

GAVA

MONITORING OF VITAMIN A SUPPLEMENTATION

A GUIDE FOR DISTRICT (AREA-BASED) PROGRAMME MANAGERS

DISTRICT GUIDE



The Global
Alliance
for Vitamin A



mi

Micronutrient
Initiative

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CDC

CENTERS FOR DISEASE
CONTROL AND PREVENTION

This guidance document was developed with the aim of providing information to district level programme managers to develop simplified monitoring plans for their vitamin A supplementation (VAS) programs, and to facilitate the improved use of data for programme decision making.

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PREFACE

On behalf of Global Alliance for Vitamin A (GAVA) partners, *Monitoring of Vitamin A Supplementation: A Guide for District (Area-based) Programme Managers* was developed by the Micronutrient Initiative (MI), UNICEF, Helen Keller International (HKI), and the U.S. Centers for Disease Control and Prevention (CDC). This guidance document was developed with the aim of providing information to district level programme managers to develop simplified monitoring plans for their vitamin A supplementation (VAS) programs, and to facilitate the improved use of data for programme decision making. A complementary Guide designed for national managers is also under development.

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ACRONYMS

BCC	Behaviour change communication
CDC	U.S. Centers for Disease Control and Prevention
CHD	Child Health Day
HKI	Helen Keller International
HMIS	Health management information system
IU	International Unit
LMIS	Logistics management information system
LQAS	Lot Quality Assurance Sampling
MI	Micronutrient Initiative
NID	National Immunisation Day
PECS	Post event coverage survey
SIA	Supplemental immunisation activity
SMS	Short messages services (text messaging)
VAS	Vitamin A supplementation
UNICEF	United Nations Children's Fund
WHO	World Health Organization

GLOSSARY

Activity (in context of logic model and logframe)

Actions, events, and processes required for programme implementation and performance including the execution of inputs, for example, development of policies and guidelines. Activities are required to produce the logframe outputs.

Age-appropriate dose

The recommended dose for children 6-11 months of age is 100,000 IU of vitamin A, and for children 12-59 months of age it is 200,000 IU. Therefore, for example, for a child 10 months of age, the age-appropriate dose is 100,000 IU.

Child-centred reporting

Reporting based on records for individual children, as compared with reporting based on total numbers of children reached. Child-centred reporting enables reporting on the number of eligible children receiving one vitamin A supplement in the previous semester, through any delivery method.

Child health card

A card used to record key health-related information from birth. Usually used to record birth date and immunisations received. Can also include fields to record other clinical actions, such as vitamin A supplementation (VAS) and deworming. Facilitates child-centred reporting.

Coverage

The number of people reached in relation to the target number of people. For example, the percent of eligible children in a defined area who received vitamin A.

Denominator

This is the bottom half of a fraction. In this guide, it is the total number or population for an indicator. For example, total number of children 6-59 months of age in the district.

Disaggregation (of data)

Analysis of data by different sub-groups, for example, analysis of data by smaller administrative units or by different age group.

District

For the purpose of this guide, “district” refers to a defined sub-national administrative area.

Enabling policy environment

In a country, the programme policy is well defined and the related planning and budget are integrated into national processes, indicating national ownership.

Enabling programme environment

Clear guidelines for programme implementation exist in a country. Supporting policies, budget and planning have national support and ownership.

Equality¹

‘Equality’ in coverage implies treating all eligible children as equal in some respect, for example, their right to VAS regardless of age.

Equity^{1,2}

Equity is defined as fair or just outcomes for all sub-groups of a population. Deciding whether outcomes have been equitable in VAS programmes would involve analysis of data by different sub-populations, such as ascertaining whether VAS coverage varies by age, sex, subnational geographical area, ethnicity, religion, household composition, or citizenship status, for example.

Event-based delivery

A service that is of finite duration and periodically available, e.g. when VAS is made available through a Child Health Day, a Child Health Week or special immunisation events.

Input (in context of logic model and logframe)

Resources invested in the intervention. This includes personnel, funding, policy and strategy support.

Lot Quality Assurance Sampling (LQAS)

A sampling method that can be used locally, to quickly identify priority areas or indicators that are not reaching established targets.

It involves taking a small random sample of a population (for example, children, caregivers or health personnel), and identifying where the issue of interest (for example, VAS or knowledge about VAS) meets the expected target level.

mHealth

A collective term which applies to the use of mobile technology in existing health delivery platforms to improve effectiveness.

Micro-plan

Refers to bottom-up planning, also called Area Planning. The micro-planning process is a multi-level, decentralised planning approach that allows for area-specific detailed implementation plans.

Numerator

This is the top half of a fraction. In this guide, it is the number achieving the criteria for an indicator or population. For example, number of children 12-59 months of age who received vitamin A through one delivery mechanism in a given semester.

Outcome (in context of logic model and logframe)

Specific benefits or changes among intervention participants during or after the intervention. For VAS the outcome is coverage.

Output (in context of logic model and logframe)

Direct effect or product of activities. For example, availability of sufficient supplies at a distribution site.

Post distribution exercise and/or post-event coverage survey (PECS)

A post-event coverage survey (PECS) is used to verify administrative or tally sheet coverage data following a vitamin A distribution or campaign. It can also be used to determine factors that affected coverage, for example, knowledge about vitamin A and other services. PECS surveys should ideally be conducted within 4-6 weeks after service distribution. The sampling method allows for population-based point estimate.

Routine data quality assessment

A form of rapid assessment of: the quality of reported data for key indicators at selected sites; and the capacity of information systems to collect, manage and report quality data. Routine data quality checks can be included as part of ongoing supervision at the service delivery site.

Routine health system contact

A service that is available on a continuous, daily, basis. Either through a fixed service site health facility or through scheduled outreach from the health facility.

Semester

A 6 month period, usually considered to be January-June or July-December. When referring to VAS distribution per semester, the intended period of time between deliveries in each semester should be 4-6 months.

Supportive supervision

A supervisory approach that focuses on direct, personal contact on a regular basis to problem solve and motivate staff. A form of on-the-job training intended to strengthen the quality of service delivery.

Tally sheet

A tally sheet is used to record the vitamin A doses administered at a child health event and then these are aggregated and sent to the next level (e.g. district) as a total numerator (e.g. total number of capsules distributed). When divided by the total number of eligible children at the distribution level, it provides a coverage estimate.

Two-dose Coverage (annual)

Children who receive their age-appropriate dose in each semester when delivered 4 to 6 months apart over a calendar year. Eligible children who receive two-dose coverage annually are considered to be fully protected.

Universal Coverage

The ultimate goal of reaching all children to ensure equity.

1. Stewart, F. (2013) Approaches towards Inequality and Inequity: Concepts, measures and policies. Office of Research Discussion Paper No.2013 -01, UNICEF Office of Research, Florence
2. http://www.mymande.org/?q=what_is_equity

SECTION 1



INTRODUCTION

TERMINOLOGY

The term district is used throughout the Guide. However, the guidance provided applies to any sub-national administrative/programme unit, which could be smaller than a district (e.g. a commune) or larger (e.g. a region or province).

The term national is used to refer to the policy-making administrative level. However, in some cases, this level of administrative independence may be at a large sub-national level (e.g. State level), in which case reference to the National Guide should be taken to refer to the Guide for State level.

The term semester is used to define a 6 month period of the calendar year during which each eligible child should receive one age-appropriate vitamin A supplement. For example, the first Semester is often described as the period from January 1 to June 30, and the second Semester is July 1 to December 31.

1.1

PURPOSE OF THIS GUIDE

The purpose of this Guide is to advise on the selection, measurement and reporting of indicators that reflect the implementation of vitamin A supplementation (VAS) at the district level³. The aim is to strengthen district VAS monitoring processes and improve the quality and use of data to optimise the equitable delivery of VAS for infants and children 6-59 months of age, for both routine health system contact and event-based delivery (see Text Box 1).

The Guide also briefly introduces different assessment options to verify the data obtained and identify the cause of any problems with implementation, in order to improve VAS in subsequent semesters. Where a problem is

3. This Guide does not include reference to monitoring the provision of therapeutic doses of vitamin A. In addition, the Guide does not include extensive advice on programme adjustments that may be required to address identified gaps in programme implementation or information about the biological assessment of vitamin A status. Both of these issues are beyond the scope of this Guide.

identified, appropriate follow-up and corrective actions should be determined at the district and/or national level, depending on the local context as well as on the source and magnitude of any problem.

OBJECTIVES OF THE GUIDE

- 1.** To improve the quality of district VAS coverage estimates and reporting by semester—by providing clear guidance on how to calculate and verify coverage, taking into account different vitamin A distribution systems and different target age groups (6-11 months and 12-59 months of age).
- 2.** To improve programme performance—through strengthened monitoring and subsequent use of data documenting VAS programme activities, outputs and outcomes; in order to improve programme quality and, therefore, increase semester level coverage at the district level.

AUDIENCE

The audience for this Guide is the district, or equivalent sub-national area-based, manager responsible for implementing preventive VAS for infants and children 6-59 months of age.

RATIONALE AND SCOPE OF SEPARATE GUIDES FOR DISTRICT AND NATIONAL MANAGERS

National and district level VAS managers have different roles and responsibilities, therefore separate VAS monitoring guides have been developed in order to focus on the issues most relevant to each specific manager level. Respective responsibilities may vary according to the level of centralisation in different contexts; however, there will always be some indicators that require monitoring at the district (sub-national) level⁴.

This District Guide focuses on the monitoring and use of indicators for VAS programme processes and semester coverage for both routine health system contact and event-based delivery methods (See Text Box 1) within the defined local area, as well as on reporting this information for national use. The National

4. The level of centralisation of administrative procedures will affect whether all indicators proposed in this Guide can be effectively monitored at the district level. For example, where planning is highly centralised, the budget will be determined and, therefore, monitored at national and not district level. The detailed description of indicators presented later in this Guide should be consulted to identify those that could be added to national level responsibilities in some contexts



TEXT BOX 1**VAS DELIVERY METHODS**

There are two main methods for delivery of vitamin A supplements, which are referred to throughout this manual as “event” and “routine”.

EVENT-BASED DELIVERY usually occurs twice a year as part of a child health day or similar event/campaign. These events are the main delivery platform used to provide essential preventive services to children under five years of age in countries where routine health services are less established, under-utilised and generally do not reach children older than 12 months of age. Using this delivery platform, VAS is often co-delivered with other child survival/health interventions such as immunisation, and deworming targeted to preschool-age children.

The term “event” may refer to a range of service delivery strategies, including door-to-door administration of vitamin A supplements lasting for a few days, or to mobilisation of communities to visit fixed sites to receive the defined preventive services for a distinct period of time (often a day, a week or a month).

ROUTINE DELIVERY refers to the service being available on a continuous basis via the existing health system with children receiving the services when they are due for them. Delivery is either through a fixed-site facility or through scheduled mobile or outreach activities from the health facility to boost fixed site coverage. In most countries a fixed site facility provides services to the surrounding community. Communities far away from the fixed site facility receive a scheduled outreach visit by health staff to provide essential medical services, including immunisation and other preventative health services.

Guide also provides guidance on monitoring policy, resource allocation, coordination and reporting on national VAS coverage by semester and annually, for each delivery method.

Both Guides provide information on areas of overlapping responsibilities such as procurement, logistics, and management and use of data.

FORMAT

This Guide uses a logical framework format for monitoring VAS, which includes indicators to assess district level programme environment, supplies, human resources, social mobilisation and coverage. The logical framework indicators are introduced in Section 3 and are described in detail in Section 4. Case studies and text boxes are used to illustrate specific programme points in additional detail.

The logical framework indicators and the majority of case studies have been constructed to reflect the most typical situation for VAS programmes globally; however efforts have been made to recognise and address exceptions that are known to occur.

Guidance is provided for programme managers on the value of including timely verification methods (e.g. exit interviews or post-event coverage assessments) to complement on-going monitoring systems.



TABLE 1**SUGGESTED VITAMIN A SUPPLEMENTATION SCHEME FOR INFANTS AND CHILDREN 6-59 MONTHS OF AGE⁸**

TARGET GROUP	Infants 6-11 months of age (including HIV+)	Children 12-59 months of age (including HIV+)
DOSE	100,000 IU (30mg RE) vitamin A	200,000 IU (60mg RE) vitamin A
FREQUENCY	Once	Every 4-6 months
ROUTE OF ADMINISTRATION	Oral liquid, oil-based preparation of retinyl palmitate or retinyl acetate ^a	
SETTINGS	Populations where the prevalence of night blindness is 1% or higher in children 24-59 months of age or where the prevalence of vitamin A deficiency (serum retinol 0.70 Qmol/l or lower) is 20% or higher in infants and children 6-59 months of age.	

^a Usually delivered using soft gelatin capsule, or else from a single dose dispenser or using a graduated spoon. The higher dose (200,000 IU) capsules are generally red and the lower dose (100,000 IU) capsules are generally blue.

1.2 BACKGROUND

WHO GUIDELINE FOR VITAMIN A SUPPLEMENTATION FOR INFANTS AND CHILDREN 6-59 MONTHS OF AGE

WHO recommends VAS for children 6-59 months of age as a low-cost intervention shown to reduce child morbidity and mortality in countries where vitamin A deficiency is a public health problem⁵. The recommended dose for 6-11 month old children is 100,000 IU, and for children 12-59 months of age it is 200,000 IU (Table 1)⁶.

The protective effect of a single, large (age-appropriate) dose of oral vitamin A has been shown in clinical trials to last for up to, but not exceeding, 4-6 months⁷. As such, children 6-59 months of age are considered fully protected for a calendar year when they receive their age-appropriate dose every semester (4 to 6 months apart), for a total of two doses over 12 months.

5. Guideline: Vitamin A supplementation in infants and children 6-59 months of age. 2011. Geneva, World Health Organization.

6. Guideline: Vitamin A supplementation in infants and children 6-59 months of age. 2011. Geneva, World Health Organization.

7. Amanda C Palmer, Keith P West, Jr, Nita Dalmiya and Werner Schultink (2012). The use and interpretation of serum retinol distributions in evaluating the public health impact of vitamin A programmes. *Public Health Nutrition*, 15, pp 1201-1215.

COVERAGE INDICATORS

The outcomes of a 2006 Global Alliance for Vitamin A (GAVA) Technical Advisory Group meeting on monitoring VAS programs concluded that VAS monitoring and reporting should assess whether supplements were delivered according to international recommendations to optimise impact⁹ (i.e. to ensure children receive their age-appropriate dose 4-6 months apart, twice a year). As a result, the current VAS coverage indicators are based on the following:

- i.** Number of infants 6-11 months of age reached during the first semester of the calendar year (January to June)¹⁰;
- ii.** Number of infants 6-11 months of age reached during the second semester (July to December);
- iii.** Number of children 12-59 months of age reached during the first semester of the calendar year (January to June);
- iv.** Number of children 12-59 months of age reached during the second semester (July to December).

8. Guideline: Vitamin A supplementation in infants and children 6-59 months of age. 2011. Geneva, World Health Organization.

9. Proceedings Monitoring Vitamin A Supplementation. Global Alliance for Vitamin A (GAVA) Technical Advisory Group Meeting. New York, 19-20 July 2006

10. The timing in terms of calendar months covered by each semester may vary depending on national budget and planning cycle, e.g. the first semester may be April to September and the second semester October to March. However, the period of time for each semester should not exceed a six month period.

SECTION 2



LOGIC MODEL AND LOGICAL FRAMEWORK FOR VITAMIN A SUPPLEMENTATION

Logic models and logical frameworks (logframes) are often used as tools to structure and organise programme-related information. They can also be used to outline information needs and the processes required to collect this information; e.g. they can be designed to represent monitoring systems. This Guide presents a version of the WHO/CDC logic model for micronutrient interventions in public health¹¹, adapted by GAVA to apply to VAS programmes.

The two different formats (logic model and logframe) represent the same programme process and can be related to each other; different logframe indicators can be linked to relevant logic model components. This Guide focuses primarily on the use of the logframe for VAS, which provides operationally-applicable detail for monitoring.

TERMINOLOGY FOR PROGRAMME INDICATORS

The following terms are used to categorise VAS programme indicators used in the logic model and the logframe:

- **Programme Inputs (or resources for the programme)** For example: health workers, vitamin A capsules, money.
- **Programme Activities (or what the VAS programme and health workers actually do)** For example: development of policies and social mobilisation strategies.
- **Programme Outputs (or tangible products or the results of activities)** For example: sufficiency of supplies; well-trained, knowledgeable personnel delivering vitamin A supplements.
- **Programme Outcome (or the result of the activities)** For example: coverage of vitamin A supplementation among 6-59 month old children.

11. http://www.who.int/vmnis/toolkit/logic_model/en/index.html [accessed 17 December, 2013]

TEXT BOX 2**FUNCTIONS OF THE LOGFRAME AND COMPLEMENTARY RELATIONSHIP BETWEEN A LOGFRAME AND A LOGIC MODEL**

The main functions of a logframe are to:

- Structure and organise monitoring information
- Identify realistic (measurable) indicators
- Facilitate stakeholder understanding and agreement on the programme, related monitoring strategies and responsibilities to achieve the “monitoring targets”
- Act as the reference point for comparing the actual functioning of the programme with the intended function throughout the programme cycle (as visualised in the logic model)
- Hold programme managers and staff accountable for the performance of the programme

The logic model should facilitate programme management through easier visualisation of how a constraint identified with one logframe indicator may negatively affect achievement of subsequent programme components.

For example, where implementation of a strategy for caregiver behaviour change is weak (logframe indicator 1.13a), it can be seen from the logic model that subsequent expected targets for access to and demand for VAS (logframe indicators 1.13b and c) may not be achieved, resulting in poor coverage (logframe indicator for coverage).

Programme inputs, activities, outputs and outcome are all considered part of the programme process. The above terminology is used throughout this Guide for ease of cross-reference with the logic model (illustrated in Appendix A). The logic model is useful to show the relationship between these different indicator categories along with a description of the type of VAS programme components considered within each category.

2.1**LOGIC MODEL FOR VITAMIN A SUPPLEMENTATION**

The logic model in Appendix A provides a high level strategic overview of VAS programme components: inputs, activities, outputs and outcome; and the inter-relation between these (see Appendix A). It is important to have indicators to monitor the effective implementation of each type of component, to help identify where obstacles to implementation may arise and, if they do, which related components will be affected.

Text Box 2 includes a description and example of how the programme cycle represented in a logic model can be used by programme managers to complement the detail provided in a logical framework, as described below.

2.2**LOGICAL FRAMEWORK FOR VITAMIN A SUPPLEMENTATION**

The logical framework (logframe) for vitamin A supplementation in Appendix B is included as the framework for monitoring VAS programmes. It provides a standardised structure that should require only minimal adaptation for use in the local context (e.g. some indicators may not be required where there is a high level of decentralisation). Text Box 2 lists some of the main functions of a logframe. Each framework indicator and their application are described in more detail in Section 4 and in Appendix and C.

The VAS logframe describes the intervention in terms of indicators for the activities, outputs and expected outcome (coverage), with a brief outline of the information required for each of these, as defined further in Section 4, in particular Text Box 3.

SECTION 3



PROGRAMME MONITORING CONCEPTS AND THEIR APPLICATION TO VAS MONITORING

In general, the term “programme monitoring” refers to the on-going collection, analysis, reporting, interpretation and use of data on a programme’s inputs, activities, outputs and outcomes, as a basis for decision-making.

Ideally, a programme is continuously monitored to assess its function, based on pre-defined objectives, targets, and performance indicators, and to use the monitoring data for programme improvement. This can be termed “monitoring for programme management”.

Ideally, monitoring should be planned and designed before the programme is implemented. The monitoring process should be designed to provide programme managers with regular feedback on relevant indicators. This enables the effective assessment of programme activities to determine whether the programme is:

- i.** Being implemented as planned (output indicators).
- ii.** Progressing to achieve the programmatic goal, i.e. Universal coverage—reaching all infants and children 6-59 months of age (outcome indicator).

An indicator should be written in such a way that it is clear what is to be monitored. This in turn will help determine how it is best monitored, including the kind of information that must be collected. Indicator targets establish the standard that is aimed for in a programme.

A good quality indicator should be:

- Based on data that are readily available or easy and affordable to collect.
- Easy to understand.
- Relevant to the information needs of the programme manager, i.e. linked to corrective action (that is specific action that can be taken to improve performance).

Indicators should be continuously reviewed and adapted as required during the annual or biannual programme planning period.

If indicator targets are not being achieved, the monitoring data should be used to help identify the cause and to facilitate timely corrective action to improve future implementation and VAS coverage. The district manager responsible for VAS is expected to conduct regular reviews of programme indicators, communicate and collaborate with the national team, and take follow-up actions (for routine health system contacts and event-based delivery) as required. Effective programme practices at the sub-district level should also be identified, supported and shared.

The timing of data collection and review will vary depending on the availability of data and the purpose of monitoring a specific indicator. The logframe matrix and additional notes (Appendices B and C) include recommendations for the timing of reviews and the use of information collected for each indicator. Monitoring indicators as described in Appendices B and C allows district VAS managers to:

i. Identify gaps in VAS coverage and/or problems with programme implementation (e.g. inequality in coverage by age, weaknesses in programme management, supply, human resource availability, capacity and capability and/or service demand) in a timely manner.

ii. Generate a comprehensive programme overview through combining data from different indicators that can help assess programme status, detect the most likely causes of problems and determine whether further investigation is required.

iii. Identify possible solutions and follow-up promptly with corrective action to improve future implementation and coverage.

iv. Track semester level indicator data over time to determine whether VAS programme adjustments resulted in improved programme implementation and progress toward achieving expected coverage, in accordance with national guidelines.

v. Determine whether additional verification investigations may be required in some areas and, if so, the appropriate type and design.

Most programme performance and management indicators are indicated for review at the end of each semester. The timing of data collection and review will vary depending on the availability of data, the purpose of monitoring a specific indicator, and knowledge of the programme; for example:

- End of semester review is recommended to improve aspects of the programme, such as social mobilisation for subsequent semesters.
- In some instances, annual review may be sufficient, for example if targets have been consistently achieved in previous semesters.

