TWICE-YEARLY VITAMIN A SUPPLEMENTATION

A GUIDE FOR PROGRAM MANAGERS
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INTRODUCTION

Almost a decade ago, a meta-analysis of field trials to determine the impact of vitamin A on child mortality concluded that mortality declines in response to improved vitamin A status could be as high as 30 percent. One means of improving vitamin A status in children is the administration of high-dose vitamin A supplements. These supplements rapidly replenish body stores of the vitamin that last for four to six months.

To realize immediate public health impact, WHO, UNICEF, USAID, other development organizations, and governments took advantage of the proliferation of National Immunization Days (NIDs) by distributing high-dose vitamin A supplements during NIDs in more than 50 developing countries. NIDs provided a ready path toward high coverage with vitamin A supplementation in children and, accordingly, a path toward the saving of many lives.

In many countries, NIDs are phasing out as increasing progress is achieved towards polio eradication. In others, they are being extended for a limited time and/or replaced with more localized campaigns. And, in many countries, NIDs occur but once a year while effective prevention of vitamin A deficiency for vulnerable children (aged six months to five years) requires at least two high-dose vitamin A supplements each year. For all these reasons, an alternative means of distributing vitamin A to children is needed.

In recent years, a number of countries have implemented vitamin A capsule distribution programs for children separate from NIDs. A number of distinct approaches have been tried, including the implementation of child health weeks, the creation of micro-nutrient days, and distribution through community-based (as opposed to facility-based) channels. These approaches all share the following common themes:

— They are periodic (usually twice a year) either during a specified week or day(s).
— They are active in that, just prior to a scheduled distribution, mothers are reminded and encouraged to take their children to designated centers or outreach posts for delivery of the supplements.
— They are institutionalized in that they are run or managed routinely by health workers, frequently with the support of officials from other sectors, and sometimes with volunteers.

And the approaches are often integrated with other interventions, such as growth promotion, deworming, bed nets, vaccinations, and other micronutrient programs.

Alternatives to the periodic active, institutionalized distribution of vitamin A are often considered, such as the delivery of supplements to children individually as they reach specified ages, similar to the way children receive vaccines at health facilities. Experience to date suggests that the distribution of the supplements to all children on the same specified dates, year after year, is a more effective means of reaching a large majority of the children with supplements in environments where the health infra-

structure does not extend throughout the periphery or the utilization of health services is low. It is also surprisingly inexpensive. By limiting the distribution to two points in time each year, it becomes economically feasible to rally the caregivers of all children to participate in the distribution and, as a result, to achieve high coverage within the target population.

This guide has been developed to assist program managers in the design, implementation, and evaluation of periodic, active, institutionalized distribution programs for vitamin A.
PROGRAM IMPLEMENTATION:
AN OVERVIEW

The following is a useful guide to the design and implementation of a successful vitamin A supplementation program. Every country or region of a country has unique characteristics that lead to individualized actions and adaptations.

First steps
— Assign responsibility for coordination and oversight.
— Choose a district approach or a nationwide approach.
— Decide who will administer the vitamin A capsules.*
— Ensure accessibility for at-risk groups.
— Establish a general cycle of activities for supplementations.

Training
— Develop a training plan for capsule providers.
— Provide training for supervisors.

Demand-creation activities
— Develop key messages, select audiences and channels, pretest messages, and launch distribution.
— Monitor and evaluate demand-creation activities.

Logistics of the supplementation system
— Determine number of capsules needed.
— Provide for adequate storage of capsules.
— Identify distribution mechanism.
— Secure additional supplies.

Supervision and Monitoring
— Use observation checklists and exit interviews.
— Reward/recognize good performance.
— Monitor coverage.
— Monitor supply of capsules.

Program costs and funding
— Determine program costs.
— Secure necessary funding.

* In some countries, vitamin A is delivered in liquid form; that is, in a syrup. Throughout this document, repeated reference is made to capsules; however, the steps are quite similar in programs using syrup.
FIRST STEPS

Key decisions made early in the process of designing and implementing a supplementation program provide a solid foundation upon which to build.

- Assign responsibility for coordination and oversight.
- Choose a district approach or a nationwide approach.
- Decide who will administer the vitamin A capsules.
- Ensure accessibility for at-risk groups.
- Establish a general cycle of activities for supplementations.

1. **Who should have the responsibility for coordination and oversight of the supplementation program?**

Once the need for a supplementation program is identified and a supplementation policy utilizing a periodic, active, institutionalized distribution approach established, a government unit or some other coordinating group should be put in charge of implementing the policy. In some countries, this responsible body has been the maternal and child health division of the ministry of health. Responsibilities for program implementation should also be assigned at the regional and district level.

2. **Should the program be started in a few districts or in all districts nationwide?**

Supplementation programs can either be started in a few districts and built up to cover all districts in a country or the program can cover all districts nationwide at the outset. In Nepal, where the program implementing agency is a local NGO and a network of female community volunteers is used, the program began in a few districts and at each round additional districts have been added to the earlier ones. In Ghana, the MOH decided to go nationwide with the first distribution, using both health workers and volunteers, and has achieved high vitamin A coverage.

3. **Who should administer the vitamin A capsules?**

Some countries have raised questions about who can safely and best administer vitamin A capsules. In Nepal, trained volunteers have had sole responsibility for administering the capsules since 1994 without incident. In most countries, a combination of trained health workers and trained volunteers (village workers, school teachers, NGOs, etc.) work together to achieve high vitamin A coverage.

4. **How can the accessibility of supplementation for at-risk groups be ensured?**

An implementation approach should be chosen that is both effective in achieving high vitamin A coverage and affordable. One of the most important factors is the accessibility of the distribution sites to the target population. The number and location of

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*It is not necessary to conduct a baseline vitamin A deficiency assessment to determine the need for a supplementation program. In countries where child mortality rates are over 70 per 1,000 and/or maternal night blindness is 5 percent, it is very likely that a vitamin A deficiency problem exists.*
distribution sites should be identified in collaboration with those responsible at the regional and district levels, since they have better knowledge of the accessibility issues and how to reach the at-risk-population. It is also useful to involve the network of NGOs in the vitamin A distribution, as they usually work with hard-to-reach populations for which the MOH has difficulty providing adequate coverage, due to financial constraints. NGO involvement should be planned well prior to the distribution to maximize their participation in the process.

5. What should be the general cycle of activities in twice-yearly supplementations?

Regardless of the final mechanism for distribution of supplements, the following general cycle of activities should be anticipated, assuming that the distribution will take place in December and June.

