



VITAMIN A SUPPLEMENTATION (VAS) THROUGH FACILITY - PLUS - OUTREACH COSTS LESS AND ACHIEVES COMPARABLE COVERAGE COMPARED WITH DOOR-TO-DOOR DISTRIBUTION

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Landscape for VAS delivery is changing



- Since 2002, biannual Vitamin A Supplementation (VAS) integrated in door-to-door polio campaigns.
- However, last case of polio in DRC seen in 2011, so polio campaigns are gradually phasing out (in 2015 and 2016, only 50 - 60 % of country targeted).
- Door to door campaigns are costly (2 to 2.5 m\$ / round in DRC) and entirely funded by external actors.
- Financial capacity to support the events is reducing rapidly due to end of polio and the momentum is growing to integrate VAS (and other interventions) into the existing service delivery platforms.

The transition has started



- However, Vitamin A deficiency and under five mortality remain high in Sub-Saharan Africa (SSA).
- VAD control interventions remain limited in most countries.
- As VAS contributes significantly to reduction of under five mortality, its continuation in SSA is required.
- **As a result, HKI, UNICEF and the PRONANUT have started the transition process towards integrated cost effective models**
 - Door to door campaigns with polio (phasing out)
 - Door to door campaigns with other vaccines / services (small scale)
 - Fixed + outreach strategy for VAS and deworming (piloted)
 - Routine 6 month contact point through pre-school consultation (piloted)

- **Compare VAS coverage and delivery costs between**
 - Door-to-door campaign (every household visited)
 - Fixed facility + outreach (distribution in health facilities and at key community delivery points in far away communities)
- **Study conducted by HKI, the PRONANUT and the National Institute for Statistics**

- **Random assignment:**
 - Four health zones randomly assigned to door-to-door or Fixed facility + outreach
 - For each model, analysis stratified between urban and rural
- **Location:** Kasai Oriental Province, DRC
- **Following the implementation of the VAS campaign:**
 - Representative cross-sectional household surveys to measure coverage (2 stage random cluster sampling with 30x30 households per survey)
 - Ingredient analysis of costs of each method

Both models attained high VAS coverage

- VAS coverage was high and similar between the two delivery models

		door to door	fixed + outreach
Sample	<div style="background-color: #c00000; color: white; padding: 5px; text-align: center;"> But some differences in reasons for not being reached </div>	898	898
covered		800	804
Program Coverage		89.1%	89.5%
Main reasons for non supplementation	parents out of home	37%	42%
	team did not come	32%	-
	households not aware of distribution	-	13%

Reduced cost of fixed + outreach mostly explained by lower field distribution costs

Field distribution costs mainly represent field teams costs

Cost per item (usd)	fixed sites + outreach	Door to Door
	% of the total costs	% of the total costs
planning meeting	6%	6%
capsules field distribution	10%	24%
social mobilization	13%	8%
Field Supportive Supervision	35%	28%
Briefing & Training	1%	1%
Technical support	11%	9%
Post event coverage survey	2%	2%
stationeries & cissors	0%	5%
Transport capsules national	12%	9%
Transport capsules field	1%	0%
Coordination	1%	1%
Personnel costs	7%	5%
Total costs	39,081	49,605
Number of children supplemented	111,028	113,357
Cost per child in usd	0.35	0.43

Distance between communities and health facilities explain higher costs in rural areas for fixed + outreach model



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fixed sites + outreach approach			Total
setting	urban	rural	
rationale for program design	all population <5 km away for facility		
Number of distribution points	29 sites (19 fixed and 10 outreach)	70 sites (21 fixed and 49 outreach)	
Number of personnel involved	96	231	
total costs	19,332	19,249	38,581
Number of children supplemented	62,672	48,356	111,028
Cost per child supplemented	0.31	0.40	0.35

Distances between households explain higher costs in rural areas for door-to-door model



door to door approach			Total	
setting	urban	rural		
rationale for program design	nb of children one team can reach in one day			
Number of households / team	600	510		
Number of personnel involved	80	122		
total costs	29,698	19,405		49,103
Number of children supplemented	72,890	40,467		113,357
Cost per child supplemented	0.41	0.48	0.35	

Fixed + outreach ~20% less costly than door-to-door



• Key Results:

- Fixed sites + outreach delivery may achieve as great a coverage as door to door approach
- Fixed sites + outreach delivery model may be cheaper than door-to-door model in both urban and rural settings. Overall cost 0.35 vs. 0.43
- The main cost components of door-to-door distribution were related to transport of health staff to reach all households, whereas the main costs of facility-plus-outreach were associated with outreach and social mobilization
- Urban delivery is cheaper whatever the model considered

- Countries may need several models concurrently as they transition towards sustainable models
- Fixed + outreach model can be a promising sustainable alternative to door-to-door models but requires careful planning of outreach and social mobilization.
- More research is required to identify where costs can be reduced further without loss of performance, and in which settings which delivery models fits best.



THANK YOU.

*“Although the world is full of suffering, it is also full of overcoming it.”
-Helen Keller*

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