Proposed VAS Activities HKI Could Implement in Twelve Sub-Saharan African Countries with Additional Funding

(and rough budget estimates needed to implement those activities over a three-year period)

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Acronyms

CHDs	Child Health Days
CHWs	Community Health Workers
GAC	Global Affairs Canada
HKI	Helen Keller International
MoH	Ministry of Health
NIDs	National Immunization Days
USD	United States dollars
VAS	Vitamin A Supplementation

Introduction

In response to a request by GiveWell, HKI reached out to its twelve country offices in Africa and requested each to develop a list of activities HKI could pursue with additional funding and a rough "ideal" budget estimate to implement those activities over a three-year period. Country offices were asked to focus on activities needed to improve and/or sustain high coverage of vitamin A supplementation (VAS) using mass distribution approaches such as Child Health Days (CHDs) or similar campaigns.

The proposed activities and associated budgets reflect the full costs anticipated to support VAS distribution within the geographic scope described for each country. In some countries, additional support may be available from UNICEF and/or NI, and therefore the amounts needed would be less. However, HKI is not privy to the amounts available from these organizations. Moreover, since March 2016, when HKI's direct funding from Global Affairs Canada (GAC) finished, several countries have foregone or "missed" VAS distribution rounds due to the uncertain funding situation. As such, the proposed budgets for these countries have built in the full costs of supporting CHDs or similar campaigns. HKI does or will receive modest support for limited VAS activities from UNICEF in six of the twelve countries. In those six countries, we have proposed activities to complement UNICEF's "Reaching Every Child" strategy. However, without bringing its own resources to the table, HKI is unable to leverage funds from other donors to support CHDs or similar campaigns to achieve high VAS coverage.

Below we describe the current VAS distribution situation in each country and the major activities HKI would implement with additional funding. In six (Burkina Faso, Cote 'Ivoire, Guinea, Mozambique, Niger and Sierra Leone) of the twelve countries, HKI proposes to support VAS distribution on a national scale. In the other six countries (Cameroon, Kenya, Mali, Nigeria, Senegal and Tanzania), HKI's proposes to cover 20% to 66% of the country.

The additional funds would be used to provide technical support for VAS and be guided by the policies and strategies of each host-country government. Additionally, HKI would use the funds to strengthen government ownership, institutional capacity and accountability for VAS. These funds would allow us to strengthen our close coordination with Ministry of Health counterparts at all levels and with other partners (e.g. UNICEF and NI) and stakeholders committed to ensuring that at-risk children benefit from this life-saving intervention.

1. Burkina Faso

In Burkina Faso, since HKI stopped supporting VAS, it has been extremely difficult for the Nutrition Directorate of the Ministry of Health (MoH) to find funding to support the campaigns. After many delays, the 2016 campaigns were finally organized using funds from a Global Affairs Canada (GAC) grant to Nutrition International. In 2017, stakeholders are not expecting funds to be available to support national campaigns. Therefore, Burkina Faso is organizing a transition towards a more cost-effective model than door-to-door delivery. Four-day door-to-door campaigns will continue being organised in urban areas, but Child Health Days (CHDs) will be implemented in rural areas using Community Health Workers (CHWs) as the main VAS distributers. The number of CHWs in the country recently

increased significantly because of a government-sponsored monthly incentive of USD $36. The current plan is to organize CHDs twice per year and distribute VAS at health facilities and health posts, supplemented with CHWs delivering VAS in their respective communities. This is a “hybrid” approach (i.e. door-to-door in urban areas but facility-based CHDs using CHWs for community VAS distribution) is likely to help maintain high coverage but will need careful monitoring during its initial trial rounds. With additional funds, HKI would help pilot the hybrid delivery model, and based on careful review of the pilot and any necessary revisions to the implementation strategy, would help the government scale-up these lower-cost CHDs campaigns throughout the country. Specific activities would include supporting the government in the planning, implementation and monitoring of the campaigns (around $ 870,000 USD per year, or $ 2,610,000 USD for three years).

