

Phase 2 ORSZ Program Overview

In May 2024, Clear Solutions, in partnership with Kano State Ministry of Health and iDevPro Africa, ran a post-pilot scale-up, “Phase 2”, ORSZ distribution in Dambatta and Wudil LGAs in Kano, Nigeria, with a target reach of **20,000 children under-5**, approximately **3x the size of our [pilot](#)**.

Our primary goals, beyond direct impact, were two-fold:

1. **Scalability**: implement and test approaches to unlock a much larger scale.
2. **Evaluation rigour**: improved survey approaches and quasi-experimental methodology.

Distribution of approximately 25,000 ORSZ co-packs (2 ORS sachets + 10 zinc tablets each) was performed by community health workers (CHWs) of the “[CHIPS](#)” and “VCM” cadre under **training and supervision of the local primary healthcare leaders**. CHWs provided free ORSZ to households with children under-5 in their community.

We trained the healthcare leaders on their own responsibilities for the program, provided daily monitoring & role guides, and “train the trainer” content for delivery to CHWs. This supervision structure **reduced the execution bottleneck** of our implementation partner’s staff capacity, enabling us to serve much larger populations. The national footprint of CHW programs in Nigeria provides a strong basis for further scale.

During distribution, the CHWs, who typically do not have smartphones or familiarity thereof, record information for each recipient household on a paper monitoring sheet. To enable the processing of these paper trackers at scale, we formatted them for machine-readability and built a Microsoft Azure AI pipeline to extract structured (spreadsheet) data from scanned images of the paper sheets. This **hybrid paper-digital approach provides a scalable monitoring solution** within the educational and resource constraints of the setting. It was supplemented with “spot-checks” of a sample of households by smartphone-equipped supervisors and data enumerators.

Data enumerators performed community surveys before ORSZ distribution (“baseline”) and monthly post-distribution follow-ups to record diarrhoea rates, treatment norms, and other contextual data. We use a **quasi-experimental methodology**, including surveys of comparison communities where no ORSZ distribution took place in each of the intervention wards. We also extended the surveys to record **ORSZ acquisitions - paid purchases or free treatments** - to understand how the distribution may influence these behaviours.

We applied operational variants in 2 (of the 8 total) ORSZ geographic wards to assess their potential for future distributions. These were “**double co-pack**”: providing 2 co-packs instead of 1 for each under-5; and “**refill**”: enabling caregivers to **claim replacement copacks** on presenting empty ORS sachets.

Read with caution: preliminary analysis

At the time of writing [July’24], we have data from 1-month Follow-Up surveys with rough initial analysis. The preview outputs below should be **read with caution**: it is aggregated unadjusted data, not yet properly error-checked, with analysis that is pending review. We will be presenting a more rigorous analysis in due course.

	Baseline	Follow-Up (1m)
No-distribution (comparison) settlements	41.8%	47.5%
ORSZ Distribution settlements	41.4%	82.7%

Table 1. % of under-5 diarrhoea cases treated with ORS, both LGAs, excluding “refill” and “double co-pack” wards