<table>
<thead>
<tr>
<th>General cycle of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>November:</strong> Completion of the preparation for promotion of vitamin A supplementation, training, and orientation of health staff, volunteers and community members; as well as assurance that the correct amount of capsules are sent to the districts and from the districts to the health posts and that scissors or nail cutters are sent to the districts.</td>
</tr>
<tr>
<td><strong>December:</strong> Vitamin A distribution; community promotion, completion of tally sheets, supervision and observational visits.</td>
</tr>
<tr>
<td><strong>January/February:</strong> Mini-survey conducted in selected districts.</td>
</tr>
<tr>
<td><strong>March/April:</strong> Aggregation of tally information, estimation of coverage, compilation of supervisory and observational visit reports, completion of report on distribution; use of findings to reward districts for their good performance. Validation of the coverage from the mini-survey with the coverage from the tally sheets.</td>
</tr>
<tr>
<td><strong>May:</strong> Preparation for second distribution round: mass media, community-level promotion, district training/orientation, logistic support for capsule supplies.</td>
</tr>
<tr>
<td><strong>June:</strong> Second-round distribution, completion of tally forms, supervision and observational visits.</td>
</tr>
<tr>
<td><strong>July/August:</strong> Mini-survey conducted in selected districts.</td>
</tr>
<tr>
<td><strong>September:</strong> Aggregation of tally information, estimation of coverage, compilation of supervisory and observational visit reports, completion of report on second-round distribution. Validation of the coverage from the mini-survey with the coverage from the tally sheets.</td>
</tr>
<tr>
<td><strong>October:</strong> Summarization of annual vitamin A supplement activities; completion of annual report summarizing various indicators of program progress over the course of both rounds for the year.</td>
</tr>
</tbody>
</table>
TRAINING

As many health providers and/or community leaders are not informed about vitamin A and its important role in preserving child health, special training that addresses the benefits of vitamin A and the means of its distribution may be needed at the start of a program. This training may well be quite intensive and, therefore, expensive at the start of a program; however, as the program matures and the training is a refresher course rather than an introduction, training expenses will decline.

- Develop training plan for capsule providers, covering time needed, methodology, and content.
- Provide training for supervisors, covering supervisory skills and observation of capsule distribution and exit interviews.

1. **How much time is required for training and how far in advance of the vitamin A distribution should it be held?**

In order to provide the basic training regarding vitamin A and its distribution rapidly, many countries adopt a cascading model for training in which people at the center are trained first and those individuals train colleagues at the regional level who, in turn, train people at district level. The providers who will administer and record vitamin A supplementation usually require two days of orientation and training, depending on their previous exposure to vitamin A training. The training should take place several weeks in advance of the vitamin A distribution so that the districts and the peripheral (frontline) level have time to complete their part of the training.

2. **What training methodology should be used?**

Experience to date suggests that a training methodology that gives the trainees the opportunity to solve problems in a simulation of the distribution event is more effective than a methodology relying only on lectures. Problem-solving discussions that involve providers in stating and determining ways to overcome barriers to successful capsule distribution have proven useful in identifying effective approaches and, by increasing ownership, increasing provider motivation. As part of this process, an awareness of the importance of vitamin A supplementation can be generated among staff at all levels of the system.

3. **What should the training cover?**

Training should focus on provider motivation, by covering the benefits of and basic information on vitamin A, and the behavioral expectations for providers, including correct capsule distribution and communication skills.

a) **Information on benefits/basic facts about vitamin A.** Providers, and particularly health workers, may believe that preventive services are a low priority and that nutrition programs have little impact and are complex. They may also be unaware that vitamin A can save lives as surely as immunizations do. Providers need to know the benefits associated with vitamin A capsules as well as other basic facts about vitamin A (see box below). One way of assuring that providers
have this knowledge is through the use of overhead presentations (see examples in Appendix A) that stress the mortality effect of vitamin A deficiency, the gains associated with good coverage, and the benefits from vitamin A capsule distribution for health services because of less demand for drugs and service.

**Benefits/basic facts about vitamin A**

**Health facts about vitamin A.** Vitamin A protects children from becoming seriously ill from common illnesses; decreases the risk of children dying from diseases such as measles and diarrhea; and prevents serious eye disease and night blindness.

**Biological facts about vitamin A.** Vitamin A is stored in the body for up to four to six months but is lost quickly when a child has an infection. Vitamin A is available in liver, eggs, meat, dark-green leafy vegetables, papayas, mangos, orange-fleshed sweet potatoes, and red palm oil, but children must eat adequate quantities of these foods regularly to get enough; if the diet is not adequate, supplementation is necessary.

**Supplementation safety and side effects.** There is a good safety margin for vitamin A, so that you do not need to worry excessively about the exact age of the child, although you should ensure that a child is at least six months old. The side effects from vitamin A supplementation are rare but can include nausea and vomiting, which will go away with time. There are no conditions or illnesses that would prevent a child from being dosed; however, children who come for dosing who are sick with measles or xerophthalmia should be referred to the health facility for treatment.

b) **Skill development for capsule providers.** Clear performance objectives for providers related to the administration of vitamin A capsules and provider-caregiver communication can be developed through agreement with those most involved, including nutrition units, ministries, and the providers themselves.

Experience has taught that workers need to be and feel competent in administering vitamin A capsules correctly—knowing proper dosage, estimating age, cutting capsules, tallying, etc. (See box on opposite page.) These skills are more complex than expected and need careful training. Demonstration with practice works best, with the opportunity to problem solve; for example, workers should be asked to demonstrate how to use a 200,000 IU capsule for a child under one. A short worker aid that clearly shows dosages and how to give the capsules, including the correct way to cut the capsule, may need to be provided with the capsules.

With regard to provider-caregiver communication, the provider should tell the caregiver that the child is receiving vitamin A, say something positive to the caregiver about participation (“vitamin A will help your child resist disease/grow well/be strong/stay healthy”), and remind the caregiver when to come back for the next capsule.
Correct dosage of vitamin A

Blue capsules=100,000 IU          Red capsules=200,000 IU

Children from six months to 11 months of age. Give a blue capsule that contains 100,000 IU of vitamin A for each dosing round. You can also give half of a red capsule if there are not enough blue capsules.

Children over one year and up to five years of age. Give a red capsule that contains 200,000 IU of vitamin A for each dosing round. You can also give two 100,000 IU capsules if there are not enough 200,000 IU capsules.

Note: In certain countries, like India, the vitamin A is given in syrup rather than capsule form.

Guidelines for administration of vitamin A*

Step 1. Check that you know what dose of vitamin A to give to what age group. If you are using two sizes of capsules, make sure you know which capsule contains 100,000 IU and which contains 200,000 IU.

Step 2. If you are using only 200,000 IU capsules, you need to calculate the number of drops for a half-dose (100,000 IU). Open a few capsules (with scissors or nail clippers), squeeze out the contents, and count the number of drops per capsule. Calculate the average number of drops, and divide by two for the number of drops for a half-dose (100,000 IU).

Step 3. Check to see that you are well positioned at the post to allow you to do all the tasks associated with administration of vitamin A. Good positioning will minimize interruption to the flow of children through the post.

Step 4. As each child arrives, find out his/her age group (below 6 months, 6–11 months, or 12–59 months) and decide the correct dose for the age group. Use a method appropriate for the culture to determine the age of the child. This may simply be done by asking the caregiver or observing the child. A child who is walking is likely to be at least 12 months old. In some programs age rosters can be prepared in advance, simplifying this step.

Step 5. Tell the caregiver that the child is receiving vitamin A, that vitamin A makes children grow better, faster, and stronger, and to bring the child back in six months for another capsule.

