Distribution models for vitamin A supplementation (VAS) in DRC

Context-Strengths-Challenges

Par Jean Pierre Banea MD, PhD

Directeur du PRONANUT

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Contexte de la RDC

- 104 for 1000 : infant and child mortality rates (EDS 2013-2014)
- 43% : chronic undernutrition in children <5 (EDS-2013-2014)
- 47% : Rates of anemia in children <5 (EDS-2013-2014)
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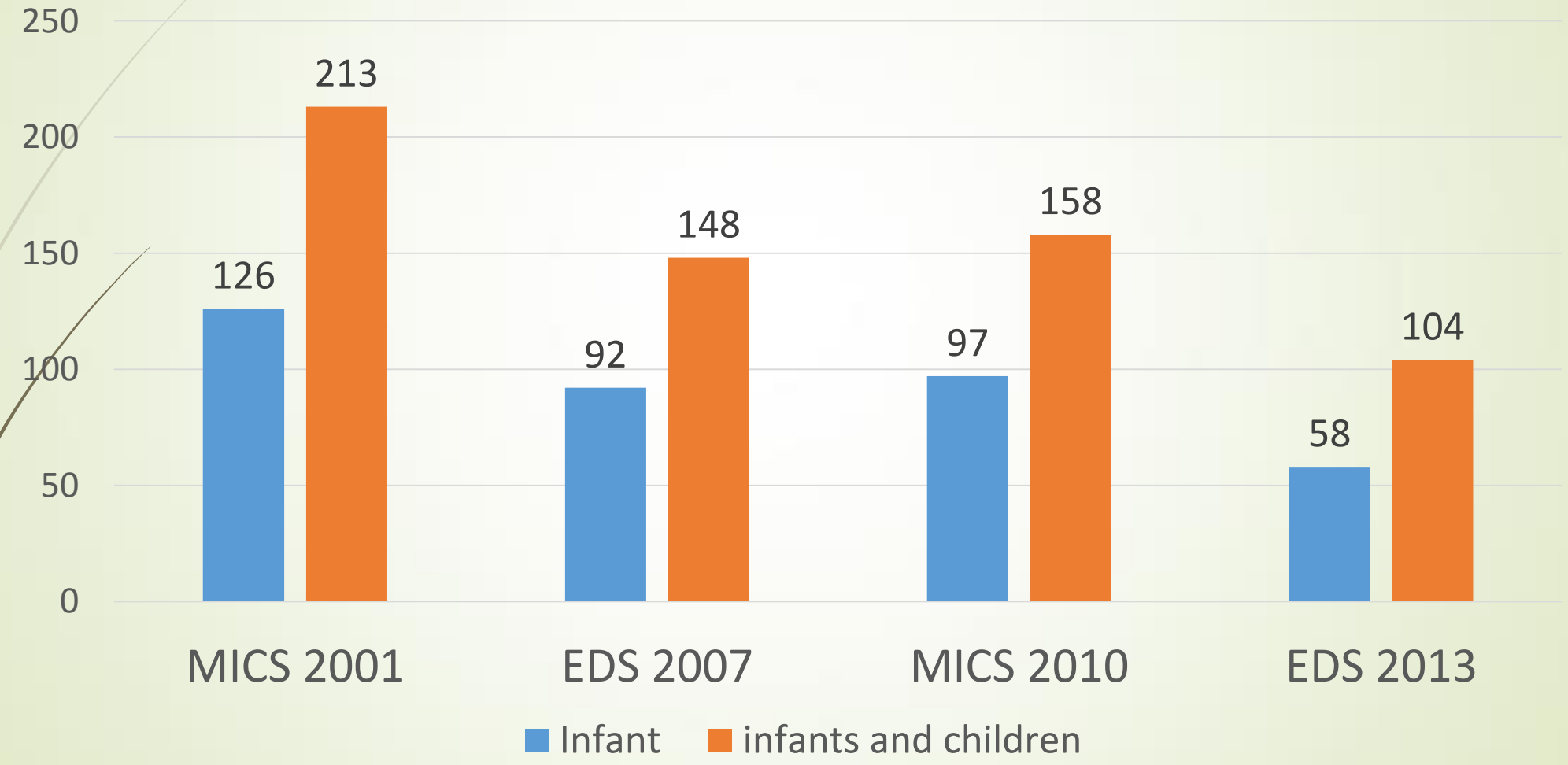
- 38% : Rates of anemia in women (Enquête nationale2005).
- 61% of vitamin A deficiency in children 6 to 36 months (Enquête nationale1998).