- On-going situation assessment and review are recommended to troubleshoot known problems which can potentially be addressed as they arise, for example to prevent stock-outs of vitamin A supplements at VAS events; or when programme changes are being implemented.

All monitoring information collected should link directly to decisions and actions that will improve the function and quality of the programme.

Without regular, targeted, monitoring programme managers risk not meeting the programme objectives because obstacles to implementation are not identified and corrected in a timely manner.

It is easy to generate a long list of ‘indicators’ to monitor, however it is critical that monitoring systems are designed with the primary purpose of improving programme effectiveness. In other words, programme managers should select indicators that enable them to propose and support adjustments to improve programme outputs as needed.

The monitoring system for VAS may be designed at the district level or by a higher administrative level for use at the district level. In both cases, district level VAS management teams need to understand the rationale behind the indicators and make recommendations where they find that the selected indicators may not be relevant and/or able to fulfil their expected purpose, or where alternative indicators may be more helpful.

KEY POINTS

When designing a monitoring system, consider:

- The purpose and objectives of the monitoring system
- Who will use the monitoring data, and how the information can be tailored to meet their needs (this will relate to information needs at both district and national levels)
- Timing of data collection, to coordinate with the programme planning and review cycle
- Resource availability:
 - Human and financial resource requirements for monitoring should be considered as a standard component of programme costs.
 - Non-human resource needs may include training time and materials, transport, field work tools, and the data management system infrastructure (e.g. computers, software, storage capacity, and, potentially, mobile technology equipment)*
- How the information and results will be used to make programme adjustments where needed.

*Depending on the national context, district—level resource allocation may be determined either at national and/or at district level. For either situation, it is important for district and national

SECTION 4



MONITORING VITAMINA SUPPLEMENTATION—COLLECTING, REPORTING AND USING INFORMATION TO IMPROVE COVERAGE

This section is based on the VAS logframe (Appendix B). More detailed information about the definition and calculation of all the indicators is provided in Appendix C, which is arranged in tabular form with the same sub-headings for each indicator, and includes the following information:

- Type of Indicator (outcome, output or activity¹²), indicator title and number (as they appear in the logframe)
- Rationale for Monitoring
- Operational Definition of the Indicator
- Indicator Target
- Monitoring Information Sources and Frequency of Collection
- Assumptions
- Responsibilities and Use of Data
- Recommendations

12. The logframe does not include reference to “input” indicators because these are more related to underlying system infrastructure and programme establishment, which are less relevant to district level VAS monitoring. Input targets and indicators would be more appropriately described in a VAS (or child health intervention) Programme Guide.

Additional information about each of these terms is provided in Text Box 3.

Key points for the use of logframe indicators in this Guide include:

- Review all indicators to see whether they are relevant for the VAS programme in the district then delete, adapt, or add others, as needed. For example, if all decisions on budget and resource allocation are made at the national level, some of the related activity indicators may not be required at the district level.
- Amend district-level data collection forms and checklists to allow for the collection and review of all data considered appropriate for the district. If amendments to existing checklists cannot be made immediately, include the additional indicators in any programme verification checks, evaluations or other types of studies/surveys.
- Use the monitoring data (and where relevant, the verification data) for each indicator to inform and determine programme adjustments for improved coverage in subsequent semesters; apply these adjustments.

TEXT BOX 3**DESCRIPTION OF THE INDICATOR SUB-HEADINGS
IN THE LOGFRAME APPENDICES B AND C****TYPE OF INDICATOR OUTCOME, OUTPUT,
OR ACTIVITY; INDICATOR TITLE**

- The outcome (coverage) indicator refers to “what difference the intervention processes and actions made among the population”, in terms of the proportion of eligible children who received vitamin A.
- Activity and output indicators relate to “what was done by the programme”, e.g. the number of events conducted as planned. The title of the indicator describes the specific focus of the indicator and the number refers to the number in the logframe.

**INDICATORS AND COMPONENT
INDICATORS**

Text description of the indicator and, where relevant, component indicators that feed into the overall indicator.

**RATIONALE FOR MONITORING
(APPENDIX C ONLY)**

Justifies why achieving this indicator target is important for the success of the VAS intervention and, therefore, why it is important to monitor it.

**OPERATIONAL DEFINITION
OF THE INDICATOR**

Additional explanation indicating how the indicator should be measured (count, percentage or occurrence (yes/no)). Definition of the calculation required to obtain the indicator.

Recommendations for sub-group analyses as relevant; e.g. reporting the data by routine and/or event-based delivery.

INDICATOR TARGET

States the desired goal to achieve for each indicator.

**MONITORING INFORMATION SOURCES
AND FREQUENCY OF COLLECTION**

Suggested sources of information or data needed to calculate the indicator, which may vary with national context and should be defined to fit the local situation.

Proposed frequency of collection: whether data are required annually, every semester, or only when problems are identified.

ASSUMPTIONS

Some of the assumptions made in defining the indicator that are often outside the control of the programme manager, but should be considered because they could influence the ability to measure the indicator and/or achieve the target.

**RESPONSIBILITIES AND USE
OF DATA**

This defines some key responsibilities for the programme manager in data collection and use. Brief information about the main purpose of monitoring each indicator, e.g. how the data can be used to improve programme management and effectiveness through, for example, identifying areas for further investigation and constructive feedback to district VAS staff.

RECOMMENDATIONS

Suggestions to improve programme function and to manage potential obstacles for effective VAS coverage and reporting.

TABLE 2
**SEMESTER LEVEL VAS COVERAGE DATA INDICATORS
REQUIRED AT THE DISTRICT LEVEL**

SEMESTER 1 (USUALLY JAN - JUNE)	Percentage of children 6-11 months of age who received a 100,000 IU dose	Percentage of children 12-59 months of age who received a 200,000 IU dose
SEMESTER 2 (USUALLY JULY - DEC)	Percentage of children 6-11 months of age who received a 100,000 IU dose	Percentage of children 12-59 months of age who received a 200,000 IU dose

- During analysis and interpretation of monitoring data, pay particular attention to communities that are hard to reach and low performing areas in the district. Assess specific factors that should improve the situation for these groups and apply changes.
- Check the listed assumptions and adjust the indicator if needed. It is important to understand the assumptions underlying the definition and calculation of the indicator since where these assumptions are not met the indicator may need to be changed or deleted.

4.1

**OUTCOME (COVERAGE) INDICATORS –
INCLUDING FACTORS THAT COMMONLY
AFFECT THE COLLECTION, INTERPRETATION
AND USE OF DATA TO CALCULATE VAS
COVERAGE**

VAS coverage indicators measure whether all children aged 6-59 months received an age-appropriate vitamin A supplement in each semester (six month period) through either routine health system contact or an event-based

delivery mechanism. Evidence shows that if the targets for coverage indicators are met, then the desired strategic result of reduced child mortality can be achieved for children aged 6-59 month old¹³. At the district, semester-level coverage indicators as shown in Table 2 are considered to be the main outcome indicators for VAS programmes.

An analysis of semester-level coverage by age group (6-11 months of age and 12-59 months of age), location, and delivery method (routine health system contact and event-based) enables later national-level assessment of progress toward two-dose coverage with VAS: an age-appropriate dose in each semester, annually, for infants and children 6-59 months of age. This is necessary to understand the overall performance of the public health programme and compare results across years.

13. Guideline: Vitamin A supplementation in infants and children 6–59 months of age. 2011. Geneva, World Health Organization.

TEXT BOX 4**VAS RECORDING METHODS**

Routine health system contact delivery: VAS delivered through routine health system contacts is often recorded along with other health data in health facility registers, facility-based daily, weekly and/or monthly tally sheets as well as on home-based health records. It is then reported upwards (possibly through a series of administrative levels). Finally, it is reported from district to national level through health management information systems (HMIS). Appendices Ei to Ev provide examples of VAS registration and reporting forms from health post to district levels.

The VAS data are usually sent to the district level on a monthly basis. When received, the data should be reviewed by the VAS manager in order to identify and address any problems in a timely manner. A quarterly review is recommended to assess if coverage is lower than expected and additional outreach is needed before the end of the semester.

These monthly health facility reports should be combined at the end of the semester to calculate the total number of children 6-11 months old and 12-59 months old who received an age-appropriate dose of vitamin A through routine distribution in the semester.

EVENT-BASED DISTRIBUTION: Tally sheets are generally used at events to record the total number of vitamin A capsules of each type (100,000 IU (blue) and 200,000 IU (red)) administered to children attending the event (example provided in Appendix Ei). Data from these tally sheets are summarised daily to approximate coverage for the number of children who received vitamin A supplements

(example provided in Appendix Eii). Generally, the number of 100,000 IU doses delivered is used to estimate the number of children 6-11 months of age who received vitamin A and the number of 200,000 IU doses delivered is used to estimate the number of children 12-59 months of age^a. Tally sheets are sent to the district manager within a specified time period after the event to produce a coverage estimate for each age group and each semester. Paper-based systems are still the norm, but more and more SMS and other technologies are being piloted to improve upon the data transfer during events.

FOR BOTH DISTRIBUTION METHODS: Where reports from a sub-district level have not been received as expected or are incomplete, timely follow up action should be taken by the district VAS manager.

Recording of vitamin A supplements on child health cards is recommended. However, depending on national guidelines and on the availability and format of health cards, receipt of vitamin A (date of delivery and dose) may or may not be accurately recorded. Therefore, until child-centred monitoring standards are implemented and met, child health cards may not be relied on as a data source for VAS coverage.

a. This estimation of coverage by age group does not apply in situations where either two 100,000 IU capsules are given to children 12-59 months of age, or where part of a 200,000 IU is given to children 6-11 months of age.

However it has no operational application and is not required at the district level.

At the district level the focus is on **achieving optimal coverage of all 6-59 month olds with one dose in each semester in all administrative areas**. For effective district-level programme monitoring and management, to identify shortfalls, and to make corrections to improve coverage in subsequent semesters, the main indicators of interest are semester-based coverage of all eligible children by age group, location (administrative area), supplement dose, and delivery mechanism.

Key rationale for how and why the factors (semester, age group, delivery mechanism) and the denominator used to calculate coverage, may affect the validity and reliability of VAS coverage data are provided below.

MONITORING BY SEMESTER

Monitoring by semester is necessary so that:

- Managers know what proportion of children are receiving their age-appropriate dose in the time period in which they need it.
- Data can be used in a timely way at the district level, to ensure corrective action can be taken as needed in time for the subsequent semester. For instance the district management team may need to plan extra efforts to reach more children if the data illustrate that more than 20 percent of target infants and children were left out in the previous semester.

MONITORING BY AGE GROUP

Monitoring by age group (6-11 months and 12-59 months of age) is necessary to ensure all infants and children are receiving their age-appropriate dose of vitamin A, and unless the data is collected and analysed separately, disparities in coverage between age groups may not be detected. In addition, the corrective action required often differs by age group. Coverage by age group is often linked to the delivery mechanism so these factors are also considered together below.

MONITORING BY DELIVERY MECHANISM

Text Box 1 in Section 1 describes the two main vitamin A delivery mechanisms: event-based delivery and routine health system contact. In some cases these mechanisms are not well coordinated and often have separate recording and reporting systems (see Text Box 4 for a more detailed description of VAS recording and reporting for each delivery method¹⁴). Current practice therefore is to capture VAS by delivery mechanism, within each of the age groups (infants 6-11 months of age and children 12-59 months of age) for each semester.

The relative importance of routine health system contact versus event-based delivery of vitamin A will vary according to national and district strategies; however, many countries include some combination of both delivery methods and coverage through each must be monitored separately. Examples of different delivery scenarios are:

14. Examples of recording and reporting forms for each type of delivery method are provided in Appendices F(i)-F(v) (routine) and G(i)-G(ii) (event).

i. Event-based coverage (primary delivery mechanism) with on-going delivery through routine health system contacts. The primary delivery mechanism aimed at achieving high VAS coverage may be via biannual events for all children 6-59 months of age, however delivery through routine health system contacts always continues with the aim of increasing overall coverage, this is often particularly effective for infants 6-11 months of age who attend health facilities for the recommended infant immunisation series.

ii. Routine health system contact (primary delivery mechanism) with periodic event-based delivery. The primary delivery mechanism may be through routine health system contacts however opportunities may arise to integrate VAS with a periodic event, such as a supplementary immunization activity (SIA) for measles, or other health event targeted to the VAS target age groups in any given semester.

iii. Primary delivery mechanism varies by age group. The primary delivery mechanism may differ by age group: infants 6-11 months of age may receive VAS mainly through routine health system contacts (often with measles vaccination at around 9 months of age or at a 6 month contact point specifically for VAS); while children 12-59 months of age may receive VAS mainly through biannual events designed to access this specific age group with interventions such as VAS and deworming.

TEXT BOX 5

AN EXAMPLE OF THE EFFECT OF USING DIFFERENT DENOMINATORS

EXAMPLE SCENARIO – Health facilities may use locally determined denominators which are often, but not always, higher than district-sourced denominators for each administrative area. District-level managers would therefore report higher coverage based on routine VAS when compared with health facility estimates.

POSSIBLE OUTCOMES – If health facility estimates are more accurate than district level:

- a. This may result in a failure by district managers to identify a coverage shortfall and to initiate the required follow-up to identify and correct the cause.
- b. The district level management team could underestimate VAS-related supply requirements for the next semester, potentially leading to a shortage or stock-out of supplements.

A similar scenario can be envisaged if a district uses a nationally provided census-based denominator, which is different from a district or lower administrative level-derived denominator. This could lead to insufficient or excess resources for the whole district, depending on which denominator is higher.

The use of different delivery and recording methods presents challenges for monitoring coverage. In settings where VAS is implemented through routine health system contacts and event-based delivery, adding numerator (supplements delivered) data from each source to estimate coverage could result in double counting of some infants and children who may have received supplements through both delivery methods. Therefore, the best method to estimate coverage is to report semester level estimates for each delivery mechanism and for each age group separately.

TIMELINESS AND COMPLETENESS OF SUB-DISTRICT REPORTS

To manage the programme on a semester by semester basis, prompt receipt of complete data is necessary for reliable coverage estimation, timely programme review, in-depth investigation into low coverage areas, and implementation of corrective actions. Minimum standards for timeliness of reporting to each administrative level should be well defined in the national VAS Programme Guidelines.

In situations where data for a particular period, or sub-district are late, the late report should be included in an addendum to the Semester report submitted to national level. Data submitted late should not be rejected or ignored, but should be used to update the existing data at all levels.

Incomplete reporting, where some sub-districts may not send a report or else send a report that does not cover all administrative areas, makes it difficult to calculate representative district level coverage. All efforts should be made to receive timely reports from 100% of sub-districts, however it is often the case that some will still be incomplete.

SELECTING TARGET POPULATION DENOMINATORS AND CHALLENGES WITH DENOMINATORS

An accurate denominator (number of eligible children) is important for deriving precise estimates of coverage as well as for accurate planning of district and sub-district requirements for supplies, budget and other resources. Therefore, it is important to be aware if multiple denominators are being used at different levels (typically for different purposes). When multiple denominators are being used, the sub-district and national levels must agree on a denominator to be used in determining overall planning needs, as well as those to be used to calculate, and report coverage data.

Different delivery mechanisms may use different methods to estimate their target number of eligible children. For example, the denominator for a National Immunisation Day (NID) event for a specific age group in a given area is likely to be higher than the equivalent denominator for a Child Health Day, or one that is used for routine health services. This is because the standard of practice to establish a target for NIDs is to use the number of children immunised

in the previous round, and this may include children outside of the administrative area and/or intended age group. In contrast, the denominator for VAS delivered through routine health services is most often the official population estimate for the administrative area. This point further reinforces the need to monitor and report coverage by delivery mechanism and not combine the results.

Inconsistencies in the estimated number of eligible children between district and facility levels, and/or between district and national level may also arise due to differences in data sources for the population estimates. The use of denominators based on out-dated national census versus more up-to-date, locally derived denominators may cause difficulties. Sudden fluctuations in population numbers due to migration into and out of an administrative area can also mean that the official population estimates are inaccurate, and efforts to derive a more up-to-date estimate through home visits and other methods to update birth and other health-related registries can be helpful especially for planning purposes.

An example of the potential impact of using different denominators to calculate coverage at district level is described in more detail in Text Box 5. The potential consequences of using different denominators at district and national levels are addressed in the Guide for National VAS Managers.

The denominator to be used for reporting coverage however may be determined at national, district or sub-district level, depending on national guidelines and/or specific context. For this reason, it is recommended that the data source and decision process for selection of the denominator be presented along with both the number of children reached with VAS (numerator) and the denominator used in order to avoid misinterpretation.

KEY POINTS

In many settings it is difficult to accurately estimate the total number of infants 6-11 months of age and children 12-59 months of age. Different data sources exist and different sources are often used for different VAS delivery methods. With this uncertainty, district VAS managers should:

- Determine the denominators to be used at the district level for VAS planning and coverage reporting (for each delivery method separately) and communicate this to sub-district and national managers.
- Always report the denominator source used for district VAS planning and for coverage calculations for each delivery method.
- Clearly state any potential limitations of using the district denominator when reporting and interpreting district VAS coverage data.
- Report coverage for each delivery method separately.



4.1.1**DETERMINING VAS COVERAGE ESTIMATES**

Sub-district level data should be received from each administrative area each semester (either in the form of monthly reports or as an end of semester report). These reports should include data compiled from all reporting facilities within the area, for each delivery mechanism (routine health system contacts and event-based) and for each age group (6-11 months of age and 12-59 months of age) separately. In other words, the district manager should have received the following information from each sub-district, within the national VAS guideline-defined time period after the end of each semester:

- 1.** For routine health system contact delivery (usually reported from sub-districts and onto national level on a monthly basis):
 - a.** The number of children 6-11 months of age reached with vitamin A supplements (numerator data) through routine health system contacts.
 - b.** The number of children 12-59 months of age reached with vitamin A supplements (numerator data) through routine health system contacts
- 2.** For event-based delivery (usually reported from sub-districts and onto national level on a semester level basis):
 - a.** The number of children 6-11 months of age reached with vitamin A supplements (numerator data) through events.

- b.** The number of children 12-59 months of age reached with vitamin A supplements (numerator data) through events.

At the end of each semester the district manager should calculate semester-level coverage for each delivery method and age group separately using the sum of above numerator data for the semester and the following denominator data:

- 1.** For routine health system contact delivery:
 - a.** The target population of children 6-11 months of age determined for VAS through routine health system contacts.
 - b.** The target population of children 12-59 months of age determined for VAS through routine health system contacts.
- 2.** For event-based delivery (usually reported from sub-districts and onto national level on a semester level basis):
 - c.** The target population of children 6-11 months of age determined for event-based VAS delivery.
 - d.** The target population of children 12-59 months of age determined for event-based VAS delivery.

The district VAS programme staff should review these data in a timely manner in order to quickly identify and respond to discrepancies and programme challenges within and across sub-districts and to follow-up with the sub-district team(s) in a timely manner. Part of the review should be a comparison with the same data from previous semesters.

The denominator used to calculate coverage for each delivery method should always be that which is associated with the numerator. For example, if the numerators for event-based delivery are from a National Immunisation Day (NID), then the denominator should be the target population of eligible children for the event; in other words, the denominator should be the target used to determine supply and other planning needs for the NID. Similarly, if the numerators are from routine health system delivery, then the denominator should be the one associated with routine health system contacts.

To produce overall district-level semester-specific VAS coverage estimates through **routine health system contacts for children 6-11 months of age**, follow these steps:

- 1.** Ensure complete data are reported from all sub-districts for the number of children 6-11 months of age reached with vitamin A supplements through routine health system contacts for all months during the semester (numerators). Based on the agreed-upon denominator, check whether sub-district reports reflect at least 80% of the number of children 6-11 months of age planned to be reached through this delivery method in each sub-district. If ‘yes’, proceed with the coverage calculation (step #2), but still follow up with any sub-districts not sending complete reports. If ‘no’, make additional efforts to obtain more complete sub-district reports before proceeding to step #2, calculation of district level VAS coverage for the semester for this age group.

- 2.** Sum the numerator data for routine health system contact delivery of vitamin A supplements for children 6-11 months of age for the given semester from all sub-districts.
- 3.** Divide the sum of the numerators from all sub-districts by the agreed-upon district-level denominator for vitamin A delivery to children 6-11 months of age through routine health system contacts.
- 4.** Multiply this value by 100%. The resulting value is the district level semester-specific vitamin A supplementation coverage achieved through routine health system contacts for children 6-11 months of age.

Semester-specific routine health system VAS coverage

Σ (across all sub-districts): number of children 6-11 months of age reached with vitamin A supplements through routine health system contacts during the semester

Agreed-upon district-level denominator for children 6-11 months of age for delivery of vitamin A through routine health system services

x100

Repeat the same steps for **children 12-59 months of age to obtain district level coverage data through routine health system contacts** for this age group.

To produce district level semester-specific VAS coverage estimates for **event-based delivery for children 6-11 months of age**, follow these steps:

- 1.** Ensure complete data are reported from all sub-districts for the number of children 6-11 months of age reached with vitamin A supplements through event-based delivery (numerators). Based on the agreed-upon denominator, check whether sub-district reports reflect at least 80% of the number of children 6-11 months of age planned to be reached through event-based delivery. If 'yes', proceed with the coverage calculation (step #2) but still follow up with any sub-districts not sending complete reports). If 'no', make additional efforts to obtain more complete sub-district reports before proceeding to compute district level VAS coverage for the semester for this age group.
- 2.** Sum the numerator data for event-based delivery of vitamin A supplements for children 6-11 months of age for the given semester from all sub-districts.
- 3.** Divide the sum of the numerators from all sub-districts by the agreed-upon district-level denominator for vitamin A delivery to children 6-11 months of age through the specific event-based delivery.
- 4.** Multiply this value by 100%. The resulting value is the district level semester-specific vitamin A supplementation coverage achieved through event-based delivery for children 6-11 months of age.