Step 6. Using scissors, or nail clippers, cut open the vitamin A capsule and squeeze out the drops into the child’s mouth. If only a half-dose is to be given to a child, squeeze out the required number of drops directly into the child’s mouth and discard the rest (it is not worth trying to keep the opened half-capsule for the next child because it will leak, become messy, and affect the accuracy of the dose). Do NOT ask children to swallow capsules. Do NOT give capsules to caregivers to take away.

Step 7. Discard all used vitamin A capsules in a plastic bag or container.

Step 8. Put one mark on the tally sheet for each child given vitamin A.

*Based on Distribution of vitamin A during national immunization days. WHO/BASICS. 1998.

REMEMBER: DO NOT GIVE VITAMIN A SUPPLEMENTS TO ANY MOTHER OR WOMEN OF REPRODUCTIVE AGE BECAUSE OF THE RISKS IF PREGNANT AND THE DIFFICULTY OF SCREENING CAREFULLY DURING DISTRIBUTIONS.
4. **What should be included in the training for supervisors?**

The goal of the training (usually half-day) for supervisors is to acquaint them with the skills needed to conduct effective supervision: interpersonal communication with workers, problem solving and support, and quality assurance. Included should be an introduction to and practice with the observation and exit interview forms to use during capsule distributions. (See examples of these forms on pages 25 and 26 in the section on supervision and monitoring.) The observations and exit interviews provide an ongoing measure of provider capsule administration and communication practices.
DEMAND-CREATION ACTIVITIES

The advantage of periodic supplementation lies in the ability to promote participation actively by mothers for relatively little expense, as the promotion occurs only twice each year. Over time, a well-conceived strategy to promote vitamin A as a means to preserve the health of children will result in the creation of demand throughout the community for continuing the vitamin A program.

- Develop key messages, select audiences and channels, pretest messages, and launch distribution.
- Monitor and evaluate demand-creation activities.

1. How often do demand-creation messages/materials need to be developed?

The major research and strategy design investments for demand creation are made largely in the initial start-up period, when the key messages about vitamin A are developed, the appropriate audiences and dissemination channels for the messages determined, and the materials and channels pretested. Monitoring of the reaction to the promotional activities will suggest revisions that improve and give more life to the campaign.

2. How far in advance of the vitamin A distribution should preparation of the demand-creation materials begin?

The promotion of the vitamin A program should start about a month before the distribution. The research, design, pretesting, and production of the materials—a process that typically takes several months—should be completed by this time.

3. What are the steps in developing key messages about vitamin A?

a) Formative research. Focus groups of caregivers can provide the data needed to understand any barriers to vitamin A supplementation and to produce an active, attention-getting logo and messages promoting the benefits of vitamin A that the caregivers find most appealing. After explaining the mortality and child survival benefits of vitamin A to the focus group participants, provide them with a choice of possible messages, including some on the “survival” value (saving lives, helping children recover from serious illness) and some on the “vitality” value (helping children grow strong, be active and energetic, be healthy and active).*

* Asking members of the community or even health care staff what they know about vitamin A has not proven helpful—if they know anything it is likely to relate to blindness prevention or healthy eyes. Today, eye damage or night blindness is less common and may be seen as problems of people “not like us.” “Good sight” messages are therefore not as useful as more vivid and dramatic messages related to saved lives or increased vitality and strength.
b) **Designing the messages.** Once the research is done, it is important to develop a clear statement of what caregivers should do. This process includes identifying the barriers that must be overcome and the messages or actions to overcome the barriers; a “key promise” that states clearly and persuasively the main benefits from the audience’s perspective of vitamin A capsules or vitamin A; the tone to use in discussing the issue, etc. Preparing a creative brief is a good way to do this (see Appendix B for template and examples). The creative brief can be used to develop talking points for staff, who can use these outlines to focus messages and communication on key resistance points and promote consistent and correct messages.

Experience has shown that the most useful messages are those related to saved lives or increased vitality and strength. It is also important to provide assurance from a trusted medical source that supplements are safe, as toxicity rumors may occur; and to distinguish vitamin A supplementation from other medicines or immunizations, since it is common for caregivers to confuse vitamin A with polio vaccine from NIDs.

Develop precise messages for caregivers that make it clear what it is they should do about vitamin A supplementation: for example, “Bring your children aged x to the distribution points for the protection of vitamin A twice a year during the vitamin A months, x and x.” The goal is to make the twice-yearly distributions the norm so that providers and communities take them for granted.

4. **What are the appropriate audiences and best channels for disseminating the messages?**

   a) **Audiences.** Caregivers of children over one year old should be stressed in all pictures, posters, etc., to emphasize that these new services include a new group of older children as well as the younger children who are targeted for immunization. Often parents are pleased that their older children are now offered protection and preventive services.

   b) **Channels.** In addition to mass media and community and religious leaders, local networks and village-based systems, such as town criers, market criers, and schools have been successful. The "calls to action" (telling when, where, and who) in the days before and during the distribution can rely heavily on local networks. Success depends upon reaching as many people during distribution as possible.

5. **Is it necessary to pretest the message materials and channels?**

Message materials and channels should be pretested with target audiences to assure that the materials are understood and have the desired emotional appeal/impact and that the channels are trusted by and reach the designated audiences.

6. **How should the capsule distribution be launched?**

A powerful and inexpensive way to leverage publicity for the capsule distribution is to hold a press briefing (with ample time for questions) for local print and electronic media to provide background information on program benefits and distribute handouts, photo-ready graphs, pictures, and other materials. The briefings should generate invi-
tations to talk shows, educational programs, etc., for staff, as well as free and accurate coverage. Involving senior ministry of health or other officials in the launch can increase acceptance, motivation of capsule providers, and publicity.

7. **How should demand-creation messages/materials be monitored and evaluated?**

The observation checklists and exit interviews (see pages 25 and 26 in the section on supervision and monitoring) provide an ongoing measure of changes in and levels of caregiver knowledge and intentions. In addition, mini-surveys (see page 27 in the section on supervision and monitoring) can measure caregiver knowledge and practice, exposure, recall, and reaction to specific messages and channels. As the program matures, there may be a need to adapt questions to allow closer monitoring of specific activities. For example, a question may be added on exposure by asking the respondents if they have been exposed to each one of the channels used (radio, TV, religious leaders, etc.). If some of the media are not working, it may be desirable to look further to find reasons for the problem.

Ongoing monitoring helps to keep a program dynamic and responsive to developing needs. Materials will need to be revised over time to avoid audience fatigue and boredom. Messages may also need to be revised if audience knowledge, needs, and practices change; for example, if a new focus on male involvement in assuring their family’s coverage is needed. New messages and materials will need to be pretested carefully with target audiences.
LOGISTICS

Assuring the availability of adequate quantities of the vitamin A supplements is absolutely essential to the success of a program. One of the quickest ways to destroy a program is to generate interest in that program among mothers and their families and then fail to deliver the promised services.

➤ Determine number of capsules needed.
➤ Provide for adequate storage of capsules.
➤ Identify distribution mechanism.
➤ Secure additional supplies.

