



The Global
Alliance
for Vitamin A



SIX-MONTH CONTACT POINT

A TIMELY WAY TO DELIVER ESSENTIAL MATERNAL AND CHILD HEALTH AND NUTRITION SERVICES INCLUDING VITAMIN A SUPPLEMENTATION (VAS)

BACKGROUND

Six months after birth represents an important time to meet the nutrition and health needs of a mother and her infant. For women, her fertility may return at any time during the post-partum period, increasing her risk of pregnancy. Even for women practicing the lactational amenorrhea method (LAM), the risk of pregnancy increases after six months of age ¹. For the six-month-old infant, growth requirements call for added intake of nutrient-rich foods to complement breast milk. It also marks the start of the period when high-dose VAS is likely to reduce infant mortality risk. Creating a six-month postpartum contact within the health system can provide an opportunity for the timely delivery of an integrated package of interventions showing high impact on both maternal and child health and nutrition status ². Several countries have piloted this and are beginning to scale it up. This brief describes the rationale, process, results and lessons learned from country experiences.

KEY MESSAGES

- Creating a six-month postpartum contact point within the health system can provide an opportunity for the timely delivery of an integrated package of high-impact interventions for both mother and child.
- Experiences with six-month contact points in Sierra Leone, Senegal and Côte d'Ivoire show promising results in terms of increasing the coverage of VAS, family planning, counseling on infant and young child feeding (IYCF) and catch-up vaccinations at six months of age.

RATIONALE

Six months after birth is an important time for meeting the nutrition, health and reproductive needs of women and children, but few health systems include a six-month contact point.

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- **Saving lives with VAS at six-months of age:** Six months of age represents the start of the period when VAS reduces mortality risk³; yet the first dose of vitamin A is often delivered to infants three months late, during measles immunization (i.e. measles-containing-vaccine first-dose or MCV1) or Child Health Days (CHDs)⁴. A recent modeling study found an additional mortality benefit of 1.6%-1.9% when VAS was provided to the child right at the age of 6 months compared to at 9 months of age during MCV1 or at another point between the ages of 6-11 months⁴. Caution is always needed to avoid double-dosing in settings where many vitamin A interventions target infants 6-11 months of age, however, it also found the intervention to be safe even if a second dose of VAS is given as soon as 1 month after the first dose.

- **Improving infant and young child feeding (IYCF) practices:** By the age of six months, a baby has

usually doubled its birth weight, and is becoming more active. After six months of age, it becomes increasingly difficult for breastfed infants to meet their nutrient needs from human milk alone and complementary foods should be introduced to make up the difference⁵. At about six months of age, an infant is also developmentally ready for other foods. The complementary feeding period typically runs from 6-23 months of age and represents a very vulnerable period as evidenced by poor post-natal growth that contributes significantly to the high prevalence of malnutrition in children under five years of age worldwide. Thus, six months after birth represents an important time to provide mothers with counseling on appropriate infant and young child feeding behaviors⁶ including cognitive stimulation. It is also an age when the delivery of other nutrition interventions targeting young infants, such as micronutrient powders⁷ and/or lipid-based nutrient supplements can begin or as in the case of growth monitoring, be continued.

- **Improving immunization coverage:** While there is no specific vaccine schedule for children 6 months of age, a 6-month contact point would fall between the 14-week diphtheria-tetanus-pertussis (DTP) and the 9-month MCV1 contact, and thus shorten the gap between visits from approximately 6 months to 3 months. The six-month contact could help reduce attrition rates for three doses of DTP and oral polio vaccine (OPV), increase inactivated polio vaccine (IPV) uptake and would provide an opportunity for catch-up vaccinations. The six-month contact could thereby help reach the Global Vaccine Action Plan (GVAP) goal of attaining 90% national coverage and 80% coverage in every district for all vaccines in national programs by 2020⁸.

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- **Birth spacing:** Six months after birth represents the end of the fertility protection period for a woman who has been practicing LAM to reduce pregnancy risk⁹. It therefore is an ideal time to provide counseling in family planning and birth spacing methods.

