



The Global
Alliance
for Vitamin A

The Global Alliance for Vitamin A (GAVA)

STRATEGIC PLAN

2016-2020

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Acronyms

CDC	U.S. Centers for Disease Control and Prevention
CHD	Child health day
CI	Confidence interval
GAVA	Global Alliance for Vitamin A
HKI	Helen Keller International
ICN	International Congress of Nutrition
IU	International unit
MI	Micronutrient Initiative
NI	Nutrition International (formerly Micronutrient Initiative)
NID	National immunization day
REC	Reaching every community
SUN	Scaling-up nutrition
U5MR	Under-5 mortality rate
UNICEF	United Nations Children’s Fund
VAD	Vitamin A deficiency
VAS	Vitamin A supplementation
WAHO	West African Health Organization
WHO	World Health Organization



Where are we with vitamin A supplementation?

Vitamin A deficiency (VAD) is a major contributor to the mortality of children under five.

According to most recent global estimates, VAD (defined as serum retinol $< 0.70 \mu\text{mol/l}$), affects 29% of pre-school age children living in low- and middle-income settings, with highest prevalence estimates observed in sub-Saharan Africa and South Asia¹. The primary causes of VAD are non-exclusive breastfeeding, high infectious disease burden, low maternal vitamin A status (leading to low breast milk vitamin A concentrations)²⁻⁵, as well as insufficient dietary vitamin A intake in the weaning period^{6,7}.

There is an urgent need to control infectious diseases and increase vitamin A intakes in children, through improved infant and young child feeding practices, nutrition education, and nutrition-focused agricultural programs⁸⁻¹⁰. Furthermore, the industrial fortification of staple foods with vitamin A and targeted home fortification of complementary foods with small-quantity lipid-based nutritional supplements or multiple micronutrient powders are promising approaches. However, their impact on addressing VAD among young children remains an ongoing challenge¹¹⁻¹³.

Until such dietary strategies are optimized, guaranteeing high coverage of twice-yearly vitamin A supplementation (VAS) among children from 6-59 months is therefore critical, not only to eliminating vitamin A deficiency as a public-health problem, but also as a central element of the child survival agenda¹⁴.

For more information on the benefits of VAS for child survival, see Appendix 1.

The role of GAVA

Who is GAVA?

The Global Alliance for Vitamin A (GAVA) is an alliance of partners committed to reducing vitamin A deficiency by improving and sustaining high coverage of vitamin A globally to maximize its impact on child survival.

The main role of GAVA is to provide a forum wherein international agencies and experts can share vitamin A information, distil lessons learnt, develop technical documents and coordinate and disseminate policy and advocacy statements. The core rationale is to improve the visibility, financing, effectiveness and efficiency of vitamin A supplementation programs and efforts to reduce vitamin A deficiency throughout the world.

GAVA provides support through:

- Providing technical assistance for VAS programs, especially countries undergoing either epidemiologic and/or programmatic transitions that affect VAS strategies
- Sharing tools, lessons learnt resources, case studies and technical briefs
- Improved alignment of VAS with other health and nutrition programs
- Convening technical consultancies on core issues
- Providing advocacy resources for VAS

GAVA is informal group with a Chair for the purpose of coordination. The core group of agencies currently includes Nutrition International (NI), the United Nations Children’s Fund (UNICEF), Helen Keller International (HKI), the Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO). A core-working group manages the GAVA work plan and monitors the progress of the strategic plan. There is an annual planning meeting in August/September, during which the members of GAVA review the progress of activities included in the work plan, identify priority areas for research and programing, and engage in strategic planning for the upcoming year(s).

Vision

A world where child deaths and illnesses associated with vitamin A deficiency are eliminated.

Mission

To provide guidance on policy and program approaches related to preschool vitamin A supplementation, within the context of other evidence-based health and nutrition interventions, and to accelerate progress toward child survival and reduce the impact of vitamin A deficiency around the world.



Goals

GAVA has defined four main goals:

- GOAL 1: To catalyze consensus for evidence-based VAS policies and programs within broader child mortality and vitamin A deficiency reduction and control strategies
- GOAL 2: To identify and address priority knowledge gaps for VAS programs
- GOAL 3: To provide program support to improve effective implementation and monitoring of VAS programs
- GOAL 4: To advocate for political will, sustained attention and financial and technical support for VAS in the context of the broader global nutrition landscape

These goals intend to provide additional support to help mitigate some of the main challenges currently affecting VAS programs. Challenges include:

- A renewed need to provide an updated evidence base on the relevance of VAS for child mortality;
- The adoption and scale-up of additional delivery platforms due to the scale-back of poliomyelitis campaigns;
- The need for global advocacy to support VAS and to maintain it as a priority child survival intervention;
- The need to improve data collection methodologies to ensure that precise national coverage data is available on a large scale; and
- A lack of guidance on the scaling-back of VAS in countries that have sustained decreases in U5MR and have a low prevalence of VAD.

