

## Sustaining vitamin A supplementation requires a new vision

Although vitamin A supplementation has been ongoing for decades in some countries, systematic scaling-up in the context of child survival programmes began in the late 1990s. There has been a renewed commitment to vitamin A supplementation and an increasing focus on achieving universal coverage as part of UNICEF's integrated health and nutrition strategy,<sup>1</sup> largely informed by the *Lancet's* child survival series.<sup>2</sup>

When UNICEF first began reporting on progress through *The State of the World's Children* report in 2000,<sup>3</sup> global coverage with at least one dose was about 50%, achieved in large part by linkage of vitamin A supplementation with national immunisation days for poliomyelitis eradication. Although national immunisation days guarantee delivery of one supplemental dose, only 18 countries distributed the requisite second dose in 1999, translating into roughly 16% of children receiving supplements as per international recommendations.<sup>4</sup> Although many expressed concern that progress would falter with the phase-out of national immunisation days for poliomyelitis, coverage has steadily improved in recent years: 42 countries ensured two rounds of vitamin A supplementation in 2004, the most recent reporting year; increasing global two-dose coverage to 58%.<sup>4</sup> Gains might be attributed to the advent of integrated delivery mechanisms—either modelled around child survival or, to a lesser extent, other micronutrient interventions. Progress is also evident in terms of programme sustainability: more than half of countries reporting vitamin A supplementation in 2004 (57%) were contributing to operational costs, and a growing number are procuring at least a portion of their own capsules (12 countries in the most recent ordering cycle). Substantial advocacy efforts, particularly in eastern and southern Africa countries, have also led to the inclusion of vitamin A supplementation in poverty reduction strategies and coordinated health sector investment approaches.

Although vitamin A supplementation coverage is high compared with other nutrition interventions, such as antenatal iron supplementation,<sup>5</sup> attaining the goal of universal coverage presents substantial challenges. Only a few countries have dedicated delivery mechanisms to sustain even current levels of coverage; most rely on annual or semi-annual planning. Reaching

children not receiving supplements will require further effort still, in terms of planning and likely expenditure. A key barrier to sustainable programming remains the lack of recognition of the need for vitamin A supplementation. Although opportunistic linkages with other interventions produced high coverage, minimum efforts have been made to effectively communicate the importance of vitamin A for child survival. Knowledge, attitude, and practice surveys have revealed this failing at all levels, from consumers to policymakers.<sup>6</sup> Until this knowledge gap is addressed, we cannot expect a transition from a push-driven to a demand-driven intervention. This transition is critical at the policy level. Generous global support, from the governments of Canada and the United States in particular, has driven progress,<sup>7</sup> and continued investment will be necessary in the medium term for external technical assistance. However, it is time for countries to assume some of the costs of vitamin A supplementation through health and child survival budgets.

In the countdown to the 2015 child survival goal, we need to focus on increasing two-dose vitamin A supplementation coverage to all children aged 6–59 months in the developing world. Universal coverage will need multiple delivery strategies: countries must consider all available delivery mechanisms and fully investigate the cost-effectiveness of those mechanisms, with continued work towards integrated delivery of child

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survival services. Special efforts will be necessary to reach those children currently missed by supplementation; hard-to-reach children are likely to be most in need and therefore most likely to benefit from the intervention. Effective advocacy and communications will be critical to achieving coverage goals, for the purpose of influencing policymakers and generating community demand. Finally, advocacy efforts should focus on increasing countries' commitment to sustaining vitamin A supplementation efforts in the broader child survival framework. Opportunities exist to tap into resources from joint donor (basket) funding to countries' own national health budgets: integrated delivery of vitamin A as part of a child-health package is likely to facilitate these increased funding opportunities.

With the role of vitamin A supplementation coverage as a proxy for programme effect and an internationally agreed-on indicator of progress towards child survival goals, strengthening monitoring at all levels is key. A meeting of implementing partners, held in New York on July 19–20, set forth a vision for strengthening vitamin A supplementation coverage monitoring. Although partners agreed that it is not currently feasible to directly measure two-dose coverage as per guidelines, a modified set of indicators was recommended that would facilitate the indirect estimation of the proportion of children who are fully protected. Coverage will be reported separately for infants aged 6–11 months, children aged 12–59 months reached during the first half of the year (whether through distinct events or routine), and children aged 12–59 months reached during the second half year. Furthermore, partners called for the systematic recording of vitamin A supplementation on child health cards, irrespective of delivery strategy. Better documentation in this new era of child health packages will enable improved coverage monitoring through existing survey efforts. Finally, a framework is

under development to inform country self-assessments of programme sustainability.

Evidence supporting the role of vitamin A in child survival is irrefutable. Although initially presented as a short-term deficiency-control strategy, vitamin A supplementation alone does not solve underlying problems of inadequate nutrition and infectious disease. Vitamin A supplementation therefore needs to be continued for the foreseeable future as a central component of the broader child survival package, with special efforts to access the hard-to-reach and presumably most vulnerable, to measure coverage effectively, so that it can inform programme scale-up, and to push towards the goal of universal coverage. Many countries are making a great deal of progress, but further acceleration is required before the benefits of vitamin A supplementation reach each and every child.

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We declare that we have no conflict of interest.

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