2. Cameroon

In Cameroon, VAS has long been dependent on National Immunization Days (NIDs). An effort was made in the early 2000’s to develop CHDs, but with the resurgence of polio cases in neighbouring Nigeria, polio-supported NID campaigns had to be organised in Cameroon twice a year and VAS systematically took advantage of them. However, these polio campaigns are reducing in number and geographic scope leaving some regions unsupported. For instance, in the Littoral region of Cameroon, the 2nd VAS round in 2016 was not implemented partly because HKI had no funds to support the region. The first VAS distribution round of 2017 was thought to have achieved a coverage far lower than the targeted 80%, although in the absence of proper monitoring, coverage estimates for this round remain uncertain. The Littoral region is the third most populated in Cameroon with about 90% or the population living in an urban area. Other regions are facing similar situations. Vulnerable regions from the north are less populated but experience higher under five mortality rates. Campaigns there have been conducted but showed coverage fluctuating between 40% and 80%. To be able to support campaigns and obtain high coverage in the most relevant regions, HKI would require ~USD$1,500,000 per year or $ 4,500,000 over three years. Fifty percent of these funds would be used to support the Littoral region to transition from door-to-door to CHD campaigns, and fifty percent would be used to support door-to-door campaigns in other regions with low VAS coverage.

In the Littoral region, funds would be used to support CHDs in targeted areas and would include supporting the government in the planning, implementation and monitoring of the campaigns. Focus would be to ensure consistent >80% coverage of VAS during the three years. In regions of low coverage, HKI would provide technical assistance in all stages of planning and implementation and would provide independent monitoring.

3. Cote d’Ivoire

In Cote d’Ivoire, after HKI stopped supporting VAS in 2016, the Government took an approach to integrate VAS into a CHDs model that was funded by the Ivorian National Budget.

Although HKI concurs with the Government that CHDs is an excellent approach to deliver a package of highly effective, life-saving nutritional interventions including VAS, deworming,

and screening for severe and moderate acute malnutrition cases, national VAS coverage rates dropped significantly during the period that the CHDs were used. This was mainly because the 2016 CHDs were significantly underfunded. Of the 84 health districts in Cote d'Ivoire, the Government, in 2016, was only able to supplement eight districts, as well as parts of the City of Abidjan. The declared coverage rates in the eight districts were 89.8% and in the City of Abidjan 102.2%, but these rates are unconfirmed and questionable as there was no external monitoring of the campaigns.

Because of the failures of the CHDs in 2016, in 2017 the Government decided to go back to delivering VAS by piggybacking on the polio NIDs campaign. Coverage rates improved significantly, and during the first round of VAS conducted in March 2017, coverage rates returned to 94% across all health districts of the country. However, HKI and the Government both realize that distributing VAS through the polio platform is a short-lived and unsustainable venture. Since Cote d'Ivoire was declared polio-free by the WHO in December 2015, it is highly likely that NIDs will be discontinued soon.

HKI-Cote d'Ivoire proposes to support the Ivorian Government's CHDs approach on a national level and would need an additional ~USD$1,800,000 per year or $5,400,000 over three years to achieve it. This amount would cover the technical assistance provided by HKI to the government at national and district level for planning, monitoring and implementing the campaigns. It would also include supportive supervision and capacity building and support to national policy making and coordination. The Government would be expected to mobilize its own resources, including medical staff and its own facilities and assets, to assure the success of the CHDs campaigns.

4. Guinea

Since 1999, Guinea has consistently achieved >90% VAS coverage by piggy-backing VAS distribution onto NIDs organised for polio vaccination. However, no NIDs were organised during the Ebola virus outbreak that Guinea experienced in 2014 and 2015. Since then the country has failed to raise the necessary funding to continue VAS in part due to Guinea becoming a polio-free country. The Ministry of Health, HKI and other stakeholders are committed to transition to CHDs but lack funds to implement it at scale.

Additional funds will be devoted to ensuring >90% for VAS nationwide through CHDs. Through this CHD approach, VAS will be integrated with other high impact interventions such as immunization, deworming, health, nutrition and hygiene promotion (funded by other actors). HKI will share its expertise through the planning, implementation, monitoring and evaluation of the CHDs that will focus on a fixed strategy complemented by outreach and mobile distribution points. Some key activities will include supporting districts in micro-planning for CHDs, supporting the design and implementation of social mobilization approaches, providing training to field workers, supporting supervision of campaigns and implementing independent monitoring activities (coverage survey, real time monitoring)

To carry out these activities HKI needs ~USD$730,000 per year or ~USD $ 2,190,000 for three years. This amount will be used to implement CHDs twice a year. This should enable

the country to implement biannual administration of vitamin A to children from 6 months to 59 years and achieve ~90% coverage.

