THE GLOBAL ALLIANCE FOR VITAMIN A (GAVA)

Capitalizing on the integrated approach of child health days to increase vitamin A supplementation coverage to improve child survival and achieve Millennium Development Goal 4 in sub-Saharan Africa

Dakar, Senegal

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Delegates from 20 sub-Saharan African countries and from development partners assembled in Dakar, Senegal on 23-25 March 2009 to discuss progress and challenges of vitamin A supplementation (VAS) programs. The meeting was hosted by the Ministry of Health in Senegal and organized by the Global Alliance for Vitamin A (GAVA), which is an informal partnership between A2Z, the Canadian International Development Agency (CIDA), Helen Keller International (HKI), Micronutrient Initiative (MI), the United Nations Children's Fund (UNICEF), the United States Agency for International Development (USAID), and the World Bank. The MI's Africa Regional Office helped coordinate the meeting. The following consensus statement was endorsed by the participants:

CONSENSUS STATEMENT

High rates of child mortality persist in most countries of sub-Saharan Africa, and progress to reach Millennium Development Goal (MDG) 4 has therefore been slow. Global comparisons show that sub-Saharan Africa carries a vastly disproportionate burden of child mortality. Even though it is home to merely 10.5% of the global population of children under the age of five, sub-Saharan Africa accounts for 29.5% of global mortality in this age group. Based on the poor progress towards MDG 4 and the large mortality burden, we, the workshop participants, call for the strengthening and scaling-up of high-impact interventions for child survival in sub-Saharan Africa.

VAS among young children is a low-cost, high impact intervention that can reduce all cause mortality in children 6-59 months of age by an average of 23%. Given the high rates of under five mortality in many countries in sub-Saharan Africa, and the high prevalence of under nutrition and micronutrient deficiencies, ensuring sustained high coverage of twice-yearly VAS among children 6-59 months, particularly among hard-to-reach groups, has the potential to save a significant number of young children's lives in the region. We therefore highlight VAS as a crucial intervention to reach MDG 4 in sub-Saharan Africa.

At this approximate mid-point of the MDGs, we note that while many countries in sub-Saharan Africa have made great achievements in twice-yearly coverage with VAS programs, we now must accelerate our efforts to achieve and sustain universal coverage of twice-yearly VAS among all children aged 6-59 months.

We embrace twice-yearly events targeting children 6-59 months of age, as an effective and sustainable method for health systems to deliver vitamin A and other high-impact interventions for child survival, often called Child Health Days or Weeks. The package of life-saving, preventative child health and nutrition interventions provided through such events varies between countries, but commonly includes childhood immunizations, de-worming, and insecticide-treated bed nets, in addition to VAS.

We recognize that for infants 6-11 months of age, the current delivery mechanism for VAS often relies on the EPI schedule, reaching infants at 9 months instead of at 6 months – thereby leaving these infants unprotected during this highly vulnerable period. To address this, efforts are needed to establish additional contacts with infants at 6 months, and some countries have already started to take on this programmatic challenge.

Data-driven decision making is crucial to guide our VAS programs. Timely and robust data systems not only help to track and improve performance of VAS programs, but also provide the basis for advocacy efforts.

Strong data systems also help to design more equitable VAS programs. They should allow for the reporting of data separately for children aged 6-11 months and those age 12-59 months to ensure all targeted children are being reached. District-specific analyses will help to identify districts with low VAS coverage and to tailor appropriate support. In all districts, we must identify the 'hard-to-reach' children, who may also be the most vulnerable and thus are those who will benefit most from VAS. Using strong data systems, we thus pledge to create more equitable VAS programs by improving coverage in low-performing districts and reaching the 'hard-to-reach' children.

VAS programs have to date been successfully scaled up as partnerships between governments and donor agencies. The time has now come to institutionalize VAS and other child survival interventions at national levels. VAS and other child survival interventions must become part of the national health system's recurrent programming, planning, financing, delivery, and monitoring systems. Many countries in sub-Saharan Africa are poised to address this challenge, and we will continue to build effective partnerships among the child survival community at the national, regional, and global levels. With our partners, we will make efforts to better harmonize investments and share responsibilities.

To help with the process of institutionalization, we understand that countries may greatly benefit from sustainability analyses, which may help identify threats to existing systems. We also note that achieving sustainability is a process that may require many small steps, rather than an immediate transition.

We are aware that VAS among young children is a key intervention in an integrated control strategy for vitamin A deficiency. This strategy also includes the promotion of optimal breastfeeding, complementary feeding practices, the support of dietary diversification and food fortification, and the prevention and treatment of infectious and parasitic diseases.

In view of the unequivocal benefits of VAS for child survival in sub-Saharan Africa, we are committed to institutionalize twice-yearly supplementation improve regular supplementation for infants at six months to achieve and sustain universal coverage as a means to reduce child mortality by two-thirds by 2015 (MDG4), in sub-Saharan Africa.