1. How is the number of capsules needed for the distribution calculated?

The number of vitamin A capsules required depends on the type of capsule(s) used: 100,000 IU; 200,000 IU; or both.

a) If using only 100,000 IU capsules, you will need two capsules per child over 12 months, and one capsule per child 6–11 months, plus 10 percent extra to avoid shortages.

   Number of 100,000 IU capsules required =
   
   \[ \text{[(No. of children 6–11 months) x 1.1] + [(No. of children 12–59 months) x 2.2]} = \]

b) If using only 200,000 IU capsules, you will need one capsule per child 6–59 months, plus 10 percent extra to avoid shortages. For children 6–11 months, use only half of the capsule and discard the rest.

   Number of 200,000 capsules required =
   
   \[ \text{[(No. of children 6–59 months) x 1.1]} = \]

c) If using both 100,000 IU and 200,000 IU capsules, you will need one 100,000 IU capsule per child 6–11 months and one 200,000 IU capsule per child over 12 months, plus 10 percent extra to avoid shortages.

   Number of 100,000 capsules required =
   
   \[ \text{[(No. of children 6–11 months) x 1.1]} = \]

   Number of 200,000 capsules required =
   
   \[ \text{[(No. of children 12–59 months) x 1.1]} = \]

In countries where communities or health facilities at the periphery have accurate estimates of the number of children living in the community, an estimate of the number of capsules needed at all administrative levels of the system can be generated by aggregating those estimates.

Districts should ask each health post for the number of capsules needed, based on the number of children in the health post’s catchment area. This information should then be sent to the central level, where a list of distribution sites with the number of capsules needed should be compiled.
In countries where estimates of the number of children living in communities are nonexistent or believed to be inaccurate, the number of capsules needed nationally can be generated from national census data.

When determining the population in question, take into account how long ago the demographic data were collected and adjust them accordingly. In order to dispatch the capsules at the subnational level, each district (or subnational unit) should be responsible for requesting the amount of capsules needed for their districts.

2. **How can supplies of capsules be obtained and when should they be ordered?**

Vitamin A capsules can be obtained from UNICEF, and they are often free of charge. If there are no capsules in country, they need to be ordered; and since it can take a long time before they arrive, orders should be placed six to eight months before a distribution.

3. **How should capsules be stored?**

Vitamin A capsules have an opaque outer covering made of a gelatinous substance and require special handling when storing and transporting. The capsules do not need refrigeration, but in hot climates they may stick together, so it is best to store them in a cool, dry place. If they are left in the refrigerator, they may need to sit out at room temperature in order to soften the outer coating. The capsules should never be frozen. Even though their opaque covering blocks some of the sun’s damaging rays, the capsules should never be exposed to direct sunlight in order to maintain the integrity of the vitamin A. When possible in the field, capsule packets should be kept in the shade. Opened bottles of capsules are good for one year; unopened bottles remain good for two years. It is suggested that the different doses be stored separately to ensure that the proper amount is administered. Vitamin A capsules can be repackaged in ziplock bags and distributed to each post.

4. **What is the best logistics distribution mechanism for capsules?**

   a) *Independent system.* Experience indicates that an independent system (separate from EPI, essential drugs, etc.) focused on vitamin A supplementation may be appropriate in the beginning, while districts and providers get used to implementing supplementation activities.

   b) *Routine system.* If the routine logistics distribution system is used, the ordering/delivery of vitamin A supplies must be coordinated with other logistics needs. Including orders and delivery for supplies not used on a continuous basis requires additional planning and negotiation to ensure timely delivery. Vitamin A should eventually be on the essential drugs list and incorporated in the order forms used by the ministry of health.

5. **What other supplies are needed for vitamin A distribution?**

Each post must have one pair of scissors/nail cutters for each person distributing the vitamin A, promotional material for distribution or reference, and an adequate supply of health care recording forms, training materials, and job aids. Each person supplying vitamin A should have enough tally sheets to cover the number of children in the
catchment area (see example of a tally sheet in Appendix C). Since a tally sheet usually covers 100 children under six months of age and 100 children six months to five years of age, the number of tally sheets needed would be equal to the number of children divided by 100, plus an additional 10 percent.
SUPERVISION AND MONITORING

Supervision during the vitamin A distribution contributes to the proper implementation of the program. The implementation of a system to monitor program performance gives structure to the supervisory effort, generates information that can be used to improve the program, and can be used to generate estimates of coverage needed for the ongoing advocacy for resources to keep the program alive.

- Use observation checklists and exit interviews.
- Reward/recognize good performance.
- Monitor coverage.
- Monitor supply of capsules.

1. What are the role and the responsibilities of supervisors in a vitamin A supplementation program?

Supervision ensures the quality of the capsule distribution—that is, that the capsules are cut correctly, the right dosage given, the essential health messages provided. Supervisors must also ensure that providers have enough capsules to cover their catchment areas, be able to handle personnel problems that may arise, and should always reward and recognize good work done by capsule providers.

2. What are effective supervisory tools?

a) Observation checklist. A checklist for observation of vitamin A providers during capsule distribution should be designed and administered by supervisors. The checklist provides an ongoing measure of needed improvements, gaps, and new areas for training or new communication messages, as well as positive feedback for capsule providers.

<table>
<thead>
<tr>
<th>Observation checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site________</td>
</tr>
<tr>
<td>Time started________</td>
</tr>
<tr>
<td>Action</td>
</tr>
<tr>
<td>a. Provider determines child’s age.</td>
</tr>
<tr>
<td>b. Provider gives correct dose of vitamin A.</td>
</tr>
<tr>
<td>c. Provider cuts capsule correctly.</td>
</tr>
<tr>
<td>d. Provider tells mother child is receiving vitamin A.</td>
</tr>
<tr>
<td>e. Provider welcomes mother or says something encouraging or positive to mother about receiving vitamin A capsule.</td>
</tr>
<tr>
<td>f. Provider tells mother when to return.</td>
</tr>
<tr>
<td>Time ended________</td>
</tr>
</tbody>
</table>
b) Exit interview. An exit interview that provides an indication of how much and what the caregiver understood from the encounter can be done at the same time as the observation checklist. (See sample interview form below.)

c) Recognizing/rewarding good performance. Vitamin A providers should receive recognition for good work and organization. A system of incentives, such as special certificates for highest coverage centers or choosing high achievers to present their experience in the orientation sessions for the next year, is a good way to do this.