5. Semester- specific event-based VAS coverage, for children 6-11 months of age

Σ (across all sub-districts): number of children 6-11 months of age reached with vitamin A supplements through event-based delivery during the semester

x100

Agreed-upon district-level denominator for children 6-11 months of age for delivery of vitamin A through event-based delivery

Repeat the same steps for **children 12-59 months of age to obtain district level coverage data through event-based delivery** for this age group.

In accordance with local guidelines for reporting formats and timelines, all data for the district should be sent to the national level manager responsible for VAS. Include clear indication of separate coverage estimates by delivery method for each age group. Include the actual data (numerators and denominators) used to make the calculation, with indication of the source of data used for the denominator(s).

Review and maintain reports for all data, from both routine health system contact and event-based delivery for both age groups separately. This information should be assessed along with monitoring of other programme indicators, to identify any weaknesses in either or both vitamin A delivery methods and to inform future VAS programme plans. These data will also be important for any programme assessment and data verification exercise, which may be requested by the national manager.

The delivery strategy to reach the two age groups (6-11 months of age and 12-59 months of age) may differ from place to place. For the purpose of illustration, Appendix D includes detailed tables for each of three potential scenarios described below:

Scenario 1: Both age groups are targeted to receive vitamin A through both routine health system contacts and event-based methods in the same semester. In this scenario, the district manager will calculate four coverage estimates for the district:

- i)** Coverage of 6-11 month olds through routine health system contacts
- ii)** Coverage of 12-59 month olds through routine health system contacts
- iii)** Coverage of 6-11 month olds through event-based delivery
- iv)** Coverage of 12-59 month olds through event-based delivery

Scenario 2: Children 6-11 months of age are targeted to receive vitamin A through both routine health system contacts and event-based methods, but children 12-59 months of age are targeted to receive vitamin A only through an event during the semester. In this scenario, the district manager will calculate three coverage estimates for the district:

- i)** Coverage of 6-11 month olds through routine health system contacts
- ii)** Coverage of 6-11 month olds through event-based delivery
- iii)** Coverage of 12-59 month olds through event-based delivery

Scenario 3: Children 6-11 months of age are targeted to receive vitamin A through routine health system contacts only, and children 12-59 months of age are targeted to receive vitamin A through an event only during the semester. In this scenario, the district manager will calculate two coverage estimates for the district:

- i)** Coverage of 6-11 month olds through routine health system contacts
- ii)** Coverage of 12-59 month olds through event-based delivery

KEY POINTS

- All efforts should be made to achieve 100% complete reporting of VAS data from all sub-districts.
- Target population data source (i.e., denominator data source) should be the appropriate denominator for the delivery mechanism associated with the numerator.

4.2**PROGRAMME ACTIVITY AND OUTPUT INDICATORS****PROGRAMME (ENABLING) ENVIRONMENT**

Monitoring the enabling programme environment for vitamin A supplementation requires the collection of data for indicators related to policies, work-plans, and budget allocation. The degree to which deciding on and monitoring these particular indicator goals is a district level responsibility that will vary between countries, usually based on the extent of decentralisation. Where programme management is highly centralised, some of the indicators under this heading may be monitored solely from the national level.

The National VAS Monitoring Guide includes some policy-level indicators that are not included here (e.g. “National VAS policy defining the programme goals exists”) since these are the responsibility of the national VAS manager/management committee. It is important, however, that district personnel are aware of the relevant policies and that the district manager responsible for VAS understands their role in achieving the defined national programme goals.

There are five logframe indicators (1.1, 1.2, 1.3, 1.4 and 1.5) linked to an enabling programme environment that are usually managed and measured at least in part at the district level. These are listed in Table 5. Each indicator is described in more detail in Appendices B and C.

TABLE 5
PROGRAMME ACTIVITY AND OUTPUT INDICATORS RELATED TO PROGRAMME ENVIRONMENT¹⁵ – LOGFRAME NUMBER, INDICATOR AND COMPONENT INDICATOR TITLES

- 1.1** A recognised VAS-related management and coordination group uses data for planning at the district level, according to national guidelines.
 - a.** VAS-related management and coordination group with defined responsibilities exists
 - b.** Administrative data and supervision reports were used to plan for VAS for the following semester
- 1.2** District VAS work-plan exists for the forthcoming year with estimated semester-level needs for both routine health system and event-based distribution of VAS:
 - a.** Supplies (VAS supplements)
 - b.** Supplies (non-supplements)
 - c.** Human resources
 - d.** Budget
- 1.3** The district Public Health Care (PHC) system budget includes sufficient allocation for VAS programme costs.
- 1.4** All VAS events and routine health system distribution in the last semester were conducted according to the VAS micro-plan.
 - a.** VAS events started on the planned date
 - b.** VAS outreach from health facilities (routine health system contacts) conducted as planned
 - c.** Health facilities implemented VAS via routine health system contacts continuously as planned
- 1.5** Coverage reports have been submitted to district level from all administration areas for all VAS activities, as per national guidelines.

¹⁵. The degree of district level management responsibility for these indicators may depend on the level of decentralisation

Assessing the adequacy of district plans and budgets for VAS and their integration into the public health care system would be expected as part of any annual review of district-managed responsibilities for child health. An example of a tool used to plan budget and resource requirements is shown in Appendix F. Lessons learned from the review should be used to make adjustments to programme management plans for the following year.

When caregivers have been mobilised to attend a scheduled event or outreach visit, a date change is likely to decrease attendance at the newly scheduled event or visit, as well as decrease motivation for future events/visits.

Timely (end of semester or more frequent) reporting of VAS coverage data to districts allows district managers to assess and investigate any areas that might be contributing to lower than expected coverage. When reports are not submitted in the required time period, it limits the manager's ability to quickly investigate and correct problems before the subsequent semester VAS planning and implementation starts. Delayed reporting to the district then delays submission of the summary district report to national level, which potentially prevents timely amendment to factors such as the number of VAS supplies sent from the national level.

SUPPLIES

Adequacy of vitamin A supplements and of other supplies required for successful VAS and reporting are essential prerequisites to achieving coverage of all eligible infants and children with the correct vitamin A dose and recommended frequency.

District managers should estimate supply requirements for both routine health system contacts and event-based delivery, even where nationally-estimated figures exist, and be ready to take timely corrective action in the case of stock-out of any essential supply item, including vitamin A supplements. When problems do arise, supply-related indicators should be compared with planning estimates, and with coverage and supervision reports; then amendments should be made for subsequent semesters. It may be necessary to examine supply-related issues through further local investigation and/or a verification process (see Section 5) to help determine the cause(s) and any necessary follow-up actions to prevent these issues in the future.

Monitoring available supplies for VAS involves collection of data related to stocks of usable supplements (e.g. unexpired and in good condition) for each dose, and the availability of other supplies necessary for delivery and recording of vitamin A (determined according to national guidelines). Supply-related logframe indicators (1.6, 1.7 and 1.8) are shown in Table 6.

Data sources for these indicators are generally supervision reports or other similar reports for event-based delivery, and from monthly health facility reports for routine health system contact delivery. Monitoring of non-supplement supplies may be more relevant for event-based delivery and the need for an assessment would usually be triggered by supervision and/or coverage reports indicating that this was a problem. Non-supplement supplies from fixed site facilities may be used for more than one programme activity and are, therefore, more likely to be generally available and/or supplied using other resources. Where it becomes apparent that non-supplement supplies may be a constraint to effective functioning of vitamin A delivery through routine health system contacts, an additional indicator, similar to the current indicator 1.8, should be added to the logframe to reflect this.

Various methodologies exist for collecting and reporting supply provision data. Examples include health facility observations as well as mobile technology-based information systems that allow vitamin A stock levels and predicted requirements to be reported via an SMS message. Data collection tools to obtain the information required to generate each of the indicators may differ by country and by distribution method (event-based versus routine health system contacts). For reference, an example of a health facility supply report form is provided in Appendix G.

TABLE 6

PROGRAMME OUTPUT INDICATORS RELATED TO SUPPLY INDICATORS – LOGFRAME NUMBER, INDICATOR AND COMPONENT INDICATOR TITLES.

1.6 All routine health system VAS activities had sufficient stocks of appropriate vitamin A supplements (including for handling losses, etc.) to supplement 6-59 month olds at all times in the previous month.

a. Health facilities with sufficient stocks of 100,000 IU capsules in the past month, for routine health system facility-based and outreach delivery of VAS

b. Health facilities with sufficient stocks of 200,000 IU capsules in the past month, for routine health system facility-based and outreach delivery of VAS

1.7 All VAS events had sufficient stocks of appropriate vitamin A supplements (including for handling losses, etc.) to supplement 6-59 month olds at all times in the previous semester.

a. VAS events with sufficient stocks of 100,000 IU capsules in the past semester

b. VAS events with sufficient stocks of 200,000 IU capsules in the past semester

For both 1.6 and 1.7: where other forms of supplements, not capsules are used, this indicator should refer to vitamin A supplements in general rather than specific capsule types. Similarly, when only one dose type is divided or multiplied to adapt it for use in both age groups, the indicator should be adjusted accordingly.

1.8 All VAS events had sufficient quantities of other (non-supplement) supplies listed in VAS micro-plan (e.g. scissors, reporting forms, etc.) to implement supplementation activities for target infants and children for the previous semester.

HUMAN RESOURCES

Adequacy of human resources – their capacity and timeliness of service delivery – is an additional requirement to achieving VAS coverage of all eligible infants and children with the correct dose and recommended frequency.

District level management should aim to:

- Verify personnel requirements
- Provide adequate training and supportive supervision
- Establish and communicate VAS schedules and targets
- Recognise good practice
- Provide support and direction when corrective action is needed

Effective monitoring of human resource capacity and availability helps ensure that VAS proceeds according to national guidelines and, where the minimum standard of service is not met, contributes information for further investigation and amendments to address the problems identified. Human resource-related logframe indicators (1.9, 1.10, 1.11 and 1.12) are shown in Table 7.

Monitoring human resource indicators requires collection of data related to personnel numbers, adequacy of training and supervision, and to the timeliness of VAS. If personnel for indicator 1.9 (supervisory support team) are in place, then collection of data for the other indicators should be more straight forward, timely and reliable.

TABLE 7

PROGRAMME ACTIVITY AND OUTPUT INDICATORS RELATED TO HUMAN RESOURCE INDICATORS¹⁶ – LOGFRAME NUMBER, INDICATOR AND COMPONENT INDICATOR TITLES

1.9 An established supervisory support team provides support to VAS at the district level, as per national guidelines.

1.10 Personnel involved in distributing VAS (event and routine health system contacts) have been routinely trained/given refresher training, as per national VAS guidelines.

- a.** New personnel (training of personnel who started within the past 6 months)
- b.** Existing personnel (refresher training within the past 6 months)

1.11 Personnel involved in distributing VAS (event and routine health system contacts) meet minimal knowledge criteria for VAS, as per national guidelines.

This indicator may not be feasible to measure in all situations without programme amendments; it requires supportive supervision to be in place and/or some type of qualitative verification assessment.

1.12 All VAS distribution sites had sufficient human resources (as described in the VAS micro-plan) to implement VAS activities for target infants and children for the previous semester.

- a.** VAS events with sufficient human resources in the past semester
- b.** Health facilities with sufficient human resources for VAS in the past semester

16. VAS personnel includes anyone involved in VAS, e.g. health workers/other national staff, or volunteers.

Data sources to monitor human resource indicators are varied, e.g. training reports, job descriptions, and supervision reports. Appendix H provides an example of a supportive supervision checklist.

Selection and inclusion of these human resource indicators for each round of monitoring should be determined based on whether other data suggest weakness in these areas is a likely cause of low coverage. Most should be included as part of an annual review process.

DEMAND/SOCIAL MOBILISATION

Social mobilisation is essential for high attendance at child health events and to motivate caregivers to bring an eligible child to a health facility for routine health system VAS. As such, it is a key factor in achieving high coverage and should be monitored whenever supervision or coverage reports indicate that attendance is a problem.

Resource requirements and guidance for social mobilisation should be defined in national guidelines and in annual district planning documents. These should be referred to when monitoring expected social mobilisation activities and impact.

TABLE 8

PROGRAMME OUTPUT INDICATORS RELATED TO SOCIAL MOBILISATION INDICATORS – LOGFRAME NUMBER, INDICATOR AND COMPONENT INDICATOR TITLES

- 1.13** Social mobilisation activities conducted in accordance with national and/or district plans.
 - a.** Social mobilisation activities conducted in line with plans/micro-plan.
 - b.** Caregivers attending events recall key messages of the social mobilisation activities described in the plans.
 - c.** Caregivers not attending events recall key messages of the social mobilisation activities described in the plans (only monitored when additional verification activity implemented).

Monitoring the effectiveness of social mobilisation involves assessment of community awareness and caregiver motivation to bring an eligible child to a VAS event and/or for routine health system VAS. The main logframe indicator for social mobilisation (1.13) is shown in Table 8.

Monitoring caregiver access to, and recall of, social mobilisation messages can be conducted during an event (as a component of supervisory support); however, this only captures information for caregivers who are already attending an event. Other methods, such as focus group

discussions and post-event surveys can be used where attendance (for either event-based or routine health system delivery) is identified as a problem. More in-depth, post-event verification processes can be initiated and conducted from either the district or national level, depending on the situation. This is discussed in more detail in Section 5. An important component of any additional evaluation is exploratory work to understand and address any barriers preventing caregivers from bringing a child for VAS or from using health services in general.

4.3

IMPROVING COVERAGE AND PROGRAMME DATA COLLECTION AND USE: SUPPORTIVE SUPERVISION, REVIEW MEETINGS AND M-HEALTH APPLICATIONS

The following sub-sections describe methods for:

- a)** Supportive supervision
- b)** Review meetings
- c)** Collection of data using mobile technology

These methodologies can result in improved information and performance, quality of data collected, and confidence in the validity of resulting information.

4.3.1 SUPPORTIVE SUPERVISION

Supportive supervision is a supervisory approach that focuses on direct, personal contact on a regular basis to problem solve and motivate staff. It is often used as a form of on-the-job training intended to strengthen the quality of service delivery¹⁷.

National Guidelines will include recommendations on supportive supervision of events and possibly of outreach at the district level. Best practices for supportive supervision include the use of pre-developed checklists based on the delivery guidelines for the event and the type of social mobilisation activities implemented in the district. For example, a district level nutrition officer may provide supportive supervision at either 10 randomly selected event-based distribution sites or at 10 distribution sites identified as low performing during the last event. A similar selection of outreach sites could also be made.

The supportive supervisory visit checklist usually includes observation-based categories for:

- The organisation of the event
- Adequacy of staff and other non-vitamin A resources
- Timeliness of service delivery
- The availability of vitamin A supplies against district guidelines.

An example is provided in Appendix H. In addition, the nutrition officer will observe a minimum of 10 caregivers with their children and note the delivery and receipt of services (including VAS) to these children, as per district guidelines. After a selected caregiver and child receive all available services, the nutrition officer will ask the caregiver to participate in an

17. USAID. Management science for health, supportive supervision to improve integrated primary health care; Washington, DC: USAID; 2006. Occasional Paper No. 2.

exit interview during which the reliability and effectiveness of social mobilisation activities can be assessed (Indicator 1.13a and b), including the most effective methods for communication.

Programme indicators related to VAS staff knowledge and capacity (indicators 1.11 and 1.12a) are further outputs from the supportive supervision process, based on staff observation and interviews.

Data collected through supportive supervision should be used immediately by district managers to correct practices and knowledge gaps, as well as to address any issues such as stock-outs, during the event or outreach activity. These data should also be used to inform subsequent staff training and improve social mobilisation strategies. Most importantly, the data can help determine which distribution sites may be low performing and require additional support in specific areas.

4.3.2 REVIEW MEETINGS

Regular review meetings are an important factor to enhance performance and are conducted regularly for all health programmes in some countries. Review meetings are held at the district level to review programme performance (including for VAS), share experiences, and solve problems. They are

usually conducted every quarter using a standard set of indicators and procedures, which result in an improved action plan for the subsequent semester.

District teams use the VAS coverage reports to discuss the achievements of health facilities and events and then to assess ways to address problems faced by low performing facilities and events.

The review meeting serves as a tool to rank the administrative areas by VAS performance, which serves to identify areas most in need of support. It also creates a sense of achievement among well-performing areas. The experiences of supervisors from health facilities that have performed well are shared with others to learn from potentially innovative practices.

4.3.3 MHEALTH APPLICATIONS

mHealth is a collective term which applies to the use of mobile technology in existing health delivery platforms to improve effectiveness. mHealth applications are useful in addressing challenges in areas such as communication, reporting, behaviour change and awareness.

The use of mHealth should be designed to meet identified programme challenges and should only be considered where sufficient resources to establish and maintain the system are available. The use of personal phones by health workers to send data by SMS is a low cost and simple first step. Examples of where m-health may be most applicable to the monitoring and implementation of VAS programmes are:

- Stock reporting and monitoring mHealth can be used to improve tracking of supplies and deliveries of vitamin A capsules and other essential supplies. Using either SMS or pre-built forms with smart phones, stocks can be monitored at each transit point, using a coding system, as they are transferred to the health centre. Additionally, health centres can use SMS to record remaining stock and need for additional stock in real time. These systems can eliminate wastage throughout the transfer process and help ensure that health centres receive stock in a timely manner.
- Behaviour change communication (BCC) and social mobilisation

For example, prior to a VAS event, either blanketed or targeted messaging could be sent with key information on the event, including when it will take place, who should attend, where it will be held and what will be received. These messages may be made either through SMS or through Interactive Voice Response in areas where literacy is low. To increase effectiveness,

it is recommended that the messaging is targeted to key community members such as community health workers, community leaders and religious leaders who can then mobilise the community to attend.

If mHealth systems are used as soon as children receive their first vaccinations to register the child's date of birth, parent's phone number and other details (via SMS or a form-based system using smart phones), then SMS reminders to receive VAS can be sent to their caregiver and community health worker when children reach 6 months of age and every 6 months thereafter.

The decision about the technology to use for collection of data is more likely to be made at the national level therefore more detailed information is available in the National Guide, however, it is important for all management staff to understand the reasons why these methods may be employed.

SECTION 5



SYSTEMATIC ASSESSMENT OF PROGRAMME AND COVERAGE DATA TO DETERMINE WHERE ADDITIONAL INVESTIGATION AND VERIFICATION ARE REQUIRED

The systematic assessment of monitoring data will inform programme strategy, help determine the cause of any problems or inconsistencies, and identify where additional data verification is required.

PURPOSE OF A SYSTEMATIC ASSESSMENT EXERCISE

- i. To assess the quality of monitoring data
- ii. To identify specific gaps in programme implementation or available data
- iii. To verify reported VAS coverage
- iv. To recommend additional verification of data during subsequent semesters where needed

ASSESSMENT OF MONITORING DATA

Review and assessment should be done by the VAS management and coordination group which usually includes the district health management team and implementing and/or supporting partners. Monitoring data for both programme and coverage indicators should be reviewed and its quality should be assessed including for timeliness, completeness and confidence in the data. The sources of these data are given in the logframe and expanded logframe indicator tables (Appendices B and C).

The initial question should be, "Are we confident in the coverage data?" Examples of further questions include, "Is the estimated coverage in line with previous semesters for the same/similar distribution mechanism, with that of other co-delivered interventions, and with programme implementation data (for human resources, supplies, social mobilisation, etc.)?" and "Is it believed to be indicative of the overall status of the VAS programme in the district?"

If the VAS management group is not satisfied that the data represents the actual situation for coverage and/or programme implementation, then additional investigation should be conducted.

Assessment data should always be checked against data from previous semesters to check that there is a gradual trend or consistency in findings. Any sudden change in either programme implementation or coverage indicates the need for additional investigation.

FIGURE 2

**OUTCOME OF VAS MANAGEMENT GROUP ASSESSMENT
OF COVERAGE AND PROGRAMME PERFORMANCE DATA AND
RELATED RECOMMENDATIONS FOR FOLLOW-UP**

HIGH → COVERAGE INDICATORS	CELL A: DATA SUGGEST Poor Implementation yet High Coverage Suggest further investigation with health facilities and/or event-based teams where data are poorest. If reasons behind data discrepancies are still unclear, suggest a routine data quality assessment during the next semester to determine where in the data collection process the problem occurred.	CELL B: DATA SUGGEST Strong Implementation and High Coverage No verification assessment suggested
CELL C: DATA SUGGEST Poor Implementation and Low Coverage No verification assessment suggested	CELL D: DATA SUGGEST Strong Implementation yet Low Coverage Suggest further investigation with at least 10 poor performing health facilities and/or event-based teams through key informant interviews and focus groups to determine the reasons behind data discrepancies.	
POOR → PROGRAMME IMPLEMENTATION INDICATORS → STRONG		

There are many ways to address the findings from an assessment exercise and each district will have their own specific knowledge of the situation and related recommendations to improve and sustain the quality of data and implementation.

Figure 2 provides an example illustration of how the outcome of the VAS management review can be categorised and can recommend follow-up actions. The text provides additional detail on possible review outcomes and what they may represent in terms of programme status, data quality and recommended additional investigation.

CELL A: Inconsistent – Data suggests Poor Programme Implementation and yet High Coverage – therefore requires further investigation

- It seems unlikely that coverage would be high in a situation with poor programme implementation, therefore there may be little confidence in the data. Examples of poor implementation may include: insufficient funds allocated to social mobilisation, or stock-outs of supplies.

- Suggested actions are: to confirm results with a few key informants at identified problem health facilities and/or event-based distribution teams. Information should be collected about any perceived problems with implementation or data recording/reporting during VAS and the likely causes. If these investigations reveal issues that explain the data inconsistencies that can be used to improve programme management in future semesters then further verification is probably not required.

If the reasons behind the poor data quality remain unclear it may be useful to conduct a routine data quality assessment during the next semester to determine where the problem occurred in the data collection process.

CELL B: Consistent – Data suggest Strong Programme Implementation and High Coverage – does not require further investigation

- These data are in line with each other and provide confidence that they reflect the actual situation.
- Examples of good practice should be shared with lower performing areas and with the national manager responsible for VAS. Lessons learned should focus on sustaining success.

Assuming that the district team has confidence in the programme and coverage data, no further investigation is suggested.