For more information on some of the major challenges affecting VAS see Appendix 2.

How do we get there?

The aim of the GAVA strategic plan is to guide the efforts of the secretariat over the period of 2016-2020. Many aspects of VAS programs are shifting and there is a pressing need to help countries transition from current delivery platforms, to find new ways to finance VAS programs, and to continue to advocate for VAS. The 5-year plan does not consider the limitations of GAVA's existing resources and there is the expectation that additional resources will be sourced to ensure that the goals of the plan are met.

Strategic Plan

GOAL 1: CONSENSUS

Catalyze consensus for evidence-based VAS policies and programs within broader child mortality and VAD reduction and control strategies

- Achieve consensus on when to scale back universal VAS among children aged 6-59 months
- Inform decisions on the suitability of different VAS platforms
- Catalyze consensus on emerging scientific topics relevant to VAS

GOAL 2: KNOWLEDGE CURATION

Identify and address priority knowledge gaps for VAS programs

- Develop and maintain a platform to curate existing key documents, tools and resources
- Develop routine system to identify knowledge and information gaps
- Synthesize and translate existing evidence to program policy and operational guidance
- Collect and summarize existing good practices/lessons learned for program implementation and generate and make available resources, such as toolkits, program guides and manuals to help improve the implementation of vitamin A programs

GOAL 3: PROGRAM SUPPORT

Provide program support to improve effective implementation and monitoring of VAS programs

- Provide technical assistance to countries identified as faltering or are undergoing large shifts in their program
- Facilitate and encourage networking and cross-learning among practitioners and stakeholders

GOAL 4: ADVOCACY

Advocate for political will and sustained attention for VAS in the context of broader global nutrition landscape

- Advocate for adequate funding and prioritization for VAS as a life-saving intervention, in VA deficient contexts, among host-country governments, development partners and donors
- Promote VAS delivery platforms that are integrated and institutionalized within health systems
- Campaign for better alignment of VAS with other child survival and VAD programs to improve complementarity, reduce overlap and optimize resources and impact

GOAL 1: To catalyze consensus for evidence-based VAS policies and programs within broader child mortality and vitamin A deficiency reduction and control strategies

A core role of GAVA is to serve as the authoritative voice for VAS and to facilitate the development of global consensus for evidence-based VAS programming. It aims to complement and support WHO guidelines and encourage consistent guidance and approaches from various organizations and across initiatives that intersect with VAS.

Target 1.1: Achieve consensus on when to scale back universal VAS programs among children aged 6-59 months

WHY	VAS is a proven public health intervention for increased child survival in settings where VAD is prevalent. Even though the prevalence of VAD remains high in south Asia and sub-Saharan Africa, many middle and some lower-income countries have made great strides towards improving the regular consumption of sufficient quantities of vitamin A and therefore reduce VAD. If dietary intake is sufficient over a sustained period and biochemical VAD has been controlled, universal vitamin A supplementation becomes unnecessary and should not continue, for both safety and cost-efficiency reasons. In such settings, a shift to targeted supplementation of high-risk sub-groups of the population, or complete phase-out, of the program can be considered. However, consensus on this topic has not been achieved, and programming tools to inform such decisions are currently not available.
HOW	GAVA will work to achieve global consensus on when to scale-back universal VAS programs among preschool-aged children, through a meeting of leading experts in the field of VAS and VAD control.

Target 1.2: Inform decisions on the suitability of different VAS delivery platforms

WHY	The first VAS events, initiated in the 1990s, linked VAS with national immunization days (NIDs) for polio eradication. With a resurgence of polio NIDs in recent years, these events remain an important VAS delivery platform in many countries where VAD prevalence is high. With renewed progress towards polio eradication, these VAS delivery platforms are likely to disappear within the next few years. VAS will be integrated into other delivery platforms and health delivery systems.
HOW	GAVA will support country programs to identify alternative VAS delivery strategies. GAVA will collaborate with other relevant sectors, such as the immunization, to devise programmatic approaches to ensure the delivery of VAS alongside other high-impact interventions.