5. Kenya

In Kenya, the transition from NIDs campaigns to CHDs was organised in 2007 and immediately led to a decrease of coverage of VAS from more than 90% coverage to less than 30%. HKI assessments concluded that the low performance of CHDs was associated with poor planning, limited social mobilization and lack of funding. Currently, CHDs are not taking place in many parts of the country due to the absence of funding, and VAS is only distributed when it can take advantage of measles campaigns, which occur once every 2 or 3 years. Routine distribution of VAS does not work in most cases. From 2014 to 2016, HKI and Nutrition International partnered to develop alternative delivery mechanisms to facilitate the implementation of the CHD campaigns by using early child development centres, schools, market places and other well-known distribution points in communities. The approach also proposed to increase the number of days for distribution from 5 days to up to one month, as was done successfully in Tanzania. The approach successfully raised coverage close to 80% during initial pilots conducted by HKI in early 2016. With additional funding, HKI will support county governments to fully implement CHDs and will build their capacity for sustainable implementation of the campaigns. It is expected that financial support of USD$36,000 per county per distribution round would be needed. HKI would support CHD implementation in 30 of Kenya's 47 counties, requiring an annual budget of $2,160,000 per year (30 counties x $36,000 x 2 distribution rounds per year) or a total three-year budget of around $6,480,000. Funds would mainly be used to support the planning of CHDs, conduct social mobilisation activities, train field staff and monitor campaigns.

6. Mali

CHDs have been implemented in Mali for more than a decade. They are organised as a door-to-door approach and aim to deliver a package of high impact interventions that include VAS and deworming. Over the years, HKI has provided financial and technical support in several regions of the countries where performance was low and funding insufficient.

Currently, as Mali is about to be declared polio-free, and as the fight against polio has been a key source of funding, there is a clear risk of seeing CHDs not taking place at all. In 2017, the first round did not take place due to lack of funding and the second round may also be in jeopardy. With Mali showing one of the highest under five mortality rates in Sub-Saharan Africa, this situation is extremely worrying.

HKI's additional funding estimates are ~USD$600,000 per year ($1,800,000 for three years) to support at least two large regions of Mali. The campaigns would use a "mixed strategy" involving community health centres, motorcycle outreach to nearby villages, and some door-to-door efforts in hard-to-reach areas. HKI would also work with the Nutrition Division of the MoH, UNICEF, and other relevant partners to refine its VAS distribution strategy to achieve sustained high VAS coverage among preschool-age children. HKI would use the funds to support planning, social mobilization, implementation and independent monitoring, including conduct of PECS.

7. Mozambique

CHDs have existed in Mozambique since 2008. Coverage was initially low but was raised to over 90% thanks to technical support from HKI and other partners. Recently, the MoH and donors have decided to phase out these campaigns in favor of providing VAS through routine health services using UNICEF's Reaching Every Child (REC) strategy. Delivery of VAS through routine services in Mozambique draws on three delivery platforms: (1) health facilities (for people living <5 km from facility), (2) mobile brigades (outreach events for people living 5 to 8 km from facility), and (3) community-delivery through CHWs (for people living 8 – 25 km from facility).

With UNICEF funding and MoH collaboration, HKI has been requested to support the country as it transitions its VAS distribution strategy. However, HKI foresees many challenges in implementing the REC approach that may cause VAS coverage to significantly fall. These challenges include insufficient and slow funding for mobile brigades, lack of health staff at facilities to participate in mobile brigades, heavy workload of CHWs, and the sheer remoteness of a large part of the population. It is estimated that almost 70% of the Mozambican population lives in underserved areas that are too far from health services.