Text Box 6 gives an example of how verification data were used to develop confidence in the administrative data so that verification surveys were no longer considered as necessary to indicate performance.

CELL C: Consistent – Data Suggest Poor Implementation and Low Coverage – does not require further investigation

- These data indicate that low coverage is probably a result of poor programme implementation.
- Since the coverage reflects the poor implementation, it is suggested that districts intervene and conduct further investigation of programme weaknesses in health facilities, at outreach sites and during events. For example, if indicators reveal that social mobilisation activities were not conducted in a timely manner, district management teams may intervene to ensure that timely training, funding, materials and technical support are provided in the next few semesters to strengthen capacity.

No verification assessment is suggested.

CELL D: Inconsistent – Data suggest Strong Implementation and yet Low Coverage – therefore requires further investigation

- Data indicate good programme implementation however coverage remains low. For example, even though logframe indicators show that social mobilisation activities were conducted on time, health workers were well informed about VAS, and all past rounds of coverage have been high, the coverage for this semester was found to be low.

TEXT BOX 6

EXAMPLE OF WHEN DATA VERIFICATION SURVEYS ARE NOT REQUIRED

Post Event Coverage (PEC) surveys are not always required as a component of the data assessment framework. For example, in Côte d'Ivoire, a PEC survey was implemented after each of the two rounds of health intervention delivery in 2011 and 2012. Both surveys found high correlation between administrative data and PEC data, as well as high and consistent coverage of over 90% for all interventions including VAS.

Administrative data were therefore subsequently accepted as an appropriate and valid source of data for VAS coverage. A PEC survey or other investigation would only be considered necessary if changes were made in the implementation and monitoring of the campaigns or if large, unexpected changes in data were observed.



- The district VAS management group should first consider the accuracy and appropriateness of the denominator used to determine coverage. If significant differences in coverage are found when using local (health facility/event), versus district, versus national denominators then a discussion should be held with all levels to determine the appropriate denominator to reflect the actual situation.
- If the denominator is not the cause of the low coverage, the next step should be to contact a few low performing health facilities and/or event-based teams and conduct key informant interviews to determine what they think could account for these conflicting data. Responses should be used to develop a larger assessment of at least 10 representative health facilities (including outreach teams) and event-based teams to determine the completeness of data reported and other possible reasons for low coverage.
- The problem may be that the quality of the implementation data is poor, and is presenting a falsely positive situation. There may be problems in implementation not captured by the current indicators, and additional monitoring may be required.

TEXT BOX 7

EXAMPLE OF UNEXPECTED SUB-DISTRICT DATA AND FOUR POTENTIAL OUTCOMES FROM SUBSEQUENT ASSESSMENTS

Two adjoining administrative areas reported significantly different coverage following event-based delivery in both areas.

Administrative area 1: coverage for children 12-59 months old: $(3,687/16,243) \times 100 = 23\%$

Administrative area 2: coverage for children 12-59 months old: $(31,510/24,987) \times 100 = 126\%$

Combined coverage for children 12-59 months old in administrative areas 1 and 2:
 $((3,687+31,510)/(16,243 + 24,987)) \times 100 = 85\%$

A follow-up investigation conducted with local area-based VAS personnel to assess the situation in both areas may have found that:

a. There was acceptable motivation (demand) in admin area 1. However, caretakers from this area chose to go to a VAS event in admin area 2 (e.g. due to easier access, or previous problems with stock-out in admin area 1).

b. There was low motivation (demand) in admin area 1; possibly they received different social mobilisation services to admin area 2. Caretakers in admin area 1 therefore did not access VAS in any location.

c. Higher than expected coverage and participation found in admin area 2 could have been due to, e.g. unexpected recent migration into the area, delivery of VAS to children outside the target age-groups that were still recorded on the tally sheets, or an outdated denominator.

d. The situation occurred due to a combination of the above, or other factors.



- Focus groups with caregivers may be needed to determine reasons for low coverage and attendance at the vitamin A supplementation event/health facilities.

Suggest initial investigation of the denominator and completeness of data received, followed by further investigation with low performing health facilities and/or event-based teams to determine the reasons behind the data discrepancies. If no satisfactory reason is found, consider an additional verification exercise to closely monitor programme implementation and data reporting during the next semester.

District level assessments should focus initially on sub-districts where data and/or other indicators suggest they may be the cause of any overall data inconsistencies. Text Box 7 presents an example of data irregularities at the sub-district level and possible findings from additional investigations.

Multiple options for verification are possible. The format and scale of the investigation needs to be discussed and agreed upon by the district VAS management team and/or will be suggested and implemented from the national level. Verification methods initiated at national level usually include survey-based assessments, for example Post Event Coverage Surveys (PECS)¹⁸. This method is described in more detail in the National VAS Monitoring Guide.

The district manager responsible for VAS should discuss with the district management team and with the national manager responsible for VAS to determine the need for a more extensive verification exercise, in particular where initial assessments resulted in the findings described in cells A and D of Figure 2. Where possible, any verification exercise should be combined with an assessment of other child health indicators for more efficient use of resources.

18. PECS is the specific term used for verification surveys implemented by Helen Keller International. Other national and international partners also support this type of verification exercise, for example in combination with the immunisation programme.

Verification initiated and conducted at the district level could include rapid household survey-based assessments such as Lot Quality Assurance Sampling (LQAS)¹⁹. Initially, however, verification is often likely to involve a detailed review and investigation at the point of delivery (health facility or event) to assess and compare the supporting environment, implementation process and reported coverage. Verification methods in this case may involve key informant interviews with supervisory support team members and health facility personnel, and focus group discussions with caregivers. Focus group discussions can be used to identify the more important issues preventing caregivers taking their children for VAS, as well as to identify local relevant terminology and possible solutions. An example of focus group discussion facilitation and consent sheets are provided in Appendix I²⁰.

19. Steps to carry out an LQAS are described in a UNICEF's Guidebook: An equity-focused programming and monitoring approach to enhance district performance for better maternal and child health outcomes. For more information about this Guidebook, contact your country UNICEF office.

20. The example provided is an adapted excerpt from: UNICEF (2012) Assessment of barriers to demand. A guide to assess barriers to key maternal, newborn and child health interventions from the perspective of beneficiaries and to involve them in identifying solutions. UNICEF Health Section, UNICEF New York. For more information, contact your country UNICEF office.

KEY POINTS

- Regular, well-conducted, district assessments of VAS, alone or as part of an assessment including delivery of other health interventions, help emphasise the importance of VAS and provide event-based delivery staff and health facility staff with insight and feedback on how they and the programme are performing.
- Feedback from an assessment should result in improved quality of data recording at delivery and in overall reporting of all logframe indicators, which will improve the reliability and credibility of district coverage estimates.
- These initially desk-based district assessments represent a good use of resources; they identify where in-depth verification exercises are really needed and where alternative (lower resource) approaches may be implemented.
- When monitoring data suggest strong programme implementation along with high VAS coverage there is usually no need to conduct further verification. In this situation, regular desk review of monitoring data and its assessment should continue to ensure that programme success is sustained. In addition, the programme manager may want to identify and promote particularly good implementation practices, particularly those that produce highest equity of coverage.

SECTION 6



ADJUSTMENT AND SUSTAINABILITY OF VAS MONITORING SYSTEMS

Whenever changes to the scope of the VAS programme occur within the country, the monitoring system and use of data need to be reviewed to ensure they are in line with the changes. For example, if recording of VAS becomes more child-centred in the future, then greater emphasis will be placed on child health cards as a data source, making numerator calculations more accurate.

In general, this type of programme amendment and subsequent recommended alteration to guidelines would occur at the national level, therefore it is not covered in detail here. District managers responsible for VAS would be informed of any changes to data collection tools and reporting processes, then any related changes to the logframe should be made at that time.

6.1

SUMMARY OF KEY COMPONENTS AND TOOLS FOR MONITORING VITAMIN A SUPPLEMENTATION

6.1. KEY COMPONENTS FOR VAS MONITORING

- i.** Only collect information that is useful to, and will be used to improve or sustain, the VAS programme.
- ii.** Adapt the logical framework (logframe) to fit with the specific district context (add, delete, or amend indicators). For monitoring, identify and prioritise the key bottlenecks and barriers which affect district level implementation
- iii.** Report coverage from both delivery methods where implemented and estimate semester coverage for each age group and delivery method by district.
- iv.** Report all data and calculations to the national manager responsible for VAS (numerator and denominator, separately for each delivery methods and for each age group).

v. Schedule routine end of semester assessments of key monitoring data and allow for additional reviews where problems are identified mid-semester to facilitate timely programme amendments and improved coverage.

vi. Track programme activity, output and coverage indicators over time to determine areas of weakness in programme implementation and make the required programme amendments. Where needed, conduct further investigation and verification of the information before amending the programme.

6.2

TOOLS FOR VAS MONITORING

The following tools are included in Appendices A-I and may be useful examples for efficient planning, data collection and verification:

- A.** Logic model.
- B.** Logical framework (logframe).
- C.** Detailed description of each logframe indicator for monitoring VAS at the district level.
- D.** Budgeting and planning tool, including a non-supplement supply checklist and micro-plan tool.
- E.** Supportive supervision checklists for observation and exit interviews.
- F.** Routine health system monthly VAS recording and reporting forms for health post, health facility, sub-district, and district level (Ethiopia examples).
- G.** Event VAS registration and reporting forms for reporting to district level (Nigeria examples).
- H.** Supply monitoring form for routine health system VAS.
- I.** Example of Focus Group Discussion facilitation and consent sheets

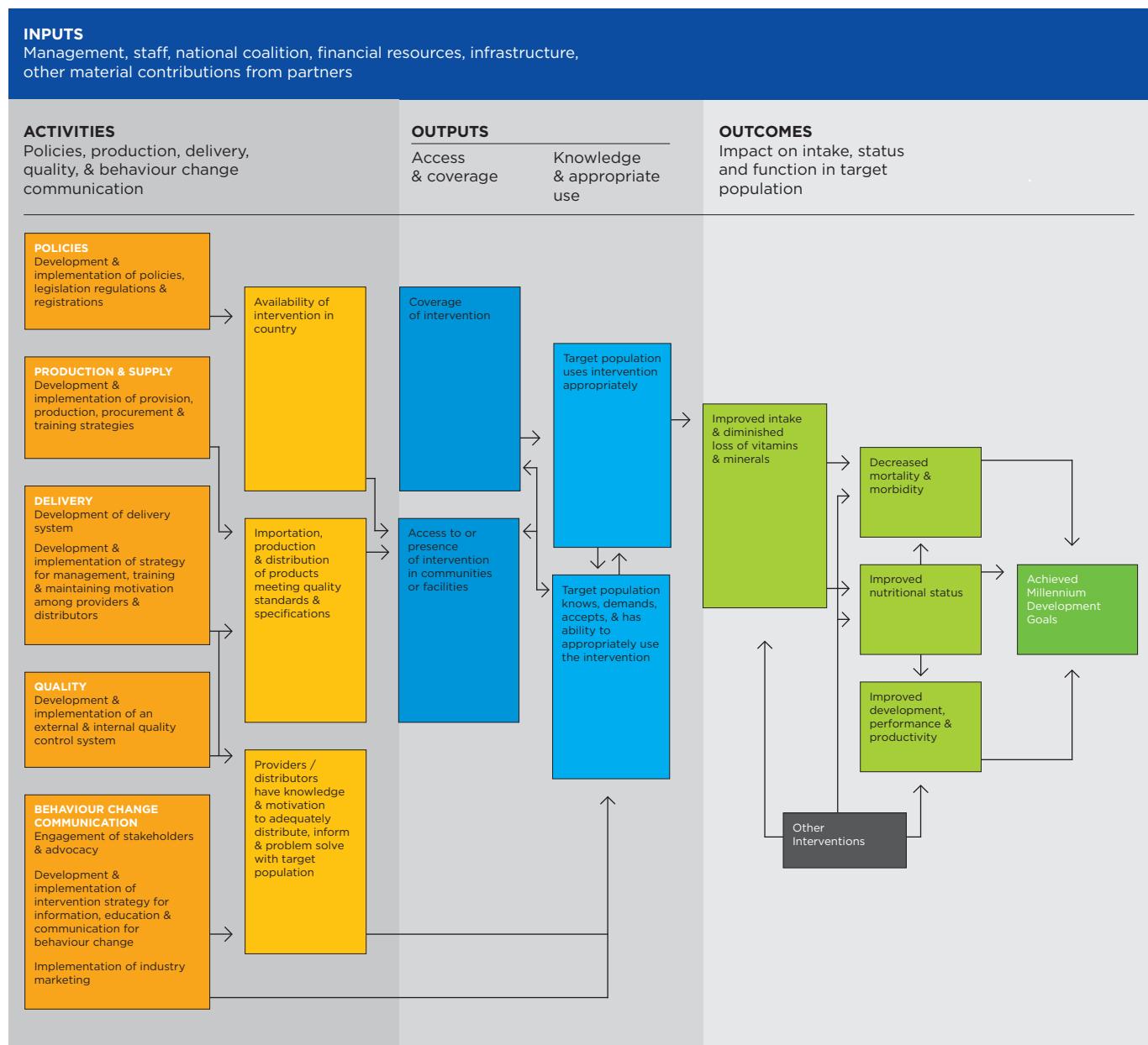


APPENDICES



APPENDIX A

LOGIC MODEL FOR VITAMIN A SUPPLEMENTATION (DISTRICT LEVEL)



←———— EFFECTIVE PROJECT MANAGEMENT & MONITORING AND EVALUATION —————→

APPENDIX B

DISTRICT LEVEL LOGFRAME FOR MONITORING VITAMIN A SUPPLEMENTATION

The logframe refers to vitamin A supplementation with the assumption that these are provided as capsules. Where Vitamin A is provided as a syrup from a bottle, the national and/or district team should change the logframe indicators so apply to this situation.

Indicator Title	Indicators	Operational Definition of the Indicator and Sub-Group Analysis	Indicator Target
PROGRAMME OUTCOME – Semester Review			
Type of indicator: Coverage			
Coverage All infants and children 6-59 months old received an age-appropriate vitamin A supplement in the past semester	a. % of eligible infants 6-11 months of age receiving an age-appropriate vitamin A supplement through either routine health system or event-based vitamin A distribution in the past semester. b. % of eligible children 12-59 months of age receiving an age-appropriate vitamin A supplement through either routine health system or event-based vitamin A distribution in the past semester.	For each delivery method (routine health system or event-based) separately: a. (# eligible infants 6-11 months of age who received a 100,000 IU supplement during the past semester ÷ total # eligible infants 6-11 months of age in the district) x 100 b. (# eligible children 12-59 months of age who received a 200,000 IU supplement during the past semester ÷ total # eligible children 12-59 months of age in the district) x 100 For each age group calculate and report VAS coverage for the district based on data from each delivery method (routine health system or event-based) separately.	a. Target = 100% b. Target = 100%

Monitoring Information Sources & Frequency	Assumptions	Responsibilities and Use of Data	Recommendations
<hr/>			
<p><i>Sources:</i> Tally sheet and/or health facility report forms/HMIS.</p> <p><i>Frequency:</i> Every semester at minimum.</p> <p><i>Ideally:</i> Health facility reports reviewed quarterly.</p> <p>Upon receipt of reports from an event.</p>	<ul style="list-style-type: none"> - Infants and children of both age groups in the district are eligible for VAS. - VAS is implemented through routine health systems and, in some semesters, through event-based delivery systems targeting one or both age groups. - Reliable denominator estimates for each delivery method are available. - There is no overlap in numerator or denominator counts between health facilities. 	<p><i>District manager responsible to:</i></p> <ul style="list-style-type: none"> - Compile sub-district data & calculate semester coverage for the district. - Promote good practices for reaching all infants and children with VAS, among all involved personnel, to optimise coverage. - Request health facilities and event managers to submit VAS reports in accordance with national guidelines. <p><i>Use of Data:</i></p> <ul style="list-style-type: none"> - Use coverage data to identify gaps in VAS implementation. - Take follow-up action to promote and strengthen VAS. - Send numerator and denominator figures to the national level, for each delivery type and each age group. 	<p>This is the key indicator of programme implementation and should be reviewed along with some of the key process indicators below to determine which aspects of the programme are working well and which need strengthening during the following semesters.</p> <p>Close follow-up of VAS coverage estimation is needed every semester</p>

Indicator Title	Indicators	Operational Definition of the Indicator	Indicator Target
PROGRAMME ACTIVITIES AND OUTPUTS – Annual Review			
Type of indicator: Programme Environment			
1.1. A recognised VAS-related management and coordination group uses data for planning at the district level, according to national guidelines. <i>Degree of district level management responsibility may depend on the level of decentralisation.</i>	<p>a. VAS-related management and coordination group with defined responsibilities exists</p> <p>b. Administrative data and supervision reports were used to plan for VAS for the following semester</p>	<p>a. VAS management and coordination group with defined responsibilities exists and functions according to national guidelines. Yes/No</p> <p>b. VAS data are used to determine needs, identify challenges and to plan for VAS in the following semester. Yes/No</p>	<p>a. Target = Yes b. Target = Yes</p>
1.2 District VAS work-plan exists for the forthcoming year with estimated semester-level needs for both routine health system and event-based distribution of vitamin A. a. Supplies (vitamin A supplements) b. Supplies (non-supplement supplies) c. Human resources d. Budget <i>Degree of district level management responsibility may depend on the level of decentralisation.</i>	Work-plan exists with estimated needs for both routine health system and event-based distribution of vitamin A for: <ul style="list-style-type: none"> a. Supplies (vitamin A supplements) b. Supplies (non-supplement) c. Human resources d. Budget 	VAS work-plan exists Yes/No a. District work-plan includes supplement supply estimates for routine health system and event-based distribution Yes/No for routine health system. Yes/No for event b. District work-plan includes non-supplement supply estimates for routine health system and event-based distribution Yes/No for routine health system. Yes/No for event c. District work-plan includes an estimate of human resource needs for routine health system and event-based distribution Yes/No for routine health	Target = Yes for work-plan exists a. Target = Yes for routine health system and Yes for event-based distribution b. Target = Yes for routine health system and Yes for event-based distribution c. Target = Yes for routine health system and Yes for event-based distribution

Monitoring Information Sources & Frequency	Assumptions	Responsibilities and Use of Data	Recommendations
<p>Sources: District VAS management plan and meeting minutes for meeting schedule, roles planned deliverables and use of monitoring data.</p> <p>Frequency:</p> <ul style="list-style-type: none"> a. Annually (unless problems observed) b. Each semester 	<ul style="list-style-type: none"> - Infants and children in the district are eligible for VAS. - A national guideline exists that details the expected composition, role and responsibilities of a district VAS management and coordination team. - There is the risk of bias if a district team monitors itself. 	<p><i>District Manager responsible to ensure that:</i></p> <ul style="list-style-type: none"> - The VAS management and coordination system is in line with national VAS guidelines. -The management group has access to data and the outcome of any data verification exercises from previous semesters. <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Follow up to establish or improve the VAS management and coordination group, as needed. 	<p>Develop a management and coordination team with defined responsibilities, in accordance with national VAS guidelines.</p> <p>Where possible, it should be integrated with other district health and nutrition coordinating groups.</p>
<p>Sources: Review district work-plan for the forthcoming year.</p> <p>Frequency: Annually, or more frequently if problems arise.</p>	<ul style="list-style-type: none"> - Infants and children in the district are eligible for VAS. - The district has a management team (indicator 1.1), the authority to develop a work-plan and the resources to determine its own supply, human resource and budget estimates. 	<p><i>District Manager responsible to:</i></p> <ul style="list-style-type: none"> - Develop and review the VAS work-plan to ensure it is in line with national guidelines. - Estimate supply and other resource needs based on district level forecasting to distribution level (both routine health system and event-based delivery). <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Fill any gaps in the work-plan. - Allocate planned resources to health facilities and event teams. - Re-allocate resources in case of any shortfall where possible. - Investigate reasons for large differences between district and national resource estimates, look at recent actual requirements and use these to develop estimates for the forthcoming year. 	<p>Develop the annual work-plan and estimate of needs with relevant partners, based on requirements from previous years and any known changes in the local population.</p> <p>The plan may be incorporated under the umbrella of the District Operational Health Plan or similar, however it should be assessed as described here.</p>

Indicator Title	Indicators	Operational Definition of the Indicator	Indicator Target	Monitoring Information Sources & Frequency
		<p><i>system. Yes/No for event</i></p> <p>d. District work-plan includes an estimate of budget required for routine health system and event-based distribution</p> <p><i>Yes/No for routine health system. Yes/No for event</i></p>	d. Target = Yes for routine health system and Yes for event-based distribution	
1.3 The district Public Health Care (PHC) system budget includes sufficient allocation for VAS programme costs. <i>Only relevant where budget is decentralised to district level.</i>	Sufficient VAS programme costs allocated in the district PHC system budget.	<p>Sufficient VAS programme costs allocated in the district PHS</p> <p><i>Yes/No</i></p>	Target = Yes	<p><i>Sources:</i> District PHC plan and budget.</p> <p><i>Frequency:</i> Annual or by semester depending on PHC planning cycle.</p>
PROGRAMME ACTIVITIES AND OUTPUTS - Semester Review				
1.4 All VAS events and routine health system distribution in the last semester were conducted according to the VAS micro-plan. a. VAS events started on the planned date. b. VAS outreach from health facilities was conducted as planned. c. Health facilities implemented routine health system VAS continuously, as planned.	a. % VAS events not initiated as planned (in the micro-plan) during the previous semester. b. % VAS outreach (from health facilities) not conducted as planned (in the micro-plan) during the previous semester c. % health facilities where VAS not continuously implemented during	a. (# VAS events not initiated on the planned date ÷ # of planned VAS events in the district during the semester as per micro-plan) x 100 b. (# VAS routine health system outreach not conducted as planned ÷ # of VAS outreach in the district during the semester planned as per micro-plan) x 100 c. (# health facilities with zero distribution of vitamin A for a defined period in the past semester ÷ # health facilities in the district) x 100	a. Target = 0% b. Target = 0% c. Target = 0%	<p><i>Sources:</i> District and sub-district health reports, event tally sheets and supervision reports.</p> <p><i>Frequency:</i> Summarise every semester at minimum.</p> <p><i>Review:</i> every quarter (health facility reports) and upon receipt (event reports).</p>

Assumptions	Responsibilities and Use of Data	Recommendations
<ul style="list-style-type: none"> - Infants and children in the district are eligible for VAS. - The district either manages or has influence over PHC system budget. - The budget is complete and accurately reflects district costs for VAS implementation. 	<p><i>District Manager responsible to:</i></p> <ul style="list-style-type: none"> - Review PHC system documentation to ensure VAS budget is allocated. <p><i>Use of data:</i></p> <p>If budget is not allocated in the PHC system, review and advocate for allocation.</p>	<p>Develop PHC system with reference to national guidelines for VAS delivery.</p> <p>Ensure VAS programme budget is allocated in the district PHC plan. Where centrally planned and managed, verify that VAS programme costs are allocated.</p>
<ul style="list-style-type: none"> - District micro-plans with dates and duration for VAS events and outreach exist and are available. - Health facilities are expected to continuously distribute vitamin A to eligible children attending the facility. 	<p><i>District Manager responsible to:</i></p> <ul style="list-style-type: none"> - Investigate the reason for any delayed or incomplete VAS events or routine health system outreach. - Support VAS distribution teams to keep to the timing and duration stated in the micro-plan. - Investigate the reason why a health facility has a gap in VAS records. <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Take follow-up action to provide alternative sources of VAS if an event or routine health system outreach visit is missed completely. - Assess whether certain populations have consistently low access to VAS due to these problems. 	<ul style="list-style-type: none"> - Ensure semester micro-plans for VAS distribution events are available to all personnel in advance and that they understand why it is important to keep to the plan. - Support preparation to predict and overcome any obstacles to complete implementation. - Ensure that supervision reports allow for reporting of start and end dates to enable detection of any problems.