<table>
<thead>
<tr>
<th>Exit interview form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site ____________________</td>
</tr>
<tr>
<td>Provider No. ___________</td>
</tr>
<tr>
<td>Mother No. ___________</td>
</tr>
<tr>
<td>a. What did your child receive today? ______________________ (vitamin A, other)</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>b. Do you know when to return? ☐ ☐</td>
</tr>
<tr>
<td>☐ ☐</td>
</tr>
<tr>
<td>c. Do you know who is eligible to receive capsule? ☐ ☐ (child aged six months to five years)</td>
</tr>
<tr>
<td>☐ ☐</td>
</tr>
<tr>
<td>d. Can you name the benefit(s) of vitamin A? ☐ ☐ (protects child, prevents blindness, makes child grow stronger, etc.)</td>
</tr>
<tr>
<td>☐ ☐</td>
</tr>
<tr>
<td>e. Was the capsule provider polite/welcoming to you? ☐ ☐</td>
</tr>
<tr>
<td>☐ ☐</td>
</tr>
<tr>
<td>f. Will you return for the next dose? ☐ ☐</td>
</tr>
<tr>
<td>☐ ☐</td>
</tr>
<tr>
<td>g. Did know that vitamin A capsules would be distributed today? ☐ ☐</td>
</tr>
<tr>
<td>If yes—Where did you hear about vitamin A capsule distribution? Check all mentioned:</td>
</tr>
<tr>
<td>☐ Health worker</td>
</tr>
<tr>
<td>☐ Religious leader</td>
</tr>
<tr>
<td>☐ Local leader</td>
</tr>
<tr>
<td>☐ Leaflet/poster/sign/banner</td>
</tr>
<tr>
<td>☐ Neighbor/friend/relative</td>
</tr>
<tr>
<td>☐ Radio</td>
</tr>
<tr>
<td>☐ Other (list)</td>
</tr>
</tbody>
</table>

3. How can coverage of the vitamin A supplementation be monitored?

a) Recorded distribution/tally sheets. Coverage can be estimated by recording the number of doses given on a tally sheet (see example in Appendix C) and dividing by the estimate of the number of children who should have received a supplement. Estimating coverage from recorded distribution of capsules can be very accurate if the number of capsules distributed is accurate and there is adequate census or other data accurately determining the target population to use as the denominator. It should be noted, though, that the census can be old and people move from place to place, and this may not be reflected in target population figures. Thus, coverage estimates may be low if distribution is under-recorded, or high, if people from outside the target area receive capsules. Also, if some segment of society (often the poorest and most vulnerable) are not recorded in
the census and do not receive capsules, they may be missed entirely, since the coverage figure is not based on a representative sample. Tally sheets can provide a reasonable estimate of capsules distributed, however; and with reasonable data on population (and consistent across districts), the proportion receiving capsules can provide a good coverage estimate.

b) **Household-based mini-survey.** A household-based mini-survey, usually done at the district level, can be completed using a questionnaire administered to caregivers (see Appendix D for example), which determines whether a child in a household has received vitamin A. Using a cluster sample with a random selection of households within each cluster, an estimate of the proportion of children sampled provides a coverage estimate. The survey can also validate coverage reported from tally information.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Collection/reporting method</th>
</tr>
</thead>
<tbody>
<tr>
<td>–Proportion of children age 6–59 months having received vitamin A supplement during immediately preceding round, by district</td>
<td>Distribution site tally sheets, mini-surveys</td>
</tr>
<tr>
<td>–Proportion of distribution sites reporting, by district</td>
<td>District summary</td>
</tr>
</tbody>
</table>

### 4. How can the supply of capsules be monitored?

Perhaps the most critical measure of provision of service is the supply of capsules to distribution sites, with the ultimate measure of a successful logistics supply system being the total number of distribution sites per district with adequate capsules. Adequate number of capsules is defined as the number of capsules (100,000 IU/200,000 IU) sufficient to reach all children aged six months to five years of age. The calculation of the number of children can be based on population projections.

Calculation of this indicator should be done for each catchment area, used locally to identify problems, and then sent up to the next level. If it is determined that not all distribution sites had an adequate number of capsules, the next step is to identify those areas that had an inadequate supply and plan for alternative strategies for the next round of supplementation.

<table>
<thead>
<tr>
<th>Supply of capsules</th>
<th>Collection/reporting method</th>
</tr>
</thead>
<tbody>
<tr>
<td>–Proportion of distribution sites with adequate capsules during distribution (sites with adequate capsules/number of sites)</td>
<td>Distribution site tally sheet, district summary</td>
</tr>
</tbody>
</table>
PROGRAM COSTS AND FUNDING

Blanket statements are often made about the costs of delivering the vitamin A capsules. Experience suggests that those costs vary considerably, however, depending on the infrastructure in place in a country and the strategy adopted for stimulating a high level of participation. An estimate of costs by key categories is needed to raise the funding required for subsequent rounds and is of value to others planning similar programs.

- Determine program costs.
- Secure necessary funding.

1. What costs are involved in a supplementation program?
   a) **Cost of capsules**, which is approximately $0.02 for each capsule (capsules are usually supplied in containers of at least 500);
   b) **Cost of training personnel**, which includes per diem expenses and fuel;
   c) **Cost of other supplies**, such as scissors or nail cutters, tally sheets, training materials, job aids;
   d) **Cost of promotional messages** in the media and community; and
   e) **Other delivery costs**, including transport costs and per diem for travel for community outreach activities and supervision costs.

As supplementation activities are institutionalized, initial costs for promotion design, orientation of all workers, and improvements to the logistics or MIS systems will come down. Some projects provide orientation as the program matures only to providers or to those in low-coverage areas. As other services are provided (deworming, immunization), these programs can share some of the costs.

2. What funding sources are available for supplementation programs?

Adequate financial commitment—from the government, local sources, international donors, etc.—must be assured before starting implementation of a supplementation program. Historically, agencies like USAID, CIDA, MI, and UNICEF have provided funding for communication, training, supervision, and monitoring and evaluation activities, so budgets should include line items for these activities. Experience has also shown that joint funding arrangements involving different agencies are well received among donors.

Private sector and NGO support has been enlisted for specific costs, such as air time or TV spots, in return for recognition or sponsorship credit. Programs must be able to assure such new funding sources that the program will succeed and that children’s lives can be saved, and they should offer them adequate recognition in terms that the funding sources value.
ADDITIONAL SOURCES OF INFORMATION

Starter kit for vitamin A capsule distribution

- Vitamin A Facts for Health Workers
- Vitamin A capsule distribution: Key behavioral and communication issues
- Creative briefs/talking points: Developing communication strategies for vitamin A capsule distribution
- Observation and exit interview forms: Measuring the quality of the contact between client and provider during vitamin A distribution
- Making the case for vitamin A supplementation: Sample overhead presentations
- Sample household mini-survey form: Validating/assessing vitamin A capsule distribution coverage
- Analysis of observation reports from a vitamin A supplementation campaign in Zambia
- Workshop orientation session: example of participative, problem-solving orientation

(All documents in this kit are available in electronic files that can be downloaded from the MOST Web site, http://www.mostproject.org.)

Distribution of vitamin A during national immunization days: A “generic” addendum to the Field guide for supplementary activities aimed at achieving polio eradication, 1996 revision. Global Programme for Vaccines and Immunization, WHO/EPI/GEN. 1998. Includes a checklist for monitoring program components during vitamin A distribution as part of or separate from NIDs.

(The electronic file for this document can be downloaded from the WHO Web site, http://www.who.int/vaccines-documents/DoxGen/H3DoxList.htm.)
APPENDICES
APPENDIX A
Sample overhead presentations

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**Improving vitamin A status is very cost-effective**

- Just a few cents per capsule. Also minimal extra cost for fortified foods.
- Reduces health costs by lessening hospital and clinic visits.
- Easily integrated into existing public health/immunization programs.
- Reduces educational costs for blind children.
- Reduces school absenteeism due to frequent illnesses.