With additional funding, HKI proposes to assist the MoH to implement "micro-campaigns" for VAS to reach children 6-59 months old in hard-to-reach areas in the 8 provinces of Cabo Delgado, Niassa, Tete, Nampula, Zambezia, Sofala, Manica, and Inhambane. Micro-campaigns will be held twice annually, involving health staff from provincial and district health directorates, who will bolster health facility staff capacity to provide VAS. A total of 2,300,000 children under 5 will be reached (around 50% of children under five in the country representing those not reached by routine services). A total of 48 micro-campaigns will be held (2 per year, in 8 provinces, over 3 years).

To support these campaigns, HKI would need around USD$ 700,000 per year or ~$2,100,000 for three years. This will enable HKI to provide financial and technical assistance to provincial and district teams to plan, implement, monitor and evaluate (through PECS) the micro-campaigns, as well as social and behaviour change communication (community radio, community meetings, job aids, etc.) and training of health workers. The project will coordinate with UNICEF which supports the MoH in the REC approach, and receives GAVI funding for routine vaccinations, as well as with provincial and district health authorities. UNICEF will provide vitamin A capsules and deworming tablets. No funding is currently expected or available for these campaigns.

8. Niger

Since the late 1990's VAS has been delivered in Niger through NIDs, primarily organised to immunize children against polio, and has consistently reached more than 90% coverage. HKI used to provide technical assistance to a variety of regions, targeting the ones with lowest performance every year to help them achieve the required minimum 80% of coverage for VAS. However, because Niger is becoming polio-free, funds for NIDs are waning and will likely stop. There is uncertainty that VAS distribution will take place at all in 2017.

To support the transition from NIDs to a CHD model, HKI would require ~USD$1,000,000 per year or $3,000,000 for three years. During the first year of funding, half of this amount would support NIDs in low performing regions and the other half would support the transition to CHDs in other regions. Funds would be used to train workers, develop tools, reinforce social mobilization and implement a strong monitoring component. For the 2nd and 3rd years, all funds would be used to scale up and support CHD implementation nationally.

9. Nigeria

CHDs have been implemented for many years in Nigeria and shown very inconsistent results over time and across states. While some states have shown good practices and reached the expected 80% coverage for VAS, some have regularly omitted providing any post-campaign data and others remained at a coverage between 40% to 60%. CHDs in Nigeria are organised through a common fixed strategy complemented with outreach distribution sites. CHDs are not implemented in many facilities because of inadequate planning and/or lack of funds. Poor social mobilization strategies compound these factors and contribute to low VAS coverage because people are not aware that a campaign is taking place.

HKI has supported up to 9 out of a total of 36 states in the country and has managed to build their capacity and improve coverage to about 80%. However, HKI stopped supporting VAS in 2016 due to a lack of funding. Therefore, during the first CHDs in 2017, only 17 states achieved 80% coverage based on tally-sheet data which often overestimates coverage. HKI would use additional funding to ensure high coverage of VAS through CHDs in up to 10 low-performing states. HKI estimates the need for ~USD2,500,000 per year or ~$7,500,000 over over three years to support this effort. Throughout the period, 100% of the funds would be used to support CHDs by supporting the government in planning, implementing and monitoring CHDs. The goal would be to achieve >80% coverage of VAS during each CHD round for the next three years in these 10 low-performing states .

10.Senegal

Since HKI stopped supporting VAS in Senegal, all campaigns have stopped. The MoH is now fully relying on routine VAS delivery; however, with low health service use for preventive services, VAS coverage has suffered. Recognizing the danger of low VAS coverage, the MoH recently decided to organize catch-up campaigns to accompany its routine VAS delivery strategy. With additional funding, HKI would assist the government to plan and implement these catch-up campaigns in 7 regions (Louga, Diourbel, Saint-Louis, Matam, Sédhiou, Tambacounda and Kedougou) where VAS coverage is low and child mortality remains high. HKI estimates that it would need USD$700,000 per year or $2,100,000 for three years to support the local VAS catch-up campaigns. During the first funding year, 50% of the resources would go to organizing the transition from door-to-door campaigns to CHDs in the areas of Louga, Diourbel, Saint-Louis, Matam. The other 50% would help support door-to-door campaigns in Sédhiou, Tambacounda and Kedougou. In years two and three, 100% of the funds would be used to support CHDs in all 7 low-performing regions listed above by

providing technical and financial support to the government's regional health team for planning, implementing and monitoring the local catch-up campaigns or CHDs.