PROCESS OF ESTABLISHING A SIX-MONTH CONTACT POINT

Several countries in Africa—Côte d'Ivoire, Niger, Senegal, Sierra Leone— have successfully piloted the 6-month contact point and are currently scaling it up as an opportunity to administer VAS and other vital health and nutrition services. While the process for establishing this new approach varied, the following represent vital steps and activities necessary to program success in all four countries:

→ 1. ADVOCACY:

Introducing a new contact point into an established health system is challenging. It is therefore vital to meet with key stakeholders (e.g. Ministry of Health at national, regional and district levels; development partners; researchers) to build consensus and clearly explain the rationale, benefits and costs of establishing a six-month contact point. Advocacy targeting the national Expanded Program on Immunization (EPI) services is needed to integrate the six-month contact point into vaccine-related planning, reviewing and monitoring activities (e.g. comprehensive multi-year plans, annual program reviews). This advocacy is also needed to integrate the six-month contact point into the immunization calendar and into implementation and coordination activities of immunization teams at all levels of the health system.



→ 2. IMPLEMENTATION:

In many countries a 'pilot' phase was vital before establishing the six-month contact point at a national scale. The pilot phase allowed countries to identify and develop needs related to health worker skills, supply (e.g. VAS, contraceptives, IYCF materials), supervision, information systems (e.g. integrating six-month contact point into the routine immunization schedule and into the Child Health Card), and demand generation. It also allowed countries to compare coverage of VAS, vaccination, family planning and IYCF services with and without the six-month contact point to establish its value.

Moving from the pilot phase to large-scale implementation requires dedicated effort and resources to successfully establish the six-month contact point into health services. A geographically



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phased approach has been used in countries that have started to scale up this innovative delivery platform. Throughout the scale-up phase, rigorous monitoring is required beyond the country's health information system to assess the scale-up process (e.g. number of facilities delivering the services, availability of capsules) and measure change in coverage for the services delivered through the six-month contact point.

→ 3. POLICY GUIDELINES:

Scaling up the six-month contact point from a pilot phase often requires developing policy guidelines that clarify which interventions will be delivered, by whom, through what actions, for what reasons and how they will be documented. It also requires a "roll-out" plan including health worker training, community demand creation, an orientation/ training plan, job aids, and a system to monitor and evaluate the coverage and quality of this new delivery platform.

RESULTS

- In Sierra Leone, where the six-month contact point was compared with a control group, results showed (i) a higher proportion of children 6-11 months of age received their dose of vitamin A closer to the age of 6-7 months; (ii) higher coverage of family planning counseling (61.8% vs. <1.5 %) and higher provision of contraceptives (44.5% vs. 0.8%); (iii) higher exposure to IYCF counseling (62.4% vs 2.8%) and complementary feeding demonstration

(62.6% vs 0.5%); but no statistically significant difference in immunization coverage (95.8% vs. 92.4%), possibly because it was already high (>90%) in both groups ¹⁰.

- In Senegal, where SMS reminder messages and phone calls were used to inform caregivers of the six-month contact point, VAS coverage was significantly higher at six months of age in the six-month contact point group compared to a control group ¹¹.

LESSONS LEARNED FROM COUNTRY EXPERIENCES

- Unsurprisingly, in both Senegal and Sierra Leone there was a need to monitor and ensure the availability of supplies needed to deliver the services offered as part of the six-month contact point (e.g. vitamin A capsules, contraceptives, child health cards, vaccines).
- In Sierra Leone, strong collaboration with the District Health Office facilitated the uninterrupted supply of services and commodities.
- In Senegal, the provision of an initial stock of vitamin A capsules based on census data ensured an adequate supply at the start of the program, but a system to monitor and replenish dwindling supplies was vital ¹¹.



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- An SMS-based system that regularly reports on the stock of supplies helped prevent stock-outs in Senegal ¹¹.
- In Sierra Leone, there was a need for extensive training of health staff on the use of the revised child health card and other components of the six-month contact point.
- IYCF counselling, whether provided at a six-month contact point or not, requires supportive supervision and incentives, and is enhanced by demonstrations.
- In Sierra Leone, the presence of a dedicated and trained nursing aid was needed to provide family planning services as part of the six-month contact point. This may not be needed if all clinic staff are trained in family planning. In Côte d'Ivoire, the use of SMS "appointment reminder" messages significantly increased the coverage of immunization and VAS at six months of age (Penta 1: 86.6% vs. 76.1%; Penta 2: 81.0% vs. 67.3%; Penta 3: 74.2% vs 58.3%; VAS: 64.7% vs. 40.7%; MCV1:60.7% vs. 37.8%) ¹².
- In Senegal, demand generation and community awareness strategies that included multiple channels (e.g. social mobilization activities, radio, brochures, posters, SMS reminders and community health worker follow-up) was important for establishing the six-month contact point.





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