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**Improving the vitamin A status of deficient children increases their chances of survival**

- Death from measles can be reduced by 50 percent.
- Death from diarrhea can be reduced by 40 percent.
- Overall mortality can be reduced by 25 percent.

---
Improving vitamin A status also

- Prevents night blindness, xerophthalmia, corneal destruction, and blindness.
- May reduce maternal deaths by
  - improving resistance to infection.
  - helping to reduce anemia. Vitamin A helps to mobilize iron for body functions.

Improving the vitamin A status of children reduces the severity of childhood illnesses

- May reduce use of clinic and outpatient services, and hospital admissions.
- Contributes to the well-being of children and families, including better school attendance.


This chart shows reductions in mortality shown to be linked to vitamin A interventions in eight major community-based vitamin A prophylaxis trials. Analyses are based on a conservative approach, counting children in the intervention area who had access to vitamin A but who may not have all received it. This may have underestimated the impact of vitamin A on childhood mortality.

How to Calculate the Number of Preventable Deaths with Vitamin A Interventions

1. Calculate the estimated number of deaths among infants 0-1 yr. = estimated number of births x estimated infant mortality rate

2. Calculate the estimated number of deaths among children 1-4 yrs. = deaths among <5 (as given in the UNICEF publication, State of World Children)

3. Calculate the estimated number of deaths among infants 6-11 mos. = 0.15 x (1)

4. Calculate the estimated number of deaths among children 6 mos.-4 yrs. = (2) + (3)

5. Calculate the estimated number of preventable deaths among children 6 mos.-4 yrs. with vitamin A interventions = (4) x estimated % reduced mortality among children 6 mos.-4 yrs. with vitamin A interventions (use Beaton et. al estimated 23% reduction)
## APPENDIX B
The creative brief

<table>
<thead>
<tr>
<th>Creative Brief Template</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Background</strong></td>
</tr>
<tr>
<td>What is the background of this intervention? Why are you doing it?</td>
</tr>
<tr>
<td><strong>2. Target Audiences</strong></td>
</tr>
<tr>
<td>Who do you want to reach with your communication? Be specific.</td>
</tr>
<tr>
<td><strong>3. Objectives</strong></td>
</tr>
<tr>
<td>What do you want your target audience to do after they hear, watch, or experience this communication?</td>
</tr>
<tr>
<td><strong>4. Obstacles</strong></td>
</tr>
<tr>
<td>What beliefs, cultural practices, pressures, and misinformation stand between your audience and the desired objectives?</td>
</tr>
<tr>
<td><strong>5. Key Benefit</strong></td>
</tr>
<tr>
<td>Select one single benefit that the audience will experience upon reading the objective(s) you have set.</td>
</tr>
<tr>
<td><strong>6. Support Statements/Reasons Why</strong></td>
</tr>
<tr>
<td>These are the reasons why the key benefit outweighs the obstacles and the reasons that what you are promoting is beneficial. These reasons often become messages.</td>
</tr>
<tr>
<td><strong>7. Tone</strong></td>
</tr>
<tr>
<td>What feeling should your communication have? Should it be authoritative, light, or emotional? Pick a tone.</td>
</tr>
<tr>
<td><strong>8. Media</strong></td>
</tr>
<tr>
<td>What channel(s) or form will the communication take? Television? Radio? Newspaper? Poster? Point-of-purchase? Flyer? All of the above?</td>
</tr>
<tr>
<td><strong>9. Creative Considerations</strong></td>
</tr>
<tr>
<td>Is there anything else the creative people should know? Will it be in more than one language? Should they make sure that all nationalities are represented?</td>
</tr>
</tbody>
</table>
Examples from Zambia and Ghana

Zambia

**Creative Brief for Communication with Families**

Background: Vitamin A capsule (VAC) distribution has been most successful when linked to NIDs. Routine or non-NIDs distribution has had relatively poor coverage. This year the vitamin A focus areas regions will have no NIDs to build coverage. It will be key to find ways to motivate mothers and families to bring their children to the health centers in August even without the NIDs support.

Target audiences: The most difficult to reach are the children from two to six, who have completed their immunizations. Therefore, the primary target group is mothers of children two to six years, next the families of these children, thirdly, the families of children six months to two years.

Objectives: Families will bring their children of six months to six years to the health centers/posts to receive VAC.

Obstacles/barriers: Distance/time/effort; kids not sick; no information on benefits, why should they bother? Possible fear of capsules/virus/unsafe/sterilization/related to family planning/mixed messages/confusion.

Key promise/benefit: Mothers/families will be happy and confident once they have taken their children for VAC. Mothers/families will know they are good parents who take care of their children.

Support statements: Because... VAC protects my child from serious disease and saves lives; I have protected my child from blindness; VAC is free and has no side effects or dangers

Tone: Personal, emotional, parent-to-parent, reassuring, warm.

Media: Radio, cassettes for mobile vans and regional radio stations, TV, public meetings, newspapers, posters.

**Creative Brief for Communication with Health Workers**

Background: In August, many health workers (HW) will be distributing VAC without NIDs for the first time. They have not yet been informed of the upcoming distribution and have not yet come to expect it as a regular routine. They will need to be motivated and supported in achieving good coverage and reporting.

Target audiences: HW who will distribute VAC and their district managers; NGOs; neighborhood health committees

Objectives: HW will provide VAC in correct dosages to correct ages; organize community mobilization; tell mothers their child is receiving vitamin A; praise/welcome mother/family for bringing their child; remind them when to return (February); keep records/tallies; send coverage reports in to central level.

Obstacles/barriers: Have little information on what is planned; don’t see value of VAC/vitamin A, attach no importance to VAC/vitamin A; very busy; lack experience with non-NIDs campaigns; lack of VAC/promotional materials/(scissors); lack of knowledge about VAC admini-
stratification, dosages and ages, and how to cut capsules if needed; no habit/system of reporting VAC; lack of staff.

Key promise/benefit: You will feel pride in doing a good job and will help to decrease illness & demand on health services and medications in the future.

Support statements: Because VAC can reduce child illness and death (diarrhea, ARI, measles, malnutrition, eye infections and blindness) VAC can help to reduce demand for scarce services, time, drugs (talk to your HWs for other ideas). Children and their families will come for VAC who do not usually come to HC, and they can be offered other services (immunizations, de-worming, TT, sale of bednets, etc.)

Tone: Knowledgeable, professional, scientific, sympathetic (we know you have little time, many tasks, etc.)

Media: Ministry letter to be read over radio, at meetings; radio; presentations at district- and provincial-level meetings

Ghana

Talking Points Directed to Health Workers

Target audience: Health workers (HW) or others who will be distributing capsules or who can act as advocates for the distribution.

Objective: Help providers understand impact of vitamin A on child health; advantages to health services and communities; value of the distribution in improving HW image and in lessening demands on health services.

Obstacles: HWs often do not give priority to nutrition or preventative services, are not aware of the important health benefits of vitamin A in preventing child deaths. HWs are busy, lack resources, see no pay-off to themselves in investing extra time or energy into the distribution, and may lack confidence in their ability to administer capsules correctly.