Indicator Title	Indicators	Operational Definition of the Indicator	Indicator Target	Monitoring Information Sources & Frequency
	the past semester.			
1.5 Coverage reports have been submitted to district level from all admin areas for all VAS activities, as per national guidelines. a. For routine health system VAS b. For event-based VAS	a. % of admin areas submitting routine health system VAS coverage reports according to national VAS guidelines (timeliness and completeness). b. % of admin areas submitting event-based VAS coverage reports according to national VAS guidelines (timeliness and completeness).	a. (# admin areas submitting routine health system VAS reports late or incomplete ÷ # of admin areas) x 100 b. (# admin areas submitting event-based VAS reports late or incomplete ÷ # of admin areas) x 100	a. Target =0% b. Target = 0%	<i>Sources:</i> Submission date on tally sheets, health facility reports. <i>Frequency:</i> Routine health system VAS, reports are usually monthly, review quarterly. VAS events, reports typically one month after the event.
Type of indicator: Supplies				
1.6 All routine health system VAS activities had sufficient stocks of appropriate vitamin A supplements (including for handling losses, etc.) to supplement 6-59 month old children at all times in the previous month. a. Health facilities with sufficient stocks of 100,000 IU capsules in the past month, for routine health system facility-based and outreach VAS b. Health facilities with	a. % of facilities delivering routine health system VAS reporting stock-outs of 100,000 IU capsules in the past month. b. % of facilities delivering routine health system VAS reporting stock-outs of 200,000 IU capsules in the past month.	a. (# health facilities reporting stock-outs of 100,000 IU capsules in the past semester ÷ total # health facilities in the district) x 100 b. (#health facilities reporting stock-outs of 200,000 IU capsules in the past semester ÷ total # health facilities in the district) x 100	a. Target =0% b. Target = 0%	<i>Sources:</i> Monthly health facility reports, HMIS data, supplement supply and receipt records. <i>Frequency:</i> End of each month with summary each semester.

Assumptions	Responsibilities and Use of Data	Recommendations
	<ul style="list-style-type: none"> - Provide feedback to the national VAS manager indicating the occurrence (and cause) of any delays, incomplete or irregular implementation. 	
<ul style="list-style-type: none"> - National guidelines for VAS activities include expected reporting schedule and data entry standards. - Report forms include a date for report submission to district level. 	<p><i>District Manager responsible to:</i></p> <ul style="list-style-type: none"> - Follow up and support timely submission of completed reports after all VAS activities. - Investigate the reason for any delayed or incomplete reporting. <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Take follow-up action to prevent delayed or incomplete reporting. - Provide feedback to the national manager. 	<ul style="list-style-type: none"> - Ensure reporting format and schedule are clearly defined in planning documents and are available to all key personnel. - Share best practices for reporting and other aspects of VAS between health facilities.
<ul style="list-style-type: none"> - Infants and children 6-59 months of age in the district are eligible for VAS. - Health facility reports (or HMIS data) are available and include a VAS category. - Records of supply orders and receipts exist. - Health facility reports highlight supplement stock-outs. - Both 100,000 IU and 200,000 IU supplement doses are distributed where capsules are used (<i>where only one or the other dose type is used, only one of the</i> 	<p><i>District manager responsible to:</i></p> <ul style="list-style-type: none"> - Review supply records and health (or HMIS) reports to check sufficiency of each type of capsule supply. - Investigate the cause and approximate timing of any stock-out and take corrective follow-up action. <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Combine data with other available information to determine the likely cause of the stock-out and make relevant programme amendments. - Provide feedback to the national manager indicating the likely cause of any stock-outs, for their information and action as needed. 	<ul style="list-style-type: none"> - Provide regular training and supervision to improve efficiency of supply use, reduce waste and improve coverage. - Ensure vitamin A capsule requirements are well-defined in semester and annual planning and micro-planning documents. <p>Ensure that health facility reports have a field to note factors that may help determine the cause (e.g. attendance at the facility) to enable corrective follow-up</p>

Indicator Title	Indicators	Operational Definition of the Indicator	Indicator Target	Monitoring Information Sources & Frequency
sufficient stocks of 200,000 IU capsules in the past month for routine health system facility-based and outreach VAS				
<p>1.7 All VAS events had sufficient stocks of appropriate vitamin A supplements (including for handling losses, etc.) to supplement 6-59 month old children at all times in the previous semester.</p> <p>a. VAS events with sufficient stock of 100,000 IU capsules in the past semester.</p> <p>b. VAS events with sufficient stocks of 200,000 IU capsules in the past semester.</p>	<p>a. % VAS events in the district with insufficient 100,000 IU Vitamin A capsules during the previous semester</p> <p>b. % VAS events in the district with insufficient 200,000 IU Vitamin A capsules during the previous semester</p>	<p>a. (# VAS events reporting stock-outs of 100,000 IU capsules in the past semester ÷ total # VAS events in the district) x 100</p> <p>b. (# VAS events reporting stock-outs of 200,000 IU capsules in the past semester ÷ total # VAS events in the district) x 100</p> <p><i>Stock-outs during an event are defined as an uncorrected stock-out, e.g. if the stock-out is reported and it is corrected during the event it is not defined as a stock-out.</i></p>	<p>a. Target =0%</p> <p>b. Target = 0%</p>	<p><i>Sources:</i> Event tally sheets and district supervision and health reports. VAS stock, supply and receipt orders.</p> <p><i>Frequency:</i> Each semester.</p>

Assumptions	Responsibilities and Use of Data	Recommendations
<i>indicators a. or b. would be applicable).</i>	<ul style="list-style-type: none"> - Determine the appropriate stock of vitamin A supplements for routine health system distribution for the next month and on a semester basis, make alterations to the district work-plans and micro-plans as needed, inform the national manager. - Provide guidance to health facility personnel involved with VAS according to the likely cause of the stock-out, e.g. on appropriate handling of supplements to reduce wastage. 	as needed.
<ul style="list-style-type: none"> - Infants and children 6- 59 months of age are eligible for VAS. - Tally sheets are available and fully completed. - Records of supply orders and receipt exist. - Supervision reports exist and highlight stock-outs. - Both 100,000 IU and 200,000 IU supplement doses are distributed during events (<i>where only one or the other dose type is used, only one of the indicators a. or b. would be applicable</i>). 	<p><i>District manager responsible to:</i></p> <ul style="list-style-type: none"> - Review all data sources to check the sufficiency of each type of capsule during the event. - Investigate the cause and approximate timing of any stock-out and take corrective follow-up action. <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Combine data with other available information to determine the likely cause of the stock-out and make relevant programme amendments. - Provide feedback to the national manager indicating the likely cause of any stock-outs during the previous semester, for their information and action as needed. - Determine the appropriate stock of vitamin A supplements for the next semester, make alterations to the district work-plan and micro-plans as needed, inform the national manager. - Provide guidance to district personnel involved with VAS according to the likely cause of the stock-out, e.g. on appropriate handling of supplements to reduce wastage. 	<ul style="list-style-type: none"> - Provide regular training and supervision to improve efficiency of supply predictions and use, to reduce waste and improve coverage. - Ensure vitamin A supplement requirements are well-defined in semester and annual planning and micro-planning documents. - Ensure that tally sheets and reports have a field to note factors that may help determine the cause (e.g. damaged supplies) to enable corrective follow-up as needed.

Indicator Title	Indicators	Operational Definition of the Indicator	Indicator Target	Monitoring Information Sources & Frequency
1.8. All VAS events had sufficient quantities of other (non-supplement) supplies listed in VAS micro-plan (e.g. scissors, reporting forms, etc.) to implement supplementation activities for target infants and children for the previous semester.	% of VAS events conducted which reported insufficient non-supplement supplies in the past semester.	(# VAS events reporting insufficient non-supplement supplies ÷ total # VAS events in the district) x 100	Target = 0%	<p><i>Sources:</i> Supply estimates, supply orders and stock, and event supervision reports.</p> <p><i>Frequency:</i> Each semester as required (e.g. where a problem reported and/or coverage low)</p>

Type of indicator: Human Resources

1.9 An established supervisory support team provides support to VAS at the district level, as per national guidelines.	% of VAS events conducted without supportive supervision in the past semester.	(# VAS events conducted without supportive supervision ÷ total # VAS events in the district as per micro plan) x 100	Target = 0%	<p><i>Sources:</i> - District VAS micro-plan for supportive supervision plans, monitoring forms, event reports.</p> <p><i>Frequency:</i> Each semester.</p>
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Assumptions	Responsibilities and Use of Data	Recommendations
<ul style="list-style-type: none"> - National guidelines, district work-plans and micro-plans include an estimate of the type and quantity of non-supplement supplies required for VAS. - Records of non-supplement supply orders and receipts exist. - Supervision reports are available and highlight any insufficiency of non-supplement supplies. 	<p><i>District manager responsible to:</i></p> <ul style="list-style-type: none"> - Review supply records and other reports from the event, to check sufficiency of each type of non-supplement supply, where a problem is indicated. - Investigate the cause and approximate timing of any problem of inadequate supplies and take corrective follow-up action. <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Determine the appropriate stock of non-supplement supplies required for VAS events every semester. - Take corrective follow-up action to order additional supplies where needed. - Provide feedback to the national manager. - Provide guidance to VAS personnel according to expected cause, e.g. on appropriate use and handling of non-supplement supplies. - Make programme adjustments. 	<ul style="list-style-type: none"> - Provide regular training and supervision on non-supplement supply management and use. - Ensure non-capsule supply requirements are well-defined in accordance with national guidelines for the number of sites, teams and expected attendance. - Ensure that supervision reports have a field to report any non-supplement supply shortage, to enable diagnosis of the cause of any problems and corrective follow-up as needed.
<ul style="list-style-type: none"> - Infants and children 6-59 months of age in the district are eligible for VAS. - A national guideline exists that details the expected composition, role and responsibilities of a supportive supervision team. 	<p><i>District manager responsible to:</i></p> <p>Ensure that supportive supervision is planned and reported on, in line with national VAS guidelines.</p> <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Follow-up action where supervision not as planned, to assess why and make improvements for future events. - Use supervision data to improve reliability of other data where these can be compared, use together to identify gaps and possible solutions. 	<ul style="list-style-type: none"> - Develop district level supportive supervision teams and guidance, then try to ensure that events receive supportive supervision on a regular basis. - Use lessons learned from supportive supervision reports to strengthen the process and improve VAS in future semesters.

Indicator Title	Indicators	Operational Definition of the Indicator	Indicator Target	Monitoring Information Sources & Frequency
<p>1.10 Personnel involved in distributing VAS (event-based and routine health system) have been routinely trained/given refresher training as per national VAS guidelines.</p> <p><i>Relevant personnel includes anyone involved in VAS, e.g. health workers/other national staff, or volunteers.</i></p>	<p>% of assessed VAS distribution sites (event or routine health system) assessed where at least one personnel involved in distributing vitamin A had not been trained/given refresher training as per national VAS guidelines:</p> <ul style="list-style-type: none"> a. New personnel (started within the past 6 months) b. Existing personnel 	<p>a. (# VAS distribution sites where at least one new personnel had not been trained in the past 6 months ÷ total number VAS distribution sites with new personnel assessed) x 100</p> <p>b. (# VAS distribution sites where at least one existing personnel had not received refresher training in the past 6 months ÷ total number VAS distribution sites with existing personnel assessed) x 100</p>	<p>a. Target =0% b. Target = 0%</p>	<p><i>Sources:</i> District and health facility training records, training curriculum and personnel job descriptions.</p> <p>On a more occasional basis, as data are available: health facility surveys, community surveys.</p> <p><i>Frequency:</i> Each semester. Possibly more in-depth analysis on an annual basis where problems identified.</p>
<p>1.11 Personnel involved in distributing VAS (event and routine health system) meet minimum knowledge criteria for VAS, as per national guidelines.</p> <p><i>Relevant personnel includes anyone involved in VAS, e.g. health workers/other national staff, or volunteers.</i></p>	<p>% of assessed VAS distribution sites (event-based or routine health system) assessed where at least one personnel involved in distributing supplements did not meet the minimum knowledge criteria set out in the national VAS guidelines.</p>	<p>(# VAS distribution sites assessed where at least one involved personnel did not meet minimal knowledge criteria ÷ total number VAS sites assessed) x 100</p>	<p>Target =0%</p>	<p><i>Sources:</i> Supportive supervision reports, quality of care supervision reports.</p> <p>On a more occasional basis, as data are available: health facility surveys, and community surveys.</p> <p><i>Frequency:</i> Each semester when assessments conducted. Possibly more in-depth analysis on an annual basis where knowledge gaps identified.</p>

Assumptions	Responsibilities and Use of Data	Recommendations
<ul style="list-style-type: none"> - National guidelines for VAS define training expectations. - Resources are available at the national and/or district level to train personnel involved in VAS distribution. - Training curricula and records for VAS personnel are available. - Information on personnel recruitment is available. 	<p><i>District manager responsible to:</i></p> <ul style="list-style-type: none"> - Assess whether training of personnel involved in VAS distribution is being conducted as planned and that sufficient resources are available for this. - Compile and review training curricula and training records for personnel involved in VAS distribution, as feasible. <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Take corrective follow-up action where gaps are identified, adapting the training to address any gaps in knowledge or timeliness of training as needed. - Provide feedback to the national VAS manager for review and additional action or request for resources as needed. 	<ul style="list-style-type: none"> - Ensure that all relevant personnel receive training in national VAS guidelines. - Review training reports and supportive supervision reports for any potential gaps in personnel knowledge as part of the annual review. - Include an entry field on supportive supervision reports to allow for reporting of personnel training and any training/knowledge-related concerns with VAS delivery.
<ul style="list-style-type: none"> - National guidelines for VAS define minimum knowledge criteria. - Reports from supportive supervision or a post distribution investigation activity are available. - Resources are available to train personnel. - Training curricula and records for personnel involved are available. - Information on personnel recruitment is available. 	<p><i>District manager responsible to:</i></p> <ul style="list-style-type: none"> - Assess whether training of personnel involved with distributing VAS is being conducted as planned and that sufficient resources are available for this. - Compile and review training curricula and training records for relevant personnel. - Where data indicate that gaps in knowledge and training could be a problem, conduct a more in-depth analysis of training content and personnel knowledge. <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Take corrective follow-up action where gaps in knowledge are identified. - Provide feedback to the national manager for review and additional action as needed. 	<ul style="list-style-type: none"> Ensure that all personnel receive training and refresher training that complies with national VAS guidelines. Review training reports and supervision reports for any gaps in personnel knowledge as part of the annual review.

Indicator Title	Indicators	Operational Definition of the Indicator	Indicator Target	Monitoring Information Sources & Frequency
1.12 All VAS distribution sites had sufficient human resources (as described in the VAS micro-plan) to implement VAS activities for target infants and children for the previous semester.	<p>a. VAS events with sufficient human resources in the past semester.</p> <p>b. Health facilities with sufficient human resources for routine health system VAS in the past semester.</p>	<p>a. % of VAS events reporting insufficient human resources in the past semester.</p> <p>b. % of health facilities reporting insufficient human resources for routine health system VAS in the past semester.</p>	<p>a. (# VAS events reporting insufficient resources ÷ total number VAS events) x 100</p> <p>b. (# health facilities reporting insufficient resources for routine health system VAS ÷ total number health facilities) x 100</p>	<p><i>Sources:</i> District micro-plan, personnel allocation listing, job descriptions, health facility reports, and event supervision reports.</p> <p><i>Frequency:</i> Each semester if other indicators suggest it is needed. Otherwise annual.</p>

Type of indicator: Demand/Social Mobilisation

1.13 Social mobilisation activities conducted in accordance with national and/or district plans.	<p>a. Social mobilisation activities conducted prior to events as per micro-plan.</p> <p>b. Caregivers attending events recall key social mobilisation messages.</p> <p>c. Caregivers not attending events recall key social mobilisation messages.</p>	<p>a. % of social mobilisation activities not implemented in line with plans/micro-plans.</p> <p>b. % of caregivers attending events who could not recall key messages of the social mobilisation activities defined in the plans</p> <p>c. % of caregivers not attending events who could not recall key messages of the social mobilisation activities defined in the plans</p>	<p>a. (# VAS events where social mobilisation activities not conducted according to the micro-plans ÷ total number VAS events) x 100</p> <p>b. (# caregivers at VAS events who could not recall key messages as defined in the micro-plans ÷ total number caregivers interviewed at events) x 100</p> <p>c. (# caregivers not attending VAS event who could not recall key messages as defined in the micro-plans ÷ total number caregivers interviewed) x 100</p>	<p>a. Target =0% b. Target = 0% c. Target = 0%</p> <p><i>Sources:</i> a. Supportive supervision reports, event planning reports, health facility reports. b. Outcome of exit interviews b. and c. Household and community surveys.</p> <p><i>Frequency:</i> Each semester if other indicators suggest it's needed. Otherwise part of annual review, only including sub-indicator</p> <p>c. in cases where a household or community survey has been conducted</p>
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Assumptions	Responsibilities and Use of Data	Recommendations
<ul style="list-style-type: none"> - National guidelines and district micro-plans include type and number of human resources required for routine health system and event-based distribution. - Records of human resource allocation and job descriptions exist. - Supervision reports are available and highlight any insufficiency of human resources. 	<p><i>District manager responsible to:</i></p> <ul style="list-style-type: none"> - Review human resource allocation, VAS attendance numbers and supervision reports to check sufficiency of each type of human resource required against that recommended in the national guidelines and district micro-plans. - Investigate the reason for any shortfall in human resources. <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Take corrective follow up action to plan, budget for and/or recruit additional personnel where needed. - Provide feedback to the national manager on sufficiency of human resources. - Make programme adjustments based on a causal investigation of problems. 	<ul style="list-style-type: none"> - Ensure human resource requirements are well-defined in the district micro-plan, in accordance with national guidelines for the number of health facilities, event sites, teams and expected attendance. - Ensure that supervision reports have an entry field for reporting human resource shortage, to enable diagnosis of the cause of any problems and corrective follow-up as needed.
<ul style="list-style-type: none"> - National and/or district plans and micro-plans for social mobilisation prior to VAS events exist. - Materials and other resources needed to conduct social mobilisation activities for VAS are available at the district. - Micro-plans include exit interviews by supportive supervision teams at a target number of events. - Community or household surveys are conducted where indicators suggest this is required, and include questions about key social mobilisation messages. 	<p><i>District manager responsible to:</i></p> <ul style="list-style-type: none"> - Follow up and support social mobilisation coordinators prior to events - Investigate the reason for any delayed, incomplete or ineffective, social mobilisation activities <p><i>Use of data:</i></p> <ul style="list-style-type: none"> - Take corrective follow-up action in the following semester, as needed. - Determine where exit interviews and/or household/community surveys are required to identify potential problems and support modification and strengthening of social mobilisation. - Provide feedback to the national manager indicating the type, distribution and likely cause of any problems with social mobilisation activities. 	<ul style="list-style-type: none"> - Ensure social mobilisation resource requirements and guidance are included in annual planning and micro-planning documents and are available to relevant personnel. - Support preparation to ensure timely implementation of effective social mobilisation activities. - Ensure that supervision reports include an entry field to report any issues related to caregiver awareness. - Ensure that surveys include questions related to caregiver recall and awareness.

APPENDIX C

DETAILED DESCRIPTION OF EACH LOGFRAME INDICATOR FOR MONITORING VAS AT THE DISTRICT LEVEL

The logframe indicators refer to vitamin A supplementation with the assumption that these are provided as capsules. Where vitamin A is provided as syrup from a bottle, the national and/or district team should review and change the wording of the logframe indicators so they apply to this situation.

COVERAGE

COVERAGE

All eligible children 6–59 months old received a vitamin A supplement in the past semester¹.

INDICATORS

- a. % of eligible children 6–11 months old who received an age-appropriate vitamin A supplement through either routine health system OR event-based vitamin A distribution in the past semester.
- b. % of eligible children 12–59 months old who received an age-appropriate vitamin A supplement through either routine health system OR event-based vitamin A distribution in the past semester.

RATIONALE FOR MONITORING:

Evidence shows that the desired strategic result of reduced child (6–59 month old) mortality can be achieved if the targets for these coverage indicators are met. It is, therefore, a key indicator to assess.