Target 1.3: Catalyze consensus on emerging scientific topics relevant to VAS

WHY	The science on VAS, VAD control measures, and identification of populations at risk for VAD keeps evolving. There is a need for guidance and support interpreting this research for program managers.
HOW	GAVA will synthesize and interpret scientific evidence and liaise with other agencies and initiatives to generate dialogue and achieve consensus on recommended programmatic approaches. For example, GAVA will convene a meeting to discuss how to best assess vitamin A deficiency and how to interpret vitamin A status (either using retinol binding protein (RBP) or serum retinol as the measure of deficiency), in the presence of inflammation.

GOAL 2: To identify and address priority knowledge gaps for VAS programs

To improve VAS programming there is a need to establish mechanisms to identify key bottlenecks and knowledge gaps, which require improved programmatic guidance and further efforts.

Target 2.1: Develop and maintain a platform to curate existing key documents, tools and resources, and VAS program experiences

WHY	There is a need to develop a repository housing all the resources, case studies and tools. To improve VAS programs there is a need to share information better and to raise awareness that GAVA is the place to locate all VAS resources.
HOW	GAVA will use the website as a platform for all VAS related tools and resources. The website will be promoted at various events and conferences, and through social media outlets.

Target 2.2: Develop routine system to identify knowledge and information gaps

WHY	Countries implementing VAS often experience program related difficulties. As many countries transition from campaign-based strategies to more routine based platforms, there is a need to actively identify knowledge gaps and provide tools, resources and guidance to support programs.
HOW	On an annual basis GAVA partners, through their respective agencies, will identify the biggest program challenges and successes over the past year through multiple channels including program reporting, workshops, and publications. GAVA partners will intentionally report to the GAVA core team on an annual basis to identify any need for tools or any ideas for documentation which will inform the future GAVA work plan.

Target 2.3: Synthesize and translate existing evidence to program policy and operational guidance

WHY	As WHO guidelines and other research on VAS-related issues are published, there is a need to translate the information into practical programmatic guidance to assist countries implementing VAS. An example of a challenge facing countries, especially those conducting vitamin A status assessments, is that there is a lack of programmatic guidance on how to deal with the effects of inflammation on biomarkers of VAD. Currently guidance on such issues is limited and outdated.
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HOW	GAVA will lead the development and dissemination of key technical briefs and resources. In its guidance, GAVA will seek to draw upon other tools that are under development, such as economic optimization models to improve the efficiency and targeting of vitamin A interventions. As an example, GAVA is developing programming guidance for shifting from universal VAS among children aged 6-59 months, based on a global consensus meeting of leading experts in the field of VAS and VAD control.
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Target 2.4: Collect and summarize existing good practices/lessons learned for program implementation and generate and make available resources, such as toolkits, program guides and manuals to help improve the implementation of vitamin A programs

WHY	There is a need to increase access to good operational guidance on specific yet varied topics such as how to monitor VAS programs, common and valid VAS coverage & quality assessment methods for varying kinds program decisions; how to procure VA supplies; how to assess equity in VA programs; lessons learned or examples of successful advocacy for public financing, etc.
HOW	GAVA will work with partner agencies to identify key relevant case studies and lessons learned that should be documented and shared through the GAVA website. Toolkits and program guides will be developed by GAVA partners and its network and GAVA will actively advocate for, and where possible, commission, implementation research. GAVA also intends to publish a paper on the characteristics of different program delivery platforms, and to test, document and publish community-based approaches to VAS delivery.

GOAL 3: To provide program support to improve effective implementation and monitoring of VAS programs

GAVA's has a role in developing clear program guidance and fostering consensus on evidence-based VAS programming.

Target 3.1: Provide technical assistance to countries identified as faltering or are undergoing large shifts in their program

WHY	Program managers need practical recommendations and clear programmatic guidance, and often lack capacity to provide support at a country-level. VAS programs are undergoing several shifts: delivery platforms are being integrated into health systems; VAS policies are under review; in some countries, VAD reduction interventions are successfully scaling up; and many programs are shifting from universal supplementation to a more targeted approach. This is new territory for VAS programs, and requires increased technical support and operationalization guidance.
HOW	Countries or partners requiring technical assistance will continue to contact GAVA through its partners and broader network of collaborators. GAVA will continue to use existing information systems to identify any potential programs that may need support. Technical assistance may be provided on a country-by-country basis or by facilitating opportunities to bring countries together to learn from other experiences.