Key messages: In Ghana recent studies have shown that 65 percent of children under five in the North, and over 37 percent of children in the South are severely vitamin A deficient. WHO considers this level of deficiency a serious public health problem. Studies in Ghana and other countries in Africa show that providing vitamin A to deficient children will save approximately 20–30 percent of them from death. Vitamin A saves lives. It helps children resist dangerous illnesses such as measles and diarrhea.

Key benefits to the health care system: Providing vitamin A to deficient children will make health care more effective and decrease demands on scarce clinic time and supplies. Communities will appreciate the HW for providing VAC. The vitamin A contacts can be used to provide other services, such as immunization and growth monitoring, especially to older children (2–5) who do not usually come to the clinics.

Talking Points Directed to Mothers and Those Who Influence Them

Target audience: Women and caregivers of children under five, especially those with children between two and five; fathers of children under five; village leaders.

Objective: To encourage mothers and other family members to value vitamin A for their children and to be sure that their children receive vitamin A at least twice a year. To encourage fathers and village leaders to support caregivers who make sure their children are covered, and
to recognize and show appreciation to mothers and other caregivers when they do so. To clarify who is eligible, when supplements are given, where they are given, and why.

Obstacles to be aware of: Mothers are busy and may not think vitamin A capsules are important enough to invest their time; may not know where or when, may not like the health services, may fear capsules.

Key messages: Many children in Ghana lack enough vitamin A (over half the children under five in the North and a third of the children in the South do not have enough vitamin A). Vitamin A helps children to fight serious illnesses like measles and diarrhea. According to studies done in Ghana and other nations in Africa and the world, if all children get enough vitamin A child deaths can decrease 20–30 percent. Vitamin A will help your children grow strong and healthy.
# APPENDIX C

## Tally sheet and coverage form

**Vitamin A Tally Sheet**
(Use separate sheet every day)

**Date:** __/__/__
**District:** ________________
**Health Facility:** ________________
**Post:** ________________

**Type of Post (circle one):** Fixed strategy, Mobile Strategy or House-to-House

### Vitamin A

<table>
<thead>
<tr>
<th>100,000 IU (6-11 mos. old)</th>
<th>Sub-total</th>
<th>200,000 IU (12-59 mos. old)</th>
<th>Sub-total</th>
</tr>
</thead>
<tbody>
<tr>
<td>00000 0000</td>
<td>00000 0000</td>
<td>00000 0000</td>
<td>00000 0000</td>
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<td>00000 0000</td>
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<tr>
<td>00000 0000</td>
<td>00000 0000</td>
<td>00000 0000</td>
<td>00000 0000</td>
</tr>
</tbody>
</table>

### Daily summary of Vitamin A Supplies

<table>
<thead>
<tr>
<th>Allocated for SUB-NIDs 2000</th>
<th>Extra Supplies</th>
<th>Used Supplies</th>
<th>Extra Supplies</th>
<th>Name of Post Coordinator: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Wanted Supplies</th>
<th>Name of Post Coordinator: ____________________________</th>
<th>Date: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Balance in Stock after NIDs</th>
<th>Date: ____________________________</th>
</tr>
</thead>
</table>

---

43
Vitamin A Coverage Spreadsheet  
Child Survival Promotion Week

District_________________Province_________________
Date_________________

**Instruction:** To calculate coverage results use data on number of children supplemented from the tally sheet

<table>
<thead>
<tr>
<th>Vitamin A Supplementation</th>
<th>6-11 months (2% of population)</th>
<th>12-59 months (16% of population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Health Care Centre</td>
<td>Target Population</td>
<td>No. Supplemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Compiled______________________ Designation______________________
APPENDIX D
Household-based mini-survey methodology and questionnaire

Methodology
The basic approach for using a mini-survey is to train a small group (8–10 individuals) to administer the questionnaire using a pre-defined sampling methodology. Data are collected from a respondent in randomly selected households in each of 25–30 “clusters,” which are usually a manageable administrative unit such as a locality. Data collection should not take longer than two weeks, depending on the distribution of clusters to visit. If done properly, the results should be representative of the district being surveyed, and should provide a great deal of information that can be gathered from caregivers.

Selection of districts. The number of districts in which mini-surveys are completed will depend on the funds available. Districts may be selected for specific reasons, or can be selected randomly from a list of all districts, depending on the needs of the program. Ideally mini-surveys should be done within a month of vitamin A distribution, in order to get the most accurate responses from caregivers.

Selection of clusters. The ideal cluster is an administrative unit which exists in all districts, and for which population figures are available. In addition, the administrative unit must be small enough so survey team members can reach most of the households within the administrative unit within a day, allowing sampling for a given cluster to be completed in a day.

The first step in selecting clusters is to make a list of all clusters in the district along with their population. From this list, population proportionate sampling (PPS) is done. A third column is generated giving the cumulative population. The sampling interval is calculated by dividing the total population by the number of clusters to be sampled. Using a random start, clusters are selected by adding the sampling interval to the cumulative population, and selecting the cluster that falls within that figure. However, in most instances sampling is completed by central statistics offices, and a list of clusters is provided to the enumeration team.

It is important to recognize that strict adherence to sampling methods is important or else there will be concerns about how well the sample represents the overall population of the district. Therefore substitutions should not be made without consulting the statisticians involved with the survey.

Selection of households within a cluster. Once clusters have been identified, enumerators will need to sample households within each cluster. Usually between 20 and 30 households are selected from each cluster, and the questionnaire is administered to all households selected in which there is a child between 6 and 59 months of age. It is very important that all households within the cluster have an equal chance of being selected. Otherwise there may be an unexpected bias in the sample which may affect how well the data represent the district. Thus it is not acceptable to simply select the most convenient households to visit, or to visit only those that are close to the main road.

Ideally, households would be selected at random from a list of households in the cluster. However, this is usually not possible, since such a list is rarely available or current. Thus an alternative means is used to do as best as possible in allowing all households to have the same chance of being selected. One method is to identify the center of the cluster, divide the cluster into 4 quadrants, and using a random start, move through the quadrant selecting 8 households. This is done by counting or estimating the number of houses in line from the central point,
using a random number between 1 and 8 to select the first house. Then the next closest house is visited, moving in the same direction until the sample is complete for the quadrant, and then repeating for all 4 quadrants. In this way all households are equally likely to be selected. Usually survey teams include some district staff, some central staff, and a supervisor who will train enumerators in household selection, and do some practice sessions before the survey begins.

