |
| Travel | | $65,046 | $43,379.7 | $9,375 | $1,009 | 118,810 |
| Equipment and supplies | | $16,603 | $67,264.4 | $20,239 | $21,020 | 125,126 |
| Other Direct Costs | | $15,324 | $33,183.6 | $110,114 | $16,145 | 174,767 |
| Activities | Planning | $47,026 | $70,987 | $48,822 | $11,330 | 178,165 |
| | Policy | $8,450 | $0 | $4,954 | $868 | 14,273 |
| | Training | $7,203 | $1,313 | $21,240 | $16,074 | 45,829 |
| | Distribution | $0 | $4,709 | $179,464 | $38,208 | 222,381 |
| | Mobilization | $157 | $33,916 | $3,046 | $8,488 | 45,607 |
| | Research | $124,687 | $3,794 | $0 | $153,054 | 281,536 |
| | Monitoring | $57,601 | $0 | $107,607 | $0 | 165,207 |
| Sub Agreements | Planning | $64,137 | $0 | $0 | $0 | 64,137 |
| | Policy | | $0 | $0 | $0 | - |
| | Training | | $0 | $0 | $0 | - |
| | Distribution | | $0 | $0 | $0 | - |
| | Mobilization | | $0 | $0 | $0 | - |
| | Research | | $0 | $0 | $0 | - |
| | Monitoring | | $0 | $0 | $0 | - |
| Total direct costs | | $594,203 | $413,125 | $1,402,285 | $355,175 | $2,764,788 |
| Indirect Costs | | $78,707 | $94,013 | $191,515 | $52,662 | 416,896 |
| TOTAL | | $672,909 | $507,138 | $1,593,800 | $407,837 | $3,181,684 |

Table 19 shows the budgets for the coming 3 years for VAS campaigns. Note that fiscal years start on July 1st, and end June 30th, so fiscal year 2024 (FY2024) covers the period from July 2023 to June 2024, and table 19 therefore covers the period from July 2023 to end of June 2026.

Table 19. Budget for fiscal year 2024 to fiscal year 2026

| | FY 2024 | FY 2025 | FY 2026 | Total |
|---|---|---|---|---|
| Burkina Faso | $1,726,807 | $1,796,477 | $1,724,646 | $5,247,930 |
| Cameroon | $6,851,801 | $6,308,321 | $6,465,824 | $19,625,946 |
| Cote d'Ivoire | $4,776,056 | $4,023,590 | $4,427,240 | $13,226,886 |
| DRC | $5,503,754 | $6,150,958 | $6,911,008 | $18,565,720 |
| Guinea | $2,414,946 | $2,440,267 | $2,424,897 | $7,280,110 |
| Kenya | $3,790,721 | $774,700 | $463,731 | $5,029,152 |
| Mali | $2,862,861 | $2,274,839 | $2,300,073 | $7,437,773 |
| Niger | $4,361,735 | $4,286,804 | $4,647,829 | $13,296,368 |
| Nigeria | $5,639,132 | $5,172,814 | $5,450,130 | $16,262,076 |
| Madagascar | $1,434,493 | $2,164,738 | $2,164,738 | $5,763,969 |
| Management | $3,029,387 | $2,486,473 | $2,667,026 | $8,182,886 |
| Total | $42,391,693 | $37,879,981 | $39,647,142 | $119,918,816 |

More detailed financial reports are available in the excel sheet attached to this report (Financial report for Givewell, VAS delivery, 2022 – 2023).