11.Sierra Leone

VAS has been delivered through CHDs since the end of the rebel war in 2002. CHDs occur during a five-day period, every six months. Coverage rates prior to HKI assistance ranged between 41% and 73% -- significantly short of the >80% goal. Coverage also varied by child age and district of residence. In 2004, HKI started to provide technical support for microplanning, advocacy, social mobilisation, in-process monitoring and post-event coverage surveys. Since then, documented VAS coverage has consistently reached 90% or more and levels have been consistently high by child age, gender, district and religion.

A VAS distribution round was cancelled during the Ebola epidemic in 2014, but VAS coverage levels did reach 86% in the post-Ebola period. This level was achieved, in part, due to a modified social mobilisation and messaging strategy which HKI developed with the MOH to raise awareness of mothers and communities of the value and benefits of VAS.

Recently, the MoH, HKI and other stakeholders have committed to integrate VAS into routine services. This transition process will still take four more years. During this transition period, HKI would propose to use additional funds to implement mass VAS at scale twice yearly through CHDs and provide expertise to assess coverage of CHDs using PECS. To implement these activities HKI estimates an additional budget of $ 600,000 USD per year or USD$1,800,000 for three years.

12.Tanzania

In Tanzania, since HKI stopped supporting VAS, campaigns have not been conducted in some areas, and in other areas campaigns have not reached the 80% coverage target. HKI estimates the need for USD$1,000,000 per year or $3,000,000 over three years to support CHDs throughout the country by providing technical and financial support to the government for planning, implementing and monitoring of CHDs. In addition, HKI would use funds to assist with social mobilization campaigns to promote awareness of and participation in CHDs, organize district level health fairs to increase access to and demand for CHDs, and mobilize local service providers (such as eye doctors, primary care physicians, and dermatologists) to offer free screenings in conjunction with the distribution of VAS and deworming medications during CHDs.

Budget summary

Table 1 below provides a summary of the additional funding needed over 3 years to support HKI to provide technical and financial assistance in twelve Sub-Saharan Africa countries to strengthen VAS distribution through CHDs or similar campaign approaches. The amounts are rough estimates and would need further review and itemization should funds become available to HKI.

In addition to these rough cost estimates, Table 1 displays the “geographic coverage” that would be targeted using additional funds and the “number of preschool-age children” (i.e. 6-59 m of age) estimated to reside in the geographic coverage area.

With additional funding, HKI would implement a variety of activities in each country. These activities vary between countries and would likely vary over time within a country as described above in the country-specific descriptions. Overall, however, ~30% of the budget would cover personnel and operations costs for HKI within the country; ~20% would cover training of technical personnel from central to field level (e.g. regional, district and community health teams, CHWs); ~20% would cover social mobilization activities at the community level; ~20% would cover monitoring and evaluation activities (e.g. PECS) and ~10% would support coordination, advocacy and policy development at central level. In addition, a small proportion of these funds would be used to support regional technical, operational, managerial and financial oversight.

Table 1. Budget Summary, Geographic Coverage, and No. of preschool-age children targeted

Country	Three-year additional funding estimate to support HKI VAS activities (USD)	Geographic Coverage	No. of preschool-age children targeted
Burkina Faso	$2,610,000	National	3,700,000.0
Cameroon	$4,500,000	1/2 country	2,800,000.0
Cote d’ Ivoire	$5,400,000	National	4,800,000.0
Guinea	$2,190,000	National	2,500,000.0
Kenya	$6,480,000	2/3 country	6,400,000.0
Mali	$1,800,000	1/3 country	1,200,000.0
Mozambique	$2,100,000	National	2,300,000.0
Niger	$3,000,000	National	4,200,000.0
Nigeria	$7,500,000	1/3 country	10,300,000.0
Senegal	$2,100,000	2/3 country	800,000.0
Sierra Leone	$1,800,000	National	1,500,000.0
Tanzania	$3,000,000	1/5 country	2,200,000.0
Total	**$42,480,000**		**42,700,000.0**