Administering the questionnaire. The way in which a questionnaire is administered is very important, and incorrect administration can result in a consistent misrepresentation of coverage for example. It is not as easy as one would think to design the appropriate questions to determine whether a child has received vitamin A—simply asking whether they have or not may give incorrect results. There are many factors that contribute to whether such a question yields the correct answer. First, the respondent may not have been the person taking the child for distribution—it is common for friends, siblings or neighbors to take children to receive the supplement. Second, caregivers may confuse vitamin A supplementation with other medicines or immunizations—specifically, it is common to confuse vitamin A with polio from NIDs. There may also be confusion about when a supplement was received with caregivers mentioning supplements that may have been received during NIDs a year or more earlier. Thus ensuring that the response refers to the most specific distribution period is critical, as is distinguishing vitamin A from polio immunization. This is made particularly difficult by the fact that NIDs has not stressed that it is vitamin A that is being given, so caregivers may not in fact know what was given to the child other than polio. Third, caregivers tend to want to provide the “correct” answer—the answer expected by the interviewer, and this can result in overestimation of coverage. These problems can be avoided by a carefully constructed series of questions that include some prompted and unprompted questions, and recognition of the vitamin A capsule. Such a questionnaire requires careful testing, and once developed, should be administered consistently in all districts.

Enumerators should introduce themselves, and explain that they are interested in asking some questions about the health of children, and ask if there are any children age 6-59 months living in the household. They should then randomly select one child by writing names on scraps of paper and having someone blindly select one. They should then identify the best respondent—usually the caregiver who usually takes children to the clinic or outreach post. The questionnaire is then administered, being as objective as possible, and avoiding appearing to be judgmental or desiring one answer or another, and avoiding leading the respondent in any way. Enumerators should be very careful to record the answers correctly, and should be careful not to lose any of the questionnaire forms as they move from household to household. Detailed instructions are provided with the questionnaires, guiding the enumerator on how to ask each question, and how to record information.

Questionnaires are collected from each cluster, and reviewed by the survey supervisor, checking for missing information or recording that is unclear. Usually data entry and analysis are done either at the district level, or centrally, with a report on findings provided to district offices at a later date. The report should summarize all findings for the district as well as for other districts in which a mini-survey is completed.
Sample Mini-survey Questionnaire

Interviewers Name _______________________ Date of Interview [___/___/___]
Cluster No.    [ __ __ ] Village/community ____________________
Type of community: 1. urban [__] 2. rural
Household No. [__ __]

Name of head of household __________________________

Ask the mother/caretaker how many children of age group 6–60 months are in the household. Ask her to tell their names and ages in months. Write the name and the age in the given box until all the children belonging to the household are recorded.
(The mother/caretaker may not be able to specify the exact month of the children’s ages. In this case use an indirect method, such as relating the birth of the child with a local event or relating the birth of the child with the local calendar, local festival, etc.)

<table>
<thead>
<tr>
<th>Eligible Children for Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>S. No.</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
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If the household has more than one child, select one of the children randomly.

4) Name of Selected Child: ____________________________

5) Date of Birth of Child [___/___/___]
   dd/mm/yy

6) Sex of Child: [ ]
   1. Male
   2. Female
Select the person most likely to take the selected child for vitamin A supplementation (or most likely to take the child to the clinic) and ask the questions below. Note the relation of the respondent to the child.

7) Respondent is: 
   1. Mother
   2. Father
   3. Sibling
   4. Child’s grandmother
   5. Other relative
   6. Neighbor

8) Do you remember the recent vitamin A distribution? 
   1. Yes
   2. No → go to Q10

9) If yes, please describe the event when vitamin A was given
   (do not prompt or probe and check only those mentioned.)
   a. Mentioned red or blue capsule
   b. Mentioned cutting of capsule
   c. Mentioned distribution site
→ go to Q11

10) If no, do you remember any of the following about the vitamin A distribution?
    (prompt or probe for each of the following)
   10a Remember a capsule like this one? (show capsule) 
      1. Yes
      2. No
   10b Remember how it was given, i.e. how capsule was cut
      1. Yes
      2. No
   10c Remember where the distribution was done?
      1. Yes
      2. No
→ go to Q11

11) Did this child receive vitamin A? 
    1. Yes
    2. No → go to Q15
    3. Don’t know → go to Q15

12) If yes, what was the color of the capsule? 
    1. Blue
    2. Red
    3. Don’t know

13) Where did this child receive the capsule? 
    1. At the vitamin A distribution point
    2. On a routine visit to the health clinic
    3. On a visit to the clinic for illness
    4. Other _______________ (specify)

14) How long ago did the child receive the capsule? 
    (adapt question as per specific program need) 
    1. Less than 4 weeks ago
    2. 4–7 weeks ago
    3. 2 months ago
    4. more than 3 months ago
→ go to Q16
15) If this child did NOT receive a capsule, what are the reasons?
*(do not prompt, check all that are mentioned)*

a. Not registered [ ]
b. Didn't know about distribution [ ]
c. Went, but distribution point had run out of capsules [ ]
d. Child was out of village at time [ ]
e. Child was sick [ ]
f. Distribution site is far away [ ]
g. Had a concern about child receiving vitamin A [ ]
______________________________ (specify what concern was)
h. Other reason __________________ (specify)

16) Where did you hear about the vitamin A distribution?
*(do not prompt, check all that are mentioned)*

a. Did not hear about distribution [ ] → go to Q18
b. Radio [ ]
c. TV [ ]
d. Poster [ ]
e. Leaflet [ ]
f. Announcement in market [ ]
g. Neighbor, family member [ ]
h. Health worker, health center [ ]
i. Community leaders [ ]
j. Others __________________ (specify)

17) What did you hear about vitamin A? *(do not prompt, check all mentioned)*

a. Don’t know [ ]
b. Said they heard nothing [ ]
c. Date of the distribution [ ]
d. Caregivers/parents to bring child for vitamin A [ ]
e. Target age group is 6 – 59 months [ ]
f. Vitamin A is good for my child’s health [ ]
g. Protects child from illness [ ]
h. My child will need vitamin A in 6 months [ ]
i. Any negative [ ]
j. Other ________________ (specify)

18) What are the benefits of vitamin A? *(do not prompt, check all mentioned)*

a. Don’t know [ ]
b. Saves lives [ ]
c. Protects child [ ]
d. Sick children get well faster [ ]
e. Good for eyes [ ]
f. Makes child grow health and strong [ ]

19) Will you come for the next dose of vitamin A? [ ]

1. Yes
goto Q21
2. No → go to Q21
3. Don’t know → go to Q22

20) If yes, why will you bring child again? [ ]

1. Good for child
2. Told to come again by distributor
3. To complete doses of vitamin A
4. Other ________________ (specify)
→ go to Q22
21) If no, why not? [ ]
   1. Did not help child
   2. Too difficult to get to distribution site
   3. Too long to wait at distribution site
   4. Not treated nicely at distribution site
   5. Child had adverse reaction (specify_________________)
   6. Other reason (specify_________________)

Optional Questions: Examples

22) Can you tell me some food sources that might be rich in vitamin A? (list will need to be specific for vitamin A-rich foods in area)
   a. Don’t know [ ]
   b. Eggs [ ]
   c. Liver [ ]
   d. Fish (small, whole) [ ]
   e. Milk, ghee, yogurt [ ]
   f. Orange fruits (ripe mango, papaya) [ ]
   g. Orange vegetables (carrots, pumpkin) [ ]
   h. Dark-green leafy vegetables [ ]

or

How can your child get enough vitamin A?
   a. From vitamin A capsule [ ]
   b. From fortified sugar [ ]
   c. From food [ ]
   (mark if DGLVs, orange fruits/vegetable, animal sources are mentioned)