Target 3.2: Facilitate and encourage networking and cross-learning among practitioners and stakeholders

WHY	To optimize the learning potential through sharing of experiences particularly in the context of ongoing shifts in programs.
HOW	GAVA will develop a webinar series, workshops and other interactive methods of communication to facilitate sharing and learning from others working on VAS.

GOAL 4: To advocate for political will and sustained attention for VAS in the context of the broader global nutrition landscape

GAVA intends to ensure adequate funding, focus and priority for VAS as a life-saving intervention in vitamin A-deficient contexts among host country governments, development partners and donors. GAVA will continue to promote integrated delivery platforms within health systems, and advocate for better alignment of VAS with other child survival and VAD control programs to improve complementarity, reduce overlap and optimize resources and impact.

Target 4.1: Advocate for adequate funding and prioritization for VAS as a life-saving intervention, in vitamin A-deficient contexts, among host-country governments, development partners and donors

WHY	Many countries grapple with how to maintain high twice-yearly VAS coverage in light of shifting nutrition goals and priorities, competition for donor resources and a move away from single-nutrient and vertical delivery platforms. A major challenge remains to institutionalize and sustain funding, focus and prioritization of VAS as a critical child survival intervention in appropriate contexts by ensuring national ownership, adequate national and donor funding and high visibility of VAS.
HOW	GAVA will develop advocacy materials, such as case studies, consensus statements, and investment cases for dissemination at regional or national forums.

Target 4.2: Promote VAS delivery platforms that are integrated and institutionalized within health systems

WHY	VAS needs to be incorporated as a vital life-saving intervention, on par with other child survival interventions, within a health systems strengthening approach. In many countries, weak health systems hinder the reach, quality and effectiveness of child survival interventions such as VAS. These weak systems result in increased levels of child mortality, which disproportionately affect the poorest families, both between and within countries. One of the weakest components of existing health systems is community outreach and the link between the community and health centers or health posts. As such, relying on routine services often results in low coverage of preventive child survival interventions beyond immunization contacts. Many other child survival interventions also need to reach the community, so community-based delivery platforms such as child health days or weeks, or the Reaching Every Community (REC) approach used by the immunization programs, have the potential to reduce the cost of delivery while having a synergistic effect on coverage of other child health and nutrition interventions.
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HOW	GAVA will ensure that a presentation or session on critical VAS issues is included in key international and regional nutrition and health meetings from 2016-2020 (e.g. West African Health Organization (WAHO), African Minister of Health meeting, Micronutrient Forum, International Congress of Nutrition (ICN)).
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Target 4.3: Campaign for better alignment of VAS with other child survival and VAD programs to improve complementarity, reduce overlap and optimize resources and impact

WHY	Although VAS reduces child morbidity and mortality, it does not address the root causes of VAD. Greater investment is needed by governments and donors to enhance the implementation of interventions that complement VAS and lead to sustained control of VAD, including large-scale food fortification, promotion of production and consumption of vitamin A-rich crops (including bio-fortified varieties), and promotion of optimal breastfeeding, etc. There is also an urgent need to align VAS within multi-pronged complementary strategies to reduce the risk of VAD.
HOW	GAVA will advocate for the inclusion of vitamin A-related indicators into population-based surveys and program monitoring, in the context of other interventions where VAS exists.

APPENDIX 1: Benefits of VAS for child survival

Twice-yearly VAS among children aged 6-59 months is the most effective programmatic approach to reduce VAD-related mortality¹⁴. Even though high-dose VAS only transiently improves vitamin A status (as measured by serum retinol concentration), its benefits for child survival have been well documented¹⁵⁻¹⁸. The summary estimate from 17 trials indicates that VAS reduces all-cause mortality among children aged 6-59 months by 24% (95% CI= 0.69-0.83)¹⁹. The estimate was lowered to 12% when a large, loosely supervised effectiveness study from India was included²⁰, but the summary estimate for overall mortality reduction remained highly significant.

Based on these findings, WHO recommends one high-dose supplement in the form of 100,000 IU retinol to infants aged 6-11 months, and 200,000 IU retinol every 4-6 months to children aged 12-59 months in settings where VAD is a public health problem (defined as the prevalence of night blindness in children 24-59 months of age $\geq 1\%$, or prevalence of serum retinol concentration $\leq 0.70 \mu\text{mol/l}$ in children 6-59 months of age $\geq 20\%$)²¹. Historically, and in the absence of VAD data, an under-five mortality rate (U5MR) > 50 deaths per 1000 live births was suggested as a proxy indicator for VAD²². To increase sensitivity of this indicator, a U5MR > 70 deaths per 1000 live births was subsequently proposed by an international consultative group²³.