1. Semester defines a 6 month period during which each eligible child should receive one age-appropriate vitamin A supplement. Semester 1 of a given year is intended to represent the first half of the year (January to June); Semester 2 the second half of the year (July to December), however the actual months may change depending on the national planning cycle.

OPERATIONAL DEFINITION OF THE INDICATOR

Assessed as:

- a.** The percentage of children 6–11 months old who received a 100,000 IU vitamin A supplement (usually a blue capsule) through **either** routine health system or event-based distribution in the past semester;
- b.** The percentage of children 12–59 months old who received a 200,000 IU vitamin A supplement (usually a red capsule), through **either** routine health system or event-based distribution in the past semester.

Eligible children received an age-appropriate vitamin A supplement during the previous semester (take careful note of the numerator and denominator to use – see below)

a.

Number of eligible children
6–11 month old who received a
100,000 IU supplement

x100

Total number of eligible children
12–59 months old in the district

b.

Number of eligible children 12–59
month old who received a 200,000 IU
supplement

x100

Total number of eligible children 12–59
months old in the district

Calculate age-group specific indicators every semester, and for each delivery mechanism.

Determine the coverage reported for each delivery method by age group. Never combine the number of children reached through routine health system contacts with those reached through event-based delivery. Coverage estimates should be by semester, and by delivery method to avoid double counting as some children may have received a dose via routine health system contact and via an event in the same semester.

When calculating coverage by delivery mechanism, always ensure the numerator of children reached via a particular delivery mechanism is divided by the denominator specific to that delivery mechanism.

The source of data (routine health system or event-based) may be different, and may be different for the two age groups.

INDICATOR TARGET

a. 100% each semester

b. 100% each semester

MONITORING INFORMATION SOURCES AND FREQUENCY OF COLLECTION

Data sources: Tally sheets, health facility report forms, HMIS.

Frequency: Every semester. Start reviewing reports from health facilities and from events as soon as they are received in order to make timely follow-up investigations or corrections where unexpected data are observed.

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i. Children of both age groups in the district are eligible for VAS.
- ii. VAS may be implemented through routine health systems and, in some semesters, through event-based delivery systems targeting one or both age groups.
- iii. Reliable denominator estimates for each delivery method and age group are available.
- iv. There is no overlap in numerator or denominator counts between different events or health facility administrative areas.

RESPONSIBILITIES AND USE OF DATA

District VAS Manager to:

- i. Compile sub-district data to calculate semester coverage for each age group separately (using data from one delivery method for each) and combined for the district.
- ii. Promote good practices for reaching all children with VAS among all involved personnel to optimise coverage.
- iii. Request and remind health facilities and event managers to submit VAS reports in a timely manner, in accordance with national guidelines.

Use of data:

- i. Use coverage data each semester to identify problems with either VAS implementation and/or with the definition of denominators for VAS.
- ii. Take follow-up action to promote and strengthen VAS practices and, where needed, to adjust population figures to fit with the actual situation in the district.
- iii. Roll up sub-district level data to produce a district estimate per semester, which is sent to the national VAS manager.

iv. In addition to the coverage estimate calculated at district level, send summary numerators and denominators for each age group for each vitamin A delivery system (see example reporting Tables 4a and 4b in Section 4 of the main text and in Appendix D).

RECOMMENDATIONS

This is the key indicator of programme implementation and should be closely followed up each semester. Where data indicate, it should be reviewed along with some of the key process indicators below to determine which processes are working well and should be supported or shared, and which need to be strengthened to improve coverage during the following semesters.

PROGRAMME (ENABLING) ENVIRONMENT

OUTPUT 1.1.

A recognised VAS-related management and coordination group uses data for planning at the district level, according to national guidelines.

COMPONENT INDICATORS

a. VAS-related management and coordination group with defined responsibilities exists

b. Administrative data and supervision reports were used to plan for VAS for the following semester

Degree of district level management responsibility may depend on the level of decentralisation

RATIONALE FOR MONITORING:

Having a recognised group of people with responsibility for management and coordination of VAS-related activities at the district level facilitates VAS planning, implementation and reporting, as well as the analysis and use of reported data for identifying problems and making programme adjustments as needed.

OPERATIONAL DEFINITION OF THE INDICATOR

Qualitative indicators, calculated as Yes or No.

a. A district level VAS management and coordination group with defined responsibilities exists and functions in accordance with national guidelines.

Yes/No.

b. VAS data are used to determine needs, identify challenges and used to plan for VAS in the following semester.

Yes/No.

For all districts implementing VAS.

INDICATOR TARGET

a. Yes.

b. Yes

MONITORING INFORMATION SOURCES AND FREQUENCY OF COLLECTION

Data sources: Review district VAS management plan for meeting schedule, definition of group members, and their roles, responsibilities and deliverables for the forthcoming year, according to national guidelines. In general, groups are expected to meet at minimum twice a year to review semester data and plan.

Review meeting minutes for evidence that deliverables were achieved and that verification and interpretation of data from previous semesters was used to guide planning.

Frequency:

a. Annually (more frequently if unexpected data are observed)

b. Each semester

ASSUMPTIONS

In defining the indicator, it is assumed that:

i. Children in the district are eligible for VAS.

ii. A national guideline exists that details the expected composition, roles and responsibilities of a VAS management and coordination team.

iii. There is no bias in reporting of these indicators, which may arise if the VAS management team is effectively assessing its own function.

RESPONSIBILITIES AND USE OF DATA

District VAS Manager to ensure that:

- i. The VAS management and coordination system exists, meets as needed and provides deliverables in line with national VAS guidelines.
- ii. The management group has access to data and the outcome of any data verification exercises from previous semesters.

Use of data:

- i. If a VAS management and coordination system does not exist, does not have well-defined roles and responsibilities or is not using existing data effectively for programme management, then follow-up action should be taken to establish a strong, effective team and improve programme performance.

RECOMMENDATIONS

Ensure resources are available to support a strong management and coordination team that functions according to national guidelines in order to achieve the above indicator targets. Ideally the coordination team should be integrated with, or strongly connected to, a larger district health and nutrition coordination group.

OUTPUT 1.2

District VAS work-plan exists for the forthcoming year with estimated semester-level needs for both routine health system contacts and event-based distribution of vitamin A for:

- a. Supplies (VAS supplements)
- b. Supplies (non-supplement)
- c. Human resources
- d. Budget

The degree of district level management responsibility for developing these plans may depend on the level of decentralisation. Even if the plans are developed nationally, the plan should still exist for implementation at the district level.

The plan may be incorporated under the umbrella of the District Operational Health Plan or similar.

RATIONALE FOR MONITORING:

Having a clear district level work-plan with activities, timelines and responsibilities defined according to national policy guidance is crucial to creating and sustaining an enabling programme environment for high district level coverage with vitamin A supplements. The work-plan provides a reference against which semester-level micro-plans are developed and decisions can be made.

Where programme management is decentralised (planned at the district level), requirements for one or all of the following factors need to be estimated for successful programme implementation: supplies, human resources and budget. If problems with implementation or coverage arise, these factors require investigation against the work-plan to determine the cause and must allow for amendment of the work-plan where needed (e.g. supply estimates adjusted) to avoid similar problems in the following semester.

OPERATIONAL DEFINITION OF THE INDICATOR

A qualitative indicator, calculated as Yes or No for both routine health system contacts and event-based distribution for each component of the district work-plan as follows:

Overarching indicator:

District annual work-plan exists
Yes/No

Sub-indicators if the plan exists:

a) District annual work-plan includes VAS supplement supply estimates
Yes/No

b) District annual work-plan includes non-supplement supply estimates
Yes/No
e.g. scissors and forms; quantities required per number of personal according to the national guidelines

c) District annual work-plan includes an estimate of human resource needs
Yes/No
e.g. VAS-related health care workers, supervisors, drivers; according to the national guidelines required per number of health facilities and planned distribution events (campaigns)

d) District annual work-plan includes an estimate of budget required for VAS
Yes/No
e.g. budget to procure, deliver and manager VAS; according to the national guidelines.

INDICATOR TARGET

Yes — for work-plan exists (all districts).

Yes — for sub-indicators for each of routine health system contacts and event-based distribution for: a., b., c., and d (where these are applicable for the district).

MONITORING INFORMATION SOURCES AND FREQUENCY OF COLLECTION

Data sources: Review district work-plan for the forthcoming year to check that all components are included and are appropriate for the delivery methods to be used in the forthcoming semester/year.

Frequency: Annually, or as needed, e.g. where problems with budget, human resources or supplies are identified during the year then review the work-plan and amend accordingly.

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i. Children in the district are eligible for VAS
- ii. The district has a management team (indicator 1.1), and the authority to develop a work-plan and to determine its own supply, human resource and budget estimates.

RESPONSIBILITIES AND USE OF DATA

District VAS Manager to:

- i. Develop and review the VAS work-plan with the district management team and other relevant partners to ensure it includes all necessary components and/or is in line with national guidelines.
- ii. Estimate VAS supply, human resource and budget needs based on district level forecasting for both routine health system contacts and event-based delivery where these are a district level responsibility.

Use of data:

- i. Follow up to fill any identified gaps in the work-plan.
- ii. Use the work-plan as the basis for allocating supplies, budget and human resources to health facilities and event teams (as relevant to the district).
- iii. Respond to any shortfall in any of these factors with a review of the work-plan and re-allocation where appropriate and feasible.
- iv. Compare estimates with eventual coverage data during the semester and year, and investigate the reasons for any large difference between the two. Use this information to develop more accurate estimates for the forthcoming year.

v. Compare district estimates of supply, resource and budget needs with any estimates or allocations sent from national level. Discuss the data sources and the likely impact of any differences found. Advocate for amendments to the allocations as needed.

RECOMMENDATIONS

Develop the annual work-plan and estimates of supply, human resource and budget needs with relevant partners, based on actual requirements from the preceding semesters and on any known changes in the local population and/or in the number of planned events where vitamin A distribution is included.

OUTPUT 1.3

The district Public Health Care (PHC) system budget includes sufficient allocation for VAS programme costs.

Only relevant where budget is decentralised to district level, otherwise this is a national indicator only.

RATIONALE FOR MONITORING:

Allocation of VAS budget within the PHC system at district level demonstrates district level ownership and commitment to VAS, facilitates cost-sharing with other interventions delivered through the same mechanisms and provides some protection from changes in funding that may otherwise threaten implementation.

OPERATIONAL DEFINITION OF THE INDICATOR

A qualitative indicator, calculated as Yes or No

Sufficient VAS programme costs are allocated in the district PHC system budget.

Yes/No.

For all districts implementing VAS where PHC budgets are decentralised for district level management.

INDICATOR TARGET

Yes.

**MONITORING INFORMATION
SOURCES AND FREQUENCY
OF COLLECTION**

Data sources: Review district PHC system budget for the forthcoming year in comparison to the requirements outlined in the annual work-plan.

Frequency: Annually, or according to the PHC system planning cycle.

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i. Children in the district are eligible for VAS.
- ii. The district either manages or has influence over the local PHC system budget.
- iii. The PHC budget is complete and accurately reflects essential district costs for implementation of effective VAS coverage.

**RESPONSIBILITIES AND
USE OF DATA****District VAS Manager to:**

- i. Review PHC system documentation to ensure sufficient VAS budget is allocated.

Use of data:

- i. If sufficient budget for VAS is not allocated in the local PHC system, review allocation options and, where appropriate, advocate to strengthen programme implementation and sustainability.

RECOMMENDATIONS

Where a district has authority to manage its own budget, integrate VAS planning with broader PHC system planning and management, with reference to national guidelines for VAS delivery, to ensure sufficient VAS programme budget is allocated in the PHC plan.

Where the budget is centrally managed, verify that VAS programme costs are allocated in the national PHC plan.

OUTPUT 1.4

All VAS events and routine health system distribution in the last semester were conducted according to the VAS micro-plan.

INDICATORS

- a. % of VAS events which did not start on the planned date.
- b. % of VAS outreach from health facilities which were not conducted as planned.
- c. % of health facilities where VAS was not continuously implemented.

RATIONALE FOR MONITORING:

To promote caregiver motivation and facilitate maximum attendance, it is important for district managers to monitor that events start on the communicated dates and continue for the expected duration. Health facilities also need to be monitored to ensure consistent delivery of preventive vitamin A supplements which, in a similar manner, develops caregiver confidence in the facility and familiarity with VAS.

This indicator should be monitored in detail by administrative area at the district level.

**OPERATIONAL DEFINITION
OF THE INDICATOR**

Assessed as:

- a. % VAS events in the district not initiated as planned (in the micro-plan) during the previous semester:**

Number of VAS events not initiated on the planned date _____ x100

Total number of planned VAS events in the district during the semester

- b. % VAS routine health system outreach (from health facilities) in the district not conducted as planned (in the micro-plan) during the previous semester:**

Number of routine VAS outreach not conducted as planned _____ x100

Total number of planned VAS outreach in the district during the semester

- c. % health facilities in the district where VAS not conducted continuously during the previous semester:**

Number of health facilities with zero distribution of vitamin A for a defined period _____ x100

Total number health facilities in the district

INDICATOR TARGET

- a.** 0%
- b.** 0%
- c.** 0%

MONITORING INFORMATION SOURCES AND FREQUENCY OF COLLECTION

Data sources: Health facility reports, event tally sheets and supervision reports.

Frequency: Review at minimum at the end of each semester. Recommended to review as reports are received (e.g. monthly for health facility-based and outreach, post-event for event-based delivery).

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i.** District micro-plans with dates and duration for VAS events and routine health system outreach from health facilities exist and are available.
- ii.** Health facilities are expected to continuously distribute vitamin A to eligible children attending the facility.

RESPONSIBILITIES AND USE OF DATA**District VAS Manager to:**

- i.** Investigate the reason for any delayed or incomplete VAS events or routine health system outreach visits.
- ii.** Map the occurrence of delays or incomplete VAS events or routine health system outreach.
- iii.** Emphasise to personnel involved with VAS the importance of keeping to the timing and duration stated in the micro-plan.

Use of data:

- i.** Take follow-up action to provide alternative sources of VAS if an event or routine health system outreach visit is missed completely and identified prior to the end of the semester.
- ii.** Assess which communities are most affected by the delay or incomplete implementation and compare this with previous semesters to assess whether certain populations have consistently low access to VAS. Take follow-up action as needed.
- iii.** Provide feedback to the national VAS manager indicating the occurrence of any delays or incomplete implementation during the previous semester, with known reasons where these have been identified.

RECOMMENDATIONS:

- i.** Ensure semester micro-plans for VAS events and routine health system outreach visits are available to all personnel involved with VAS in advance, together with communication about why it is important to keep to the plan.
- ii.** Support strong preparation for both routine health system and event-based VAS, to predict and overcome any obstacles to timely and complete implementation.
- iii.** Ensure that supervision reports include reporting of start and end dates to enable diagnosis of any problems.

OUTPUT 1.5

Coverage reports have been submitted to district level from all administration areas for all VAS activities, as per national guidelines.

INDICATOR

% of administration areas where VAS coverage reports were not submitted to the district level according to national VAS guidelines (timeliness and completeness).

- a. For routine health system contact VAS
 - b. For event-based VAS
-

RATIONALE FOR MONITORING:

Monitoring when reports are submitted allows district managers to follow up with health facilities and event supervisors to identify the reason(s) for any delays in submission and to support corrective actions for the next semester. Ensuring timely and complete reporting is crucial to enable any necessary investigation and subsequent programme amendments to be made as soon as possible in order to improve implementation of activities and coverage in subsequent semesters.

OPERATIONAL DEFINITION OF THE INDICATOR

Assessed as:

- a. % of administration areas where coverage reports for routine health system vitamin A distribution not submitted to district managers according to the national guideline for reporting:**

Number of administration areas submitting routine VAS reports late or incomplete _____ x100

Total number of administration areas in the district

- b. % of administration areas where coverage reports for event-based vitamin A distribution not submitted to district managers according to the national guideline for reporting:**

Number of administration areas submitting event-based VAS reports late or incomplete _____ x100

Total number of administration areas in the district

INDICATOR TARGET

a. 0%

b. 0%

MONITORING INFORMATION SOURCES AND FREQUENCY OF COLLECTION

Data sources: Data collection and submission dates on tally sheets, health facility reports and other forms of coverage reports. Record of report receipt at the district level.

Frequency: For routine health system VAS, reports are usually submitted monthly. For VAS events, reports are typically due one month after the event, but national guidelines may vary.

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i.** National guidelines for VAS activities include expected reporting schedule and data entry standards, and are available to relevant personnel at all sites.
- ii.** Report forms include a date field for when the report was submitted to district level.

RESPONSIBILITIES AND USE OF DATA

District VAS Manager to:

- i. Follow up and support timely submission of complete reports after all VAS activities.
- ii. Investigate the reason for any delayed or incomplete reporting.

Use of data:

- i. Take follow-up action to prevent delayed or incomplete reporting in the following semester, as needed.
- ii. Provide feedback to the national VAS manager indicating any problems with timely reporting during the previous semester.

RECOMMENDATIONS

- i. Ensure reporting format and schedule are clearly defined and included in annual and semester planning documents, and are available to all VAS event and health facility managers.
- ii. Facilitate sharing of expertise and experience between health facilities to support best practices with reporting and other aspects of VAS delivery.

SUPPLIES

OUTPUT 1.6

All routine health system VAS activities had sufficient stocks of appropriate vitamin A supplements (including for handling losses, etc.) to supplement 6–59 month old children at all times in the previous month.

COMPONENT INDICATORS

- a. % of facilities delivering routine health system VAS reporting stock-outs of 100,000 IU capsules in the past month
- b. % of facilities delivering routine health system VAS reporting stock-outs of 200,000 IU capsules in the past month

Where only one type of capsule is used then report for that capsule only. Where vitamin A capsules are not used, this indicator should be "% of VAS events reporting stock-outs of vitamin A supplements, [e.g. syrup], in the past semester". The operational definition should be revised accordingly.

RATIONALE FOR MONITORING:

Sufficiency of vitamin A supply for routine health system supplementation at health facilities and facility-related outreach is important to assure coverage of all eligible children and to maintain caregivers' motivation to bring a child for VAS according to the recommended schedule. Monitoring the sufficiency of supplies enables timely corrective action to provide additional supplies to health facilities as soon as possible and to adjust supply estimates for subsequent months and semesters.

**OPERATIONAL DEFINITION
OF THE INDICATOR**

Assessed as:

a. % Routine health system vitamin A distribution sites (health facilities) in the district with insufficient 100,000 IU Vitamin A capsules during the previous month:

Number of health facilities reporting stock outs of 100,000 IU capsules (blue) $\times 100$
 Total number of health facilities in the district

b. % Routine health system vitamin A distribution sites (health facilities) in the district with insufficient 200,000 IU Vitamin A capsules during the previous month:

Number of health facilities reporting stock outs of 200,000 IU capsules (red) $\times 100$
 Total number of health facilities in the district

INDICATOR TARGET

a. 0%

b. 0%

**MONITORING INFORMATION
SOURCES AND FREQUENCY
OF COLLECTION**

Data sources: Review monthly health facility reports, HMIS, supplement supply records and receipt.

Frequency: At the end of each month and also a summary report at the end of each semester.

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i. Children 6-59 months old in the district are eligible for VAS.
- ii. Health facility reports (or HMIS data) are available, include a category for reporting vitamin A, are fully completed, and are submitted and reviewed monthly as scheduled.
- iii. Records of supply orders and receipts exist.
- iv. Health facility reports highlight supplement stock-outs.
- v. Both 100,000 IU and 200,000 IU supplement doses are distributed where capsules are used. (In some countries only one or the other is used to supplement all children by combining or dividing the dose, in which case only one of the indicators a. or b. would be applicable).

RESPONSIBILITIES AND USE OF DATA

District VAS Manager to:

- i. Review supply records and health (or HMIS) reports to check sufficiency of each type of capsule.
- ii. Investigate the cause and approximate timing of any stock-out and take corrective follow-up action. For example, stock-outs may reflect higher than usual attendance from among the normal target communities, a high level of recent migration of eligible children into the area served by the health facility or be the result of damaged (unusable) supplies.

Use of data:

- i. Data on stock-outs can be combined with other information to determine the likely cause of the stock-out (as examples above) and make relevant programme amendments.
- ii. Provide feedback to the national VAS manager indicating the occurrence, approximate timing and likely cause of any stock-outs during the previous semester, for their information and action as needed.
- iii. Determine the appropriate stock of vitamin A supplements for routine health system distribution for the next month and on a semester basis, make alterations to the district work and micro-plans and advise the national VAS manager of this.

- iv.** Make programme adjustments based on the investigation of likely cause of a stock-out.
- v.** Provide guidance to district personnel involved with VAS according to the determined or likely cause of the stock-out, e.g. on appropriate handling of supplements to reduce wastage.

RECOMMENDATIONS

- i.** Provide regular training and supervision to improve efficiency of supply use, reduce waste and improve coverage.
- ii.** Ensure vitamin A capsule requirements are accurate and well-defined in semester and annual planning and micro-planning documents.
- iii.** Ensure that health facility reports have a field to note factors that may help determine the cause (e.g. damaged supplies, increased attendance at the facility) to enable corrective follow-up as needed.

OUTPUT 1.7

All VAS events had sufficient stocks of appropriate vitamin A supplements (including for handling losses, etc.) to supplement 6–59 month old children at all times in the previous semester.

COMPONENT INDICATORS

a. % of VAS events reporting stock-outs of 100,000 IU capsules in the past semester

b. % of VAS events reporting stock-outs of 200,000 IU capsules in the past semester

Where only one type of capsule is used then report for that capsule only. Where vitamin A capsules are not used, this indicator should be “% of VAS events reporting stock-outs of vitamin A supplements, [e.g. syrup], in the past semester”. The operational definition should be revised accordingly.

RATIONALE FOR MONITORING:

Sufficiency of vitamin A supply at distribution events is important to assure coverage of all eligible children and to maintain caregivers' motivation to bring a child for VAS according to the recommended schedule. Monitoring whether the previous semester had insufficient supplies for events enables timely corrective action by adjusting overall supply estimates for subsequent semesters.

