Tackling Vitamin A deficiency in Cambodia: On the Road to National Coverage

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Abstract

This paper assesses the impact of implementing a new VAC distribution strategy on VAC coverage among 6-59 mo old children in 33 districts. The new strategy includes capacity building of health staff, improving the VAC logistics and management system, raising community awareness and mobilization through community volunteers and mass media, and conducting regular monitoring and supervision. It has been found that the new strategy markedly increased VAC coverage which should result in a marked reduction of underfive mortality. Health center outreach is a good channel for distributing VACs and Village Health Support Groups (VHSGs) play an important role in mobilizing community members

Introduction

- Vitamin A supplementation of children is important to reduce child mortality and improve health and nutrition. Vitamin A deficiency is a problem of public health significance in Cambodia. In 2000, nationwide VAC coverage for children 6-59 mo was 29%.
- VACs are distributed to children aged 6-59 months in Mar and Nov through integrated routine outreach by health center staff.
- In 2001, Helen Keller International (HKI) in collaboration with the National Nutrition Program (NNP), MOH developed a new strategy to improve the National VAC distribution program.
- Based on the pilot in 2001, NNP and HKI and partners expanded the new strategy to 33 operational districts (ODs) in the last 6 years in different phases.

Objective

- Increase VAC coverage to national target of 85% among children 6-59 mo in a total of 33 ODs (~590,000 children, ~ 44% of the country's eligible population) by 2006.

Methods

- For rapid and effective expansion, HKI partnered with NGOs already supporting health center outreach activities. NNP and HKI were responsible for activities and coordination at National, Provincial, OD and Health Center levels, whereas NGOs worked at community level.
- The scale-up strategy included a training cascade, monitoring & supervision, raising community awareness through mass media & IEC/BCC materials, and community mobilization and health education by health volunteers.
- Baseline (BL), post distribution and EL surveys (FU after first round and EL after second round) assessed program implementation and coverage.

Key Results

- Figure 1 Presents coverage for the currently 5 supported ODs (2005-2006).
- Figure 2 Shows that the new strategy markedly increased coverage in all ODs. At BL, coverage was below 40% in most ODs, whereas at EL coverage was above 80% in 22 of the 33 ODs and above 50% in the remaining ODs.

Figure 1: VAC coverage among children in the ongoing phase of the 5 supported ODs (2005-2006)

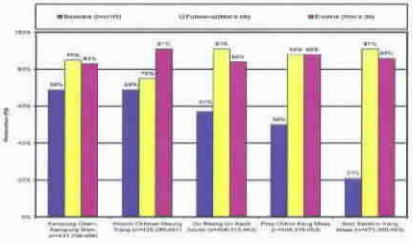
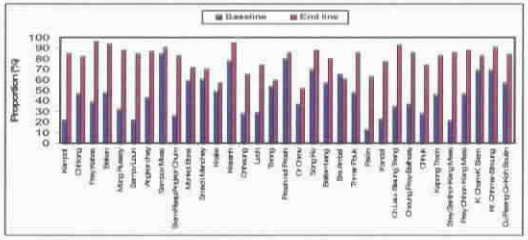


Figure 2. VAC coverage at baseline and end line in 33 ODs. Periods of implementation ranged from 2001-2002 to 2005-2006.



Established in 1915, HKI works in 22 countries to combat the causes and consequences of blindness and malnutrition by establishing programs that are based on evidence and research. HKI works in collaboration with organizations around the globe.

Conclusions

- The implementation of the new strategy markedly increased VAC coverage which should result in a marked reduction of underfive mortality
- To increase VAC coverage two things must happen at the same time:
  - Training and support for Health Centers
  - Create awareness and demand at community level
- Health center outreach is a good channel for distributing VACs and Village Health Support Groups play an important role in mobilizing community members
- The VAC distribution program should be strengthened through integration with other nutrition components, and partnering with NGOs is essential for sustainability and cost-effectiveness
- VAC coverage data are needed to evaluate whether coverage level are maintained after the 2nd supported distribution round. To this end, the Health Information System (HIS), MOH, needs to be strengthened.

This work was funded and supported by USAID Grant no. 442-G-00-06-00002-00

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