WHO recommends that VAS should be delivered during routine health system contacts, such as those used for vaccinations, and that it should be integrated into NIDs or other vertical child health and survival programs. The first large-scale VAS programs, initiated in the 1990s, linked VAS with annual NIDs for poliomyelitis eradication²⁴. To create a second annual contact point, and to deliver the package of interventions twice per year in settings where NIDs were phased out, Child Health Days (CHDs) have become an important additional delivery strategy²⁵. One-dose VAS coverage increased from 50% in 1999 to 68% in 2004. With the creation of an increasing number of platforms to achieve a second annual contact, two-dose VAS coverage increased from 16% in 1999 to 58% in 2004²⁶. Since then, two-dose VAS coverage has been maintained at 65%-80%, with a latest global coverage estimate of 69% in 2014²⁷.

Worldwide, the majority of VAS continues to be delivered through time-delimited supplementation events. In many cases, VAS delivery is integrated into poliomyelitis NIDs, which have expanded again globally since 2011 due to the reappearance of poliomyelitis. CHDs²⁸ and measles campaigns²⁹ also continue to serve as important delivery platforms. However, efforts are increasing to include VAS delivery in routine health care systems; for example, by ensuring that the first dose of VAS is administered at exactly 6 months through the routine health care system³⁰.

APPENDIX 2: Global and national challenges to VAS programs

Several of the main challenges that have affected VAS programs are described below. GAVA aims to provide additional support and resources to mitigate these challenges.

Global evidence base

In 2011, WHO renewed its support to VAS as an evidence-based intervention to reduce child morbidity and mortality²¹. VAS has been lauded among the best investments for global development in general³¹ and has been linked to reductions in under-5 mortality at the country-level³²⁻³³. Nevertheless, the continued relevance of VAS for child mortality has been questioned by some researchers³⁴⁻³⁵. To address such concerns, the evidence base for VAS needs to be updated and reinforced.

Changing delivery platforms

Poliomyelitis campaigns are going to scale down significantly by mid-2016, and with them, an important VAS delivery platform will disappear. As a result, other delivery platforms have to be used to deliver VAS, ideally with strong links to polio transition planning and global efforts for health systems strengthening. More knowledge is required to design such programs to achieve high coverage among the entire 6-59-month age range. Where CHD-type approaches are the most promising vehicle to reach children aged 6-59 months, including the most vulnerable children, with high coverage, significant funding needs to be mobilized to cover the operational costs of these events.

Global advocacy

Global policy makers created a successful narrative in the 1990s on the importance of scaling up biannual VAS as a key child survival intervention³⁶. They catalogued the required evidence, agreed on the causes of and solutions to the problem, garnered the support of powerful actors for this agenda, and effectively positioned it in the child survival agenda³⁷. Such support to VAS is crucial to maintain it as a priority child survival intervention and to ensure its support in the global Scaling Up Nutrition (SUN) movement.

Data

The determination of VAS coverage data is generally based on tally sheets completed during supplementation events³⁸. This data collection methodology makes VAS one of the few nutrition-specific interventions where national coverage data is available on a large scale³⁹. However, this methodology is subject to numerous limitations related to the determination of the numerators and denominators used⁴⁰. Data methodologies are thus needed that can validate tally-based coverage. Furthermore, collection methodologies are needed to identify subpopulations that are currently not reached through supplementation programs. Better integration of VAS information into routine health information systems is also important for tracking and planning purposes.




Scaling-back universal VAS

VAS as a child survival intervention is currently positioned as an intervention that must be scaled-up and maintained at high coverage among children aged 6-59 months³⁶. However, an increasing number of countries may not require VAS anymore due to decreases in U5MR and a low prevalence of VAD. In such settings, programs managers may prefer to focus on vulnerable subpopulations based on geography or age, such as focusing on a narrower age group. One major contributing factor to this problem is the lack of technical guidance on when shifts from universal VAS programs should be made. GAVA is currently developing technical guidance to inform shifts away from universal VAS among children aged 6-59 months⁴¹. Once the guidance is available, GAVA should support countries with the application of this guidance.



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