OPERATIONAL DEFINITION OF THE INDICATOR

Assessed as:

- a. % VAS events in the district with insufficient 100,000 IU Vitamin A capsules during the previous semester:**

Number of VAS events reporting stock outs of 100,000 IU capsules (blue) _____ x100

Total number of VAS events in the district

- b. % VAS events in the district with insufficient 200,000 IU Vitamin A capsules during the previous semester:**

Number of VAS events reporting stock outs of 200,000 IU capsules (red) _____ x100

Total number of VAS events in the district

INDICATOR TARGET

a. 0%

b. 0%

MONITORING INFORMATION SOURCES AND FREQUENCY OF COLLECTION

Data sources: Event tally sheets and supervision reports. Review VAS stock, supply and receipt orders.

Frequency: At the end of each event and at the end of every semester.

ASSUMPTIONS

In defining the indicator, it is assumed that, at the district level:

- i.** Children 6-59 months old are eligible for VAS.
- ii.** Tally sheets are available and fully completed to compare numbers of available supplements with the number of each supplement type distributed at the event.
- iii.** Records of supply orders and receipts exist.
- iv.** Supervision reports exist and highlight supplement stock-outs.

v. Both 100,000 IU and 200,000 IU supplement doses are distributed during events where capsules are used. (In some countries only one or the other dose is used to supplement all children by combining or dividing the dose, in which case only one of the indicators a. or b. would be applicable).

If the stock-out is reported and corrected during the event then it is not defined as a stock-out. Otherwise stock-outs are defined as an “uncorrected stock-out”.

RESPONSIBILITIES AND USE OF DATA

District VAS Manager to:

i. Review tally sheets, supervision reports and supply records to check the sufficiency of each type of capsule during the event.

ii. Investigate the cause and approximate timing of any stock-out and take corrective follow-up action. For example, stock-outs may reflect higher than usual attendance from among the normal target communities, a high level of recent migration of eligible children into the area served by the event, or be the result of damaged (unusable) supplies.

Use of data:

i. Data on stock-outs can be combined with other information to determine the likely cause of the stock-out and use this to make relevant programme amendments.

ii. Provide feedback to the national VAS manager indicating the occurrence, approximate timing and likely cause(s) of any stock-outs during the previous semester, for their information and action as needed.

iii. Determine the appropriate stock of vitamin A supplements for each event for the next semester, make alterations to the district work and micro-plans and advise the national VAS manager of this.

iv. Provide guidance to district personnel involved with VAS according to the determined or likely cause of the stock-out, e.g. on appropriate handling of supplements to reduce wastage.

RECOMMENDATIONS

- i.** Provide regular training and supervision to improve efficiency of supply predictions and use, in order to reduce waste and improve coverage.
- ii.** Ensure vitamin A supplement requirements are accurate and well-defined in semester and annual planning and micro-planning documents.
- iii.** Ensure that reports (tally sheets, supervision reports) have a field to note factors that may help determine the cause (e.g. damaged supplies, attendance numbers) to enable corrective follow-up as needed.

OUTPUT 1.8

All VAS events had sufficient quantities of other (non-supplement) supplies listed in VAS micro-plan (e.g. scissors, reporting forms, etc.) to implement supplementation activities for target children for the previous semester.

INDICATOR

% of VAS events conducted which reported insufficient non-supplement supplies in the past semester.

RATIONALE FOR MONITORING:

Sufficiency of non-supplement supplies increases the efficiency of VAS, which helps increase coverage of eligible children and caregivers' motivation. Therefore, it is important to monitor that non-supplement supply estimates match actual requirements and, if problems arise, event managers are able to take timely corrective action to provide additional supplies and to update the estimates for subsequent semesters.

OPERATIONAL DEFINITION OF THE INDICATOR

Assessed as:

% VAS events in the district with insufficient supplies to deliver supplements effectively during the previous semester, according to the national guidelines:

$$\frac{\text{Number of VAS events reporting insufficient non-supplement supplies}}{\text{Total number of VAS events in the district during the semester}} \times 100$$

INDICATOR TARGET

0%

**MONITORING INFORMATION
SOURCES AND FREQUENCY
OF COLLECTION**

Data sources: Review national guidance for supplies, supply estimates, supply orders, and event supervision reports.

Frequency: At the end of each semester as required (e.g. where supervisors reported a problem or where coverage is low).

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i. National guidelines, district work-plans and micro-plans include an estimate of the type and quantity of non-supplement supplies required for VAS.
- ii. Records of non-supplement supply orders and receipts exist at the district level.
- iii. Supervision reports are available and highlight any insufficiency of non-supplement supplies.

**RESPONSIBILITIES AND
USE OF DATA****District VAS Manager to:**

- i. Review non-supplement supply records and supervision or other reports from the event to check sufficiency of each type of non-supplement supply, where a problem is indicated.
- ii. Investigate the cause and approximate timing of any problem of inadequate supplies and take corrective follow-up action.

Use of data:

- i. Determine the appropriate stock of non-supplement supplies required for VAS events every semester (except in cases where this is determined at national level).
- ii. Take corrective follow-up action to order additional supplies where needed.
- iii. Provide feedback to the national VAS manager indicating the occurrence and likely timing of any non-supplement supply shortages during the previous semester.
- iv. Provide guidance to district VAS personnel according to expected cause, e.g. on appropriate use and handling of non-supplement supplies, including completion of forms to reduce wastage.
- v. Make programme adjustments based on the outcome of any investigation of the likely cause.

RECOMMENDATIONS

- i.** Provide regular training and supervision on non-supplement supply management and use, in order to reduce waste and loss.
- ii.** Ensure non-supplement supply requirements are well-defined in accordance with national guidelines and district micro-plans for the number of sites, teams and expected attendance.
- iii.** Ensure that supervision reports have a field to report any non-supplement supply shortage, to enable diagnosis of the cause of any problems and corrective follow-up as needed.

HUMAN RESOURCES

OUTPUT 1.9

An established supervisory support team provides support to VAS at the district level, as per national guidelines.

INDICATOR

% of VAS events conducted without supportive supervision in the past semester.

RATIONALE FOR MONITORING:

Supervisory support is important to promote good VAS delivery practices, to raise awareness where implementation is not proceeding as planned and to identify barriers to optimal coverage, in particular for event-based distribution. Supportive supervision can provide essential monitoring information for effective programme adjustment, so it is a key programme component to include in a monitoring framework.

OPERATIONAL DEFINITION OF THE INDICATOR

Assessed as:

% VAS events in the district without supportive supervision to promote and report on VAS, during the previous semester:

Number of VAS events conducted without supportive supervision _____ x100

Total number of VAS events in the district during the semester

INDICATOR TARGET

0%

MONITORING INFORMATION SOURCES AND FREQUENCY OF COLLECTION

Data sources: Review district VAS micro-plan for which planned events were expected to have supportive supervision. Review event reports to assess which events were conducted without a supportive supervision team and had no related reports.

Frequency: By semester.

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i. Children 6-59 months old in the district are eligible for VAS.
- ii. A national guideline exists that details the expected composition, role and responsibilities of a supportive supervision team.

RESPONSIBILITIES AND USE OF DATA

District VAS Manager to:

- i. Ensure that supportive supervision is planned and reported on, in line with national VAS guidelines.

Use of data:

- i. If supportive supervision wasn't available as planned during a VAS event, follow-up action should be taken to assess why and to make improvements for future events.
- ii. Supportive supervision data adds confidence to the reliability of other data (where these can be compared), which can then be used together to identify gaps and possible solutions.

RECOMMENDATIONS

Develop district level supportive supervision teams and guidance and ensure that events receive supportive supervision on a regular basis. Use lessons learned from supportive supervision reports to strengthen the process of VAS in future semesters.

OUTPUT 1.10

Personnel involved in distributing vitamin A (event-based and routine health system) have been routinely trained given refresher training, as per national VAS guidelines.

INDICATOR

% of assessed VAS distribution sites (event-based or routine health system) where at least one personnel involved in distributing vitamin A had not been trained given refresher training as per national VAS guidelines:

- a. New personnel (started within the past 6 months)
- b. Existing personnel

Relevant personnel includes anyone involved in VAS, e.g. health workers other national staff, or volunteers.

RATIONALE FOR MONITORING:

Regular staff training that is consistent with national guidelines helps improve the quality of VAS implementation and reporting, especially the use of correct supplement type by age group, and completeness and timeliness of reporting. It is essential that new personnel are trained when starting in the position. Further, regular refresher training is important to develop and support personnel skills and confidence. Monitoring this indicator allows VAS managers to identify and prevent potential problems related to gaps in personnel knowledge and ability.

**OPERATIONAL DEFINITION
OF THE INDICATOR**

Assessed as:

**% assessed VAS distribution sites in the district
with at least one personnel having received
insufficient (or untimely) training:**

- a.** New personnel (recruited in the past 6 months)

Number of VAS distribution sites where at least one new personnel had not been trained in the past 6 months

x100

Total number of assessed VAS distribution sites with new personnel in the district

- b.** Existing personnel (recruited more than 6 months ago)

Number of VAS distribution sites where at least one existing personnel had not received refresher training in the past 6 months

x100

Total number of assessed VAS distribution sites with existing personnel in the district

Sub-group analyses: Calculate each indicator by event and by routine health system-based distribution.

INDICATOR TARGET

a. 0%

b. 0%

**MONITORING INFORMATION
SOURCES AND FREQUENCY
OF COLLECTION**

Data sources: District and health facility recruitment and training records, training curriculum and personnel job descriptions. On a more occasional basis, as data are available: health facility surveys.

Frequency: At the end of each semester (possibly with a more in-depth analysis on an annual basis or where a human resource problem is identified, e.g. through supportive supervision reports).

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i. National guidelines for VAS are available, include training, and define the expected training refresher training frequency and content.
- ii. Resources are available at the national and or district level to train personnel involved in VAS.
- iii. Training curricula and records for VAS personnel are available.
- iv. Information on personnel recruitment is available.

RESPONSIBILITIES AND USE OF DATA

District VAS Manager to:

- i. Assess whether training of personnel involved in VAS is being conducted as planned in terms of content and frequency, and that sufficient resources are available for this.
- ii. Compile and review recruitment and training records for personnel involved in VAS, as feasible.

Use of data:

- i. Take corrective follow-up action where gaps are identified, adapting the training to address any gaps in knowledge or in timeliness of training from previous VAS rounds.
- ii. Provide feedback to the national VAS manager for review and additional action or request for resources as needed.

RECOMMENDATIONS

- i. Ensure that all relevant personnel receive regular training in national VAS guidelines.
- ii. Review training reports and supportive supervision reports for any potential gaps in personnel knowledge as part of the annual review.
- iii. Include an entry field on supportive supervision reports to allow for reporting of personnel training and any training/knowledge-related concerns with vitamin A delivery.

OUTPUT 1.11

Personnel involved in distributing VAS (event-based and routine health system) meet minimum knowledge criteria for VAS, as per national guidelines.

INDICATOR

% of assessed VAS distribution sites (event-based or routine health system) where at least one personnel involved in distributing supplements did not meet the minimum knowledge criteria set out in the national VAS guidelines.

Relevant personnel includes anyone involved in VAS, e.g. health workers/other national staff, or volunteers. This indicator may not be feasible to measure in all situations, as it requires supportive supervision and/or some type of qualitative verification assessment to be in place.

RATIONALE FOR MONITORING:

Adequate personnel training to meet the minimum knowledge criteria is essential to maintain the quality of vitamin A delivery, including use of the correct supplement type, appropriate delivery, and reporting. It is crucial that new personnel are trained and retain at least the minimum knowledge and skills required to delivery vitamin A safely and effectively. Regular monitoring to ensure that VAS personnel are distributing supplements

according to national guidelines is important in order to develop and support personnel skills and confidence, and to identify and prevent potential problems related to personnel knowledge and ability.

OPERATIONAL DEFINITION OF THE INDICATOR

Assessed as:

% assessed VAS distribution sites in the district with at least one personnel who did not meet at least the minimum knowledge criteria for VAS:

$$\frac{\text{Number of VAS distribution sites where at least one involved personnel did not meet minimum knowledge criteria}}{\text{Total number of VAS distribution sites assessed in the district}} \times 100$$

Sub-group analyses: Calculate this indicator overall for the district as well as by event and routine health system distribution type, and by new (recruited in past semester) and existing staff.

INDICATOR TARGET

0%

**MONITORING INFORMATION
SOURCES AND FREQUENCY
OF COLLECTION**

Data sources: Supportive supervision reports from events, quality of care supervision reports from health facilities. On a more occasional basis, as data are available: health facility surveys.

Frequency: At the end of each semester (possibly with a more in-depth analysis on an annual basis or where a human resource knowledge problem is identified).

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i. National guidelines for VAS are available and define the minimum knowledge criteria.
- ii. Supportive supervision is conducted in the district and reports are available, and or a post-distribution investigation or verification activity has been implemented.
- iii. Information on personnel recruitment is available.

**RESPONSIBILITIES AND
USE OF DATA****District VAS Manager to:**

- i. Where coverage is low and or reporting is inconsistent, or where other indicators indicate that personnel knowledge could be the source of lower than optimal coverage, conduct a more in-depth analysis of training content and personnel knowledge.

Use of data:

- i. Take corrective follow-up action where gaps in knowledge are identified. Training should be adapted to address any identified common gaps in knowledge and ability from previous VAS rounds.
- ii. Provide feedback to the national VAS manager for review and additional action as needed.

RECOMMENDATIONS

- i. Ensure that all personnel receive training and refresher training that complies with national VAS guidelines and that takes into account district-specific issues as needed.
- ii. Review training reports and supervision reports for any gaps in personnel knowledge as part of the annual review.

OUTPUT 1.12

All VAS distribution points had sufficient human resources (as described in the VAS micro-plan) to implement VAS activities for target children for the previous semester.

INDICATOR

- a. % of VAS events reporting insufficient human resources in the past semester.
- b. % of health facilities reporting insufficient human resources for routine health system VAS in the past semester.

RATIONALE FOR MONITORING:

Sufficient personnel helps to ensure the efficiency and timeliness of VAS and reporting. This should result in increased coverage of eligible children with VAS and improved caregiver motivation to attend an event in the future. Therefore it is important to monitor that sufficient personnel are available.

OPERATIONAL DEFINITION OF THE INDICATOR

Assessed as:

- a. % VAS events in the district reporting insufficient human resources to effectively implement VAS according to the national guidelines, during the previous semester:**

Number of VAS events reporting insufficient human resources _____ x100
 Total number of VAS events in the district during the semester

- b. % health facilities in the district reporting insufficient human resources to effectively implement routine health system VAS according to the national guidelines, during the previous semester:**

Number of health facilities reporting insufficient human resources for routine VAS _____ x100
 Total number of health facilities in the district

INDICATOR TARGET

a. 0%

b. 0%

MONITORING INFORMATION SOURCES AND FREQUENCY OF COLLECTION

Data sources: Human resource requirement estimates, personnel allocation, job descriptions and event supervision reports.

Frequency: At the end of each semester as required (e.g. where supervisors reported a problem or where coverage is low). If no problems are reported, include this as part of district annual review.

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i.** National guidelines and district micro-plans include an estimate of the type and quantity of human resources required for VAS.
- ii.** Records of human resource allocation and job descriptions exist at the district level.
- iii.** Supervision reports are available and highlight any insufficiency of human resources.

RESPONSIBILITIES AND USE OF DATA

District VAS Manager to:

- i.** Review human resource allocation, VAS attendance numbers and supervision reports to check sufficiency of each type of human resource required against that recommended in the national guidelines and district micro-plans.
- ii.** Investigate the reason for any shortfall in human resources.

Use of data:

- i.** Take corrective follow-up action to plan, budget for and or recruit additional personnel where needed.
- ii.** Provide feedback to the national VAS manager indicating the occurrence of any human resource shortages during the previous semester/year (depending on frequency of review).

RECOMMENDATIONS

- i.** Ensure human resource requirements are well-defined in the district work- and micro-plans, in accordance with national guidelines for the number of sites, teams and expected attendance.
- ii.** Ensure that supervision reports have an entry field for reporting of any human resource shortage, to help determine the cause of any problems and plan corrective follow-up.

DEMAND/SOCIAL MOBILISATION

OUTPUT 1.13

Social mobilisation activities conducted in accordance with national and/or district plans.

INDICATORS

- a. % of social mobilisation activities not implemented in line with plans/micro-plans.
- b. % of interviewed caregivers attending events who could not recall key messages of the social mobilisation activities defined in the plans.
- c. % of interviewed caregivers not attending events who could not recall key messages of the social mobilisation activities defined in the plans.

RATIONALE FOR MONITORING:

Monitoring to ensure that social mobilisation activities have been conducted according to the district micro-plan helps correct any problems and maintain or increase caregiver motivation and attendance, thereby increasing VAS coverage.

OPERATIONAL DEFINITION OF THE INDICATOR

Assessed as:

- a. VAS events where associated social mobilisation activities were not conducted according to the district/micro-plan, during the previous semester:**

Number of VAS events where social mobilisation was not conducted according to the micro-plan _____ x100

Total number of VAS events in the district during the semester

- b. Percentage of interviewed caregivers attending events who could not recall key messages defined in the social mobilisation plan:**

Number of caregivers at events who could not recall key messages as defined in the plan _____ x100

Total number of caregivers attending events interviewed, during the semester

- c. Percentage of interviewed caregivers NOT attending events who could not recall key messages defined in the social mobilisation plan:**

Number of caregivers not attending events who could not recall key messages as defined in the plan _____ x100

Total number of caregivers not attending events interviewed, during the semester

Sub-group analyses: Calculate each indicator by social mobilisation channel (where data are available).

INDICATOR TARGET

- a.** 0%
- b.** 0%
- c.** 0%

MONITORING INFORMATION SOURCES AND FREQUENCY OF COLLECTION

Data sources: Supportive supervision reports, event planning reports, health facility reports. On a more occasional basis, as data are available: outcome of exit interviews (indicator b) or household and community surveys (indicators b & c).

Frequency: At the end of each semester as required (e.g. where supervisors reported a likely problem or where attendance was much lower than expected). Otherwise as part of the annual report. Only including indicator c where a household or community survey has been conducted.

ASSUMPTIONS

In defining the indicator, it is assumed that:

- i.** National and/or district plans and micro-plans for social mobilisation for VAS events exist and are available.
- ii.** Materials and other resources needed to conduct social mobilisation activities for VAS are available at the district.
- iii.** Micro-plans include exit interviews by supportive supervision teams at a target number of events.
- iv.** Community or household surveys are conducted where indicators suggest this is required, and include assessment of knowledge of key social mobilisation messages.

RESPONSIBILITIES AND USE OF DATA

District VAS Manager to:

- i.** Follow up and support social mobilisation coordinators prior to events.
- ii.** Investigate the reason for any delayed, incomplete or ineffective social mobilisation activities.

Use of data:

- i.** Take follow-up action to prevent delayed, incomplete or ineffective social mobilisation activities in the following semester, as needed.
- ii.** Determine where exit interviews and/or household community surveys are required to identify potential problems and support strengthened social mobilisation in the following semester.

iii. Provide feedback to the national VAS manager indicating any problems with implementation during the previous semester.

iv. Carry out modification of the social mobilisation activities or plan if needed.

RECOMMENDATIONS

- i.** Ensure social mobilisation resource requirements and guidance are defined and included in annual planning and micro-planning documents and are available to all managers and relevant personnel.
- ii.** Support preparation to ensure timely implementation of effective social mobilisation activities.
- iii.** Ensure that supervision reports include an entry field to report any issues related to caregiver awareness, to enable diagnosis of any problems.
- iv.** Ensure that any verification activities include questions related to caregiver recall and awareness.

For all indicators, special consideration should be given to assessing the situation and solutions to any identified problems for areas that are hard to reach, as well as low performing areas.

APPENDIX D

DETAILED SCENARIOS FOR CALCULATING VAS COVERAGE

TABLE Di**EXAMPLE SCENARIO 1**

Calculation of district coverage for children 6-11 months of age and children 12-59 months of age for one semester, where both age groups are targeted to receive vitamin A through both routine health system contacts and event-based methods in the same semester.

INSTRUCTIONS FOR DISTRICT MANAGERS

Scenario 1 is a district where there are two concurrent delivery mechanisms in place to reach children 6-59 months with VAS. Routine health system contacts delivery method through fixed site health posts continues year round, and the Polio NID campaign has included VAS in its Semester 1 round.

1. Denominators for routine health system contacts and event-based distribution may be based on different estimates. Enter the source of denominator estimates here.

2. Enter denominators for each administrative area for each age group and delivery method here. For example: 2a) The official denominator used for routine health system services in each area should be entered in column A. 2b) If VAS is also distributed through an event such as a Polio NID in the administrative area, then list the Polio NID denominator in column C for each area.

*If you do not have the denominators separated by age group, these can be estimated. Within the age group of 6-59 months of age, the proportion of children who are 6-11 months old is generally estimated to be 0.111 and the proportion of children who are 12-59 months old is generally estimated to be 0.889.

3. Numerators refers to the number of children reached with VAS in the reporting period (Semester 1). Enter the numerator for each age group and for each delivery method separately. For example 3a) the total number of children 6-11 months old who received a supplement through routine health system

contacts in Admin Area 1 in the first semester was 22,400. This is the sum of the number of children 6-11 months old reported as having received a vitamin A supplement in each monthly report during the 6 month period for that Admin Area; 3b) the number of children 6-11 months old reported as receiving a vitamin A supplement through the Polio NID event held during this same 6 month period in Admin Area 1 was 3,211 (usually calculated from the event tally sheets).

4. Calculate coverage by age group for each delivery method separately. Coverage is calculated by dividing the numerator over the denominator. Always use the numerator and denominator that apply to the same specific delivery method. Do not mix the two. For example, 4a) coverage of children 6-11 months of age through routine health system delivery for Admin area 2 = (numerator of children 6-11 months receiving vitamin A through routine health system (column C) denominator of children 6-11 months for routine health system (column A) x 100. This works out to be $(23,498/34,556) \times 100 = 68\%$.

5. In this scenario, district level coverage of children through routine health system contacts is 45% for 6-11 month olds and 9% for 12-59 month olds; whereas the VAS delivery at the polio NID event reached 66% of children 6-11 months old and 99% of children 12-59 months of age. This breakdown allows a district manager to assess how well each delivery method is doing in reaching each age group equally, in each administrative area.

Scenario 1	Denominators										Numerators										Coverage									
	Routine					Event					Routine					Event					Routine					Event				
	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds				
Central Statistics Office	EPI / Polio NID	monthly report	monthly report	monthly report	monthly report	NID tally sheet	NID tally sheet	I	J	L	M	E/A	F/B	G/C	H/D															
Formula reference:	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z				
Admin Area 1	27,623	221,230	36,068	297,865	22,400	3,259	3,211	285,951	81%	1%	9%	96%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%				
Admin Area 2	34,536	276,760	50,335	405,148	23,498	-	5,800	401,096	68%	0%	12%	99%	0%	12%	99%	0%	12%	99%	0%	12%	99%	0%	12%	99%	0%	12%	99%			
Admin Area 3	68,009	544,685	79,029	632,956	38,765	95,898	53,739	636,125	51%	18%	68%	101%	51%	18%	68%	101%	51%	18%	68%	101%	51%	18%	68%	101%	51%	18%	68%	101%		
Admin Area 4	102,347	819,698	139,220	1,126,024	20,458	65,289	138,521	1,125,956	20%	8%	99%	100%	20%	8%	99%	100%	20%	8%	99%	100%	20%	8%	99%	100%	20%	8%	99%	100%		
to																														
Admin Area n	232,555	1,862,373	304,652	2,461,993	105,121	164,446	201,271	2,449,128	45%	9%	66%	99%	66%	99%	66%	99%	66%	99%	66%	99%	66%	99%	66%	99%	66%	99%	66%	99%		
DISTRICT LEVEL																														

TABLE Dii**EXAMPLE SCENARIO 2**

Calculation of district coverage for children 6-11 months of age and children 12-59 months of age for one semester, where the main strategy to reach children 6-11 months of age is through the routine health system delivery method, yet they are also included in the Child Health Days. Children 12-59 months of age are reached only through Child Health Days, and not through the routine health system delivery.

INSTRUCTIONS FOR DISTRICT MANAGERS

Scenario 2 is a district where the main strategy to reach children 6-11 months of age is through the routine health system contacts delivery method, yet they are also included in the Child Health Days. Children 12-59 months of age are reached only through Child Health Days, and not through the routine health system contacts delivery.

Please refer to instructions for Scenario 1 for information on most of the calculations. The information and calculations listed below illustrate the differences in this scenario as compared to Scenario 1.

1. The numerator for 6-11 month olds reached through event delivery in Admin Area 3 is zero. This may be an error but it could be intentional. The coverage through routine health system contacts delivery was high and so it is possible the Admin Area manager decided to focus the social mobilisation on caregivers bringing only their 12-59 month olds to the Child Health Day.

2. These data illustrate why we cannot add the routine health system contacts coverage to the event coverage for a particular age group. If added together it would appear that over 120% of children 6-11 months of age in Admin Area received a supplement in Semester 1. We cannot be sure that the children who attended the Child Health Day are the same children who did not receive VAS through routine health system contacts, so we must continue to report for each delivery method separately.

3. In this scenario it is not necessary to calculate a coverage estimate for children 12-59 months of age through routine health system contacts delivery as only the children 6-11 months of age are targeted by this delivery method. District level coverage of children 6-11 month olds is therefore calculated as 86% through routine health system contacts, 22% through Child Health Days and 94% of children 12-59 months of age through the Child Health Day. This breakdown allows a district manager to assess how well each delivery method is doing in reaching the 6-11 month age group, and how well the Child Health Day is doing in reaching the 12-59 age group, in each administrative area.

Scenario 2	Denominators				Numerators				Coverage			
	Routine		Event		Routine		Event		Routine		Event	
	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds
Central Statistics Office	Central Statistics Office)	Child Health Day micro-plan	Child Health Day micro-plan	monthly reports	monthly reports	CHD tally sheets	CHD tally sheets	I	J	L	M	
Formula reference:	A	B	C	D	E	F	G	H	E/A	F/B	G/C	H/D
Admin Area 1	27,623	221,230	36,068	297,865	22,400	0	14025	285,951	81%	0%	33%	96%
Admin Area 2	34,556	276,760	34,556	276,760	23,498	0	5,800	265,852	68%	0%	17%	98%
Admin Area 3	68,009	544,685	72,120	632,956	62,987	0	0	636,125	93%	0%	0%	101%
Admin Area 4 to	102,347	819,698	110,369	900,568	91,568	0	35,654	798,699	89%	0%	32%	89%
Admin Area n												
DISTRICT LEVEL	232,535	1,862,373	253,113	2,108,149	200,453	0	55,479	1,990,627	86%	22%	94%	

TABLE Diii**EXAMPLE SCENARIO 3**

Calculation of district coverage for infants 6-11 months and children 12-59 months of age for one semester, where children 6-11 months of age are targeted to receive vitamin A through routine health system contacts only, and children 12-59 months of age are targeted to receive vitamin A through the event only.

INSTRUCTIONS FOR DISTRICT MANAGERS

Scenario 3 is a district where the children 6-11 months of age are targeted to receive vitamin A through routine health system contacts only, and children 12-59 months of age are targeted to receive vitamin A through the event only.

Please refer to instructions for Scenario 1 for information on most of the calculations.

The information and calculations listed below illustrate the differences in this scenario as compared to Scenario 1.

1. The denominator estimate for children 6-11 months of age from Child Health Day micro-planning is blank because that age group is not being targeted in the scenario.

2. In this scenario, district coverage is reported as 86% of children 6-11 months of age through routine health system contacts and 94% of children 12-59 months of age through the Child Health Day event.

Scenario 3	Denominators				Numerators				Coverage	
	Routine	Event	Routine	Event	Routine	Event	Routine	Event	Routine	Event
6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	6-11 mo olds	12-59 mo olds	12-59 mo olds
Central Statistics Office	Central Statistics Office)	Child Health Day micro-plan	Child Health Day micro-plan	monthly reports	monthly reports	CHD tally sheets	CHD tally sheets	—	M	
Formula reference:	A	B	C	D	E	F	G	H	E/A	H/D
Admin Area 1	27,623	221,230	-	297,865	22,400	0	0	285,951	81%	96%
Admin Area 2	34,556	276,760	-	276,760	23,498	0	0	269,852	68%	98%
Admin Area 3	68,009	544,685	-	632,956	62,987	0	0	636,125	93%	101%
Admin Area 4	102,347	819,698	-	900,568	91,568	0	0	798,699	89%	89%
to										
Admin Area n										
DISTRICT LEVEL	232,535	1,862,373	-	2,108,149	200,453	0	0	1,990,627	86%	94%

1

2

APPENDIX Ei

ROUTINE VAS REGISTRATION FORM— HEALTH FACILITY LEVEL

ROUTINE VITAMIN A SUPPLEMENTATION AND DEWORMING REGISTRATION BOOK

APPENDIX Eii
**ROUTINE REPORTING FORM—
HEALTH FACILITY LEVEL
(EXAMPLE FROM ETHIOPIA)**
ROUTINE VITAMIN A SUPPLEMENTATION, DEWORMING AND SCREENING REPORTING FORM

REPORTING PERIOD:	
HEALTH POST	
KEBELE:	
WOREDA:	
ZONE & REGION :	
NAME OF HEALTH EXTENSION WORKER WHO PREPARED THE REPORT	
DATE	
SIGNATURE	

		VITAMIN A SUPPLEMENTATION		
		Female	Male	Total
Total population children 6-59 months	A			
Number of children 6-11 months supplemented with Vitamin A	B			
Number of children 12-59 months supplemented with Vitamin A	C			
Total number of children (6-11) + (12-59) months supplemented with Vitamin A	D = B + C			
Vitamin A supplementation coverage	E = (D / A) x 100			

		DEWORMING		
		Female	Male	Total
Total population children 2-5 years	A			
Nb of children 2-5 years dewormed	B			
Deworming coverage	C = (B / A) x 100			
		SCREENING		
		Female	Male	Total
Total population children 6-59 months	A			
Number of children 6-59 months screened with bilateral oedema SEVERE ACUTE MALNUTRITION (SAM)	B			
Number of children 6-59 months screened with no oedema and MUAC<11cm (Red) SEVERE ACUTE MALNUTRITION (SAM)	C			
Number of children 6-59 months screened with no oedema and MUAC 11-12 cm (Yellow) Moderate Acute Malnutrition (MAM)	D			
Number of children 6-59 months screened with no oedema and MUAC>12cm (Green) NO ACUTE MALNUTRITION	E			
Total number of children 6-59 months screened	F = B + C + D + E			
Screening coverage (%)	(G = F / A) x 100			
Total number of pregnant & lactating women (PLW) Screened	Total PLW screened	PLW counselled	Referred to TSFP	Total PLW received Iron/Iron Folate
Number of PLW with MUAC>= 23cm (Normal)				
Number of PLW with MUAC < 23cm (Malnutrition)				

APPENDIX Eiii

MONTHLY REPORTING FORM – HEALTH CENTRE LEVEL (EXAMPLE FROM ETHIOPIA)

Routine Vitamin A Supplementation, and Deworming and Nutritional Screening Zonal Reporting Format

Region: _____

Reported HC: _____

Zone: _____

Date of Report _____

Woreda: _____

Report by (Name & Signature) _____

Nutritional Screening for children 6- 59 months and PLW

APPENDIX Eiv

MONTHLY REPORTING FORM – SUB-DISTRICT LEVEL (EXAMPLE FROM ETHIOPIA)

Routine Vitamin A Supplementation, and Deworming and Nutritional Screening Zonal Reporting Format

Region: _____

Reported HC: _____

Zone: _____

Date of Report _____

Woreda: _____

Report by (Name & Signature) _____

Nutritional Screening for children 6- 59 months and PLW

APPENDIX Ev

MONTHLY REPORTING FORM – DISTRICT LEVEL (EXAMPLE FROM ETHIOPIA)

Routine Vitamin A Supplementation, and Deworming and Nutritional Screening Zonal Reporting Format

Region: _____

Reported HC: _____

Zone: _____

Date of Report _____

Woreda: _____

Report by (Name & Signature) _____

Nutritional Screening for children 6- 59 months and PLW

APPENDIX Fi

VITAMIN A & DEWORMING TALLY SHEET

(EXAMPLE FROM NIGERIA)

County _____ District _____ Town/Village _____ Date (s) _____

Health Facility _____ Team Member Code: _____ Supervisor Code: _____

Cross one box for each child														Total																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Blue Capsules	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
6 - 11 months	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	

Cross one box for each child														Total																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Red Capsules	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180
12 - 59 months	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210
211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	
241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	
271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	
301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	
331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	
361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	

Cross one box for each child														Total																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Blue Tablets	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
6 - 11 months	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	
12 - 59 months	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180
211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	
241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	
271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	
301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	
331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	

Received	Used	Returned	Deworming Received	Used	Returned
Blue	Red	Blue	Red	Blue	Red

Vitamin A capsules

Verified by Supervisor/DHO

FORM Fii

VITAMIN A DAILY DISTRICT SUMMARY (EXAMPLE FROM NIGERIA)

Vitamin A coverage information
A1 target population of 200,000IU
A2 target population of 100,000IU
B1 200,000IU received

APPENDIX G

PLANNING AND BUDGETING TOOLS

Data entry sheet:
Fill in yellow cells for ONE distribution

1. Name of district:

District name

2. Total population

Official population		Enter official district population estimate this year
---------------------	--	---

3. Target population

Age group	Official population estimates
6-11 months	Half of '0' year olds
12-59 months	Total 1-4 year olds

4. Number of distribution posts:

Type of distribution post	# distribution posts
Health facility (fixed post)	
Outreach post (mobile teams)	

5. Staffing of distribution posts:

Type of staff	# staff per distribution post
Health facility	
Health Staff	
Volunteers	
Outreach post	
Health Staff	
Volunteers	
Others	

6. Total number of Council supervisors:

8. Social mobilisation costs:

Activity	Currency
Meetings (refreshments, materials, etc.)	
Miking, radio and other public announcements	
Posters, pamphlets, other printed materials	
Transport and related costs in preparations	

9. Tally sheets, registers and other stationary costs

 Currency

10. Fuel costs

Cost of fuel per litre

	Number vehicle/ motorbike/boat	Average kms to be covered per vehicle	Sub total
Vehicle			0
Motorbike			0
Boat			0
Maintenance of vehicles			
Do you want maintanance? 1=Yes or 0= No		1	0

11. Per diems:

Type of staff	Per diem (rate)	Number of days	Total amount per person
Supervisors and drivers			
Supervisors			0
Drivers			0

12. Extra duties

Type of staff	Extra duty	Number of days	Total amount per person
Health Facility			
Health Staff			0
Volunteers			0
Outreach post			
Health Staff			0
Volunteers			0
Others			0

RESULTS: THE ESTIMATED DISTRICT BUDGET FOR 2 DISTRIBUTIONS**Budget excluding supply costs**

0

Currency

Budget including supply costs

Supplies	Amount
Total cost	0

APPENDIX H

SUPPLY REPORTING FORM—

HEALTH FACILITY LEVEL

(EXAMPLE FROM ETHIOPIA)

Supply report form for drugs & equipment

Region _____	Zone _____	Woreda _____	Health Facility _____
Date of report _____	Reported by: Name & Signature _____		

A. Drugs

Items	(A) Received	(B) Used	(C) Wastage/Damage
Vitamin "A"			
Albendazol			
Iron			
Iron Folate			

B. Equipment

Items	(A) Received	(B) Used	(C) Wastage/Damage
Scissors			
MUAC Tape			
Vitamin A & De-worming registration			
Screening registration book			
Tally sheet for PLW			
Monitoring Chart			

A - (B+C) Stock balance	Required	Remark

A - (B+C) Stock balance	Required	Remark

APPENDIX I

SUPPORTIVE SUPERVISION CHECKLIST

Supportive Supervision Checklist- Vitamin A Supplementation by Health Workers						
<p>This checklist should be utilized to provide regular supportive supervision to distribution teams during VAS Campaigns. The checklist should be implemented by a trained supervisor with randomly selected distribution teams throughout the implementation of the Campaign. The supervisor should use the checklist to provide real time feedback to the distribution team staff on best practices for VAS delivery to ensure that the supply and delivery of VAS meets MoH Guidelines. Major gaps in supply and delivery should be reported immediately to stakeholders to ensure corrective measures are made.</p>						
Name of Supervisor:		Date of Collection:				
District:		Time of Collection:				
Distribution Team:						
Name of Health Worker:		Task/Skill		Assessment		Comments
Items to Observe				Yes	NI	No
A. Set up and preparation for the VAS distribution						
1. Before the distribution, review with the health care worker the following:						
1. All members of the distribution team are present and on time						
2. Community mobilisation was conducted in the distribution area prior to the distribution						
3. Community mobilisation materials are visible in the distribution area						
4. If yes, please specify what type of materials are available (write in the space provided)						
5. The distribution is set up in the specified area during the specified time						
The following supplies are available prior to distribution:						
6. Vitamin A Supplementation 100,000 IU (Blue Capsule)						
7. Vitamin A Supplementation 200,000 IU (Red Capsule)						
8. Scissors to cut the capsule with						
9. Supply of Child Health Cards for children						
10. If Blue Capsules are not available, ask the health worker how they provide VAS to children 6-11 months of age						
11. If a Red capsule is used, does the health worker determine the half dose of a red capsule by counting the number of drops in a full capsule?						
For each of the below tasks, observe the health worker as VAS is delivered to children 6-59 months of age						
12. The health worker asks the age of the child						
13. The health worker asks to see the child's health card						
14. If there is no health card, does the health worker ask the caretaker if the child has received VAS in the past 1 month?						
15. If there is no health card, does the health worker show the Vitamin A capsule to the caretaker?						
16. If health card is available, does the health worker review the receipt of VAS on the health card?						
If VAS is to be given						
17. If the infant is 6-11 months of age, does the health worker select either a blue capsule or ½ of a red capsule?						
18. If the child is 12-59 months of age, does the health worker select a red capsule?						
19. Does the nurse cut the capsule with scissors and immediately squeeze the drops of liquid into the child's mouth?						
20. Does the nurse ensure that the child has swallowed the drops?						
21. Does the nurse record the dose on the child health card?						
22. Does the health worker use the provided tally sheet to record each dose of VAS?						

After distribution, please ask the health worker to answer a few questions regarding the Vitamin A Campaign

23) Were there any problems with vitamin A supplies in the last round?

- 1 No problems
- 2 Shortage of 100,000 IU capsules
- 3 Late delivery to districts
- 4 Shortage of 200,000 IU capsules
- 5 Late delivery to distributors
- 6 Don't know
- 7 Other (specify)

24) If you ran out of 100,000 IU capsules during the campaign, what did you do?

- 1 n/a, did not run out
- 2 Gave half of 200,000 IU capsule
- 3 Turned away, didn't tell them to come back
- 4 Turned away, asked them to come back later
- 5 Referred to a nearby health facility
- 6 Don't remember
- 7 Other (specify)

25) Are there any groups of targeted children in your area that tend to repeatedly get left out of the Vitamin A supplementation campaign?

- 0 No
- 1 Yes
- 2 If yes, please specify the groups of children

26) In your opinion why are these children left out?

- 1 They are nomadic or transient
- 2 They live too far away
- 3 Language differences/barriers
- 4 Cultural/tribal barriers
- 5 They don't receive information about the campaigns
- 6 They don't understand the importance of vitamin A to health
- 7 They don't trust health centers or government programs
- 8 They don't believe in taking supplements or Western medicines
- 9 Don't know
- 10 Other (specify)

22) How do you think vitamin A supplementation could be improved in your area?

- 1 Mass media campaigns to increase awareness
- 2 Sensitization of men and household decision makers
- 3 Better coordination between community and health workers
- 4 Ensuring adequate supplies of vitamin A
- 5 Regular training of health workers
- 6 Motivating health workers
- 7 Motivating of community health volunteers/workers
- 8 Don't know / there are no areas for improvement
- 9 Other (specify)

23) Additional comments:

APPENDIX J

FOCUS GROUP DISCUSSION FACILITATION GUIDE

Adapted excerpt from: *A guide to assess barriers to key maternal, newborn and child health interventions from the perspective of beneficiaries and to involve them in identifying solutions*

Focus group discussion (FGD) with caregivers of children under the age of 5 years to determine barriers to vitamin A supplementation

Objective: 1) To learn about barriers to vitamin A supplementation from the perspective of caregivers 2) To obtain caregivers' ideas about how to ensure all families get their children vitamin A supplements

Method: Focus group discussion with caregivers of children under the age of 5 years, key informant interviews with key stakeholders in the community

Key considerations

- Selection of participants should be purposive to include 10-20 caregivers of children under the age of 5 years (to be determined locally: whether or not it is appropriate to include a mix of some who used health services when their child was last ill and some who did not or whether it will be important to separate out these two types of participants)
- Facilitation team should work as one interviewer and one note taker. If possible, tape record discussion.

- Begin with standard introduction, including purpose of the assessment (see Annex). Encourage participants to share their honest opinions, even if they have different opinions to those being expressed by others in the group. Also encourage participants to be respectful of others' opinions, even when they differ from their own.

- Obtain consent for participation following locally approved guideline.
- Listen for (and document) any local terms used that might be important to inform the development of appropriate questions for the household survey.

Facilitation guide for FGD (to be modified for key informant interviews)

1. Have you heard of vitamin A supplements? If at least some participants answer yes, ask:
 - What are they and why are they given to children?
 - If participants mention that supplements can prevent and/or treat disease, ask: What kinds of diseases can be prevented / treated with vitamin A supplements?
 - Unless already mentioned, ask specifically whether or not participants have heard of "xerophthalmia" or "dry eye syndrome" (use locally appropriate term) and what causes it.

2. Do you know how often it is recommended that young children receive vitamin A supplements? After participants provide answers, confirm that children 5 years and younger should receive them every 6 months.

3. What if anything, makes it difficult for families to get vitamin A supplements for their children every six months? Probe: What are your ideas about how to ensure more families get vitamin A supplements for their children every six months? Probe until the full group provides ideas.

4. Who in households is involved in deciding whether or not a child should or should not go for immunization, get vitamin A supplements or de-worming treatment? Is there anyone else that is usually involved as well?

5. Are there community-based workers (such as community health workers) who visit homes with children who talk about vitamin A supplementation? If participants answer yes, probe to understand more about what the community workers do during these visits.

6. Thank the participants for their time and remind them of the purpose of the assessment as well as whom to get in touch with if they would like more information about the assessment.

If, based on the responses to question 4, it is discovered that others within the household (e.g., husbands, mothers-in-law, etc) are responsible for making decisions about immunization, vitamin A supplementation and deworming treatment, conduct a focus group discussion/key informant interviews with those types of participants using the above questions.

APPENDIX J_i

ANNEX: SAMPLE CONSENT FOR FOCUS GROUP DISCUSSIONS

(Can be modified for key informant interviews)

Hello, my name is _____ and these are my colleagues _____. We are here on behalf of [name of organization]. We are interested in hearing from you about barriers that affect the health of children and women in your community. Your viewpoints will be very helpful to us in getting a better understanding of the problems and difficulties people experience.

The information that you provide will be kept confidential so we hope you will feel comfortable giving your honest opinions about the problems families face. Even if you have a different opinion to those being shared by others in this group, please share it. We want to hear all your opinions. Please also be respectful of the others who share their thoughts today. If you do not agree with what they say, please feel free to let us know but you can do that in a respectful way.

Our team is working on behalf of the [District Health Management Team] but is also independent of them. We are here to learn from you. The issues you raise can help shape future health programmes and activities.

Are there any questions? (*Continue to answer any questions raised until there are no more and then proceed to the questions in the facilitation guide.*)

Please sign this form with your name or an X to signify that you agree to participate in this discussion.

Signature (or X) of participant

Date

Signature of witness

Date



CONCEPT & DESIGN: HME DESIGN COMMUNICATIONS