Evolution of infant and child mortality from 2001 to 2013



Distribution models of vitamin A in DRC

Main distribution models for the period 1998-2015 :

- Distribution of VAS in local and national immunization days
- VAS campaigns with deworming
- Child health days (CHD)
- Routine and other models

Distribution of vitamin A during door to door NiD campaigns

Context

Model that consist in providing vitamin A during National Immunization Days (NiD) (or local immunization days) devoted to polio immunization of children under 5:

- 61 % of vitamin A deficiency according to 1998 survey
- Government decision to distribute VAS for children 6-59 months through National Immunization days since 1998
- VAS in national nutrition policy since 2000

Distribution of vitamin A during door to door NiD campaigns (2)

Forces	Défis
Awareness about vitamin A deficiency	To find funds for second dose
Distribution of VA to all children 6-59 months in country	To cover the whole country if NiD only covers a few areas
Administrative coverage around 98%	Ensure that VAS is delivered with 6 months interval between 2 doses
All children targeted reached in 3 days campaigns only	Ensuee data management and quality
NiD well financed	Manage denominators issues and stock outs during campaigns
Reduces costs for actors of VAS	

VAS and deworming campaigns

Context

VAS and deworming distriction during stand alone door to door campaigns

- To ensure 2nd dose of VAS
- Because NiD target only specific provinces
- High prevalence of anemia in children and women
- Financial and technical partners: BASICS, MOST under funds from USAID;MI, Japanese Governement, UNICEF and HKI under funds from GAC / Canadian government

VAS and deworming campaigns (2)

Forces	Défis
High coverage reached in only 3 days	Financing as heavy needs in human resources, supplies and funds
Attractive effect of deworming and VAS	Increase coverage in low performing areas
GAC funds available and technical support from UNICEF & HKI	Mobilisation of funds
Provincial nutrition coordination bodies in all provinces	Data management and quality

Child Health Days (CHD)

- Twice yearly events every six months for VAS
- CHD use a combination of fixed, advanced and mobile strategies in health centres and heavily involve communities
- Compulsory minimum package:
  - VAS for children 6 to 59 months,
  - Deworming for children 12 to 59 months,
  - Catch up immunization for children 0 to 23 months and immunization for pregnant women (VAT)
  - Health promotion (one behavior per campaign tailored to health zone
- Depending on needs and supplies available
  - Distribution of long-lasting insecticide-treated nets (LLINs)
  - Detection of undernutrition

Child Health Days (CHD)

Context

- Eradication of wild poliovirus leads to end of NiD
- Reduction of financing for vertical programs such as VAS
- Strengthening the health system by offering a high impact interventions for child survival through health facilities
- Stunting as high as 43% (EDS 2013-2014)

Child Health Days (CHD)

Forces	Défis
High impact interventions package delivered	To maintain coverage beyond 80% in all health zones
More partners support CHD	Data management and quality
Coverage beyond 80%	Institutionnalization of CHD and increase ownership by national authorities
Stimulates use of health facilities and health personnel	Increase number of childre 0-11 months and pregnant women met by immunization
	Supervision, coordination and evaluation integrated between Epi and nutrition

Routine

Routine VAS for children during primary healh care once a month:

- During pre school consultations for growth monitoring organised in health facilities (for first contact at 6 months)
- During curative care for children suffering from diarrhea, measles, acute malnutrition and respiratory infections

Context

- Low coverage for children 6 months old during campaigns
- Children of 5 months during campaigns are missed
- 1000 days
- Child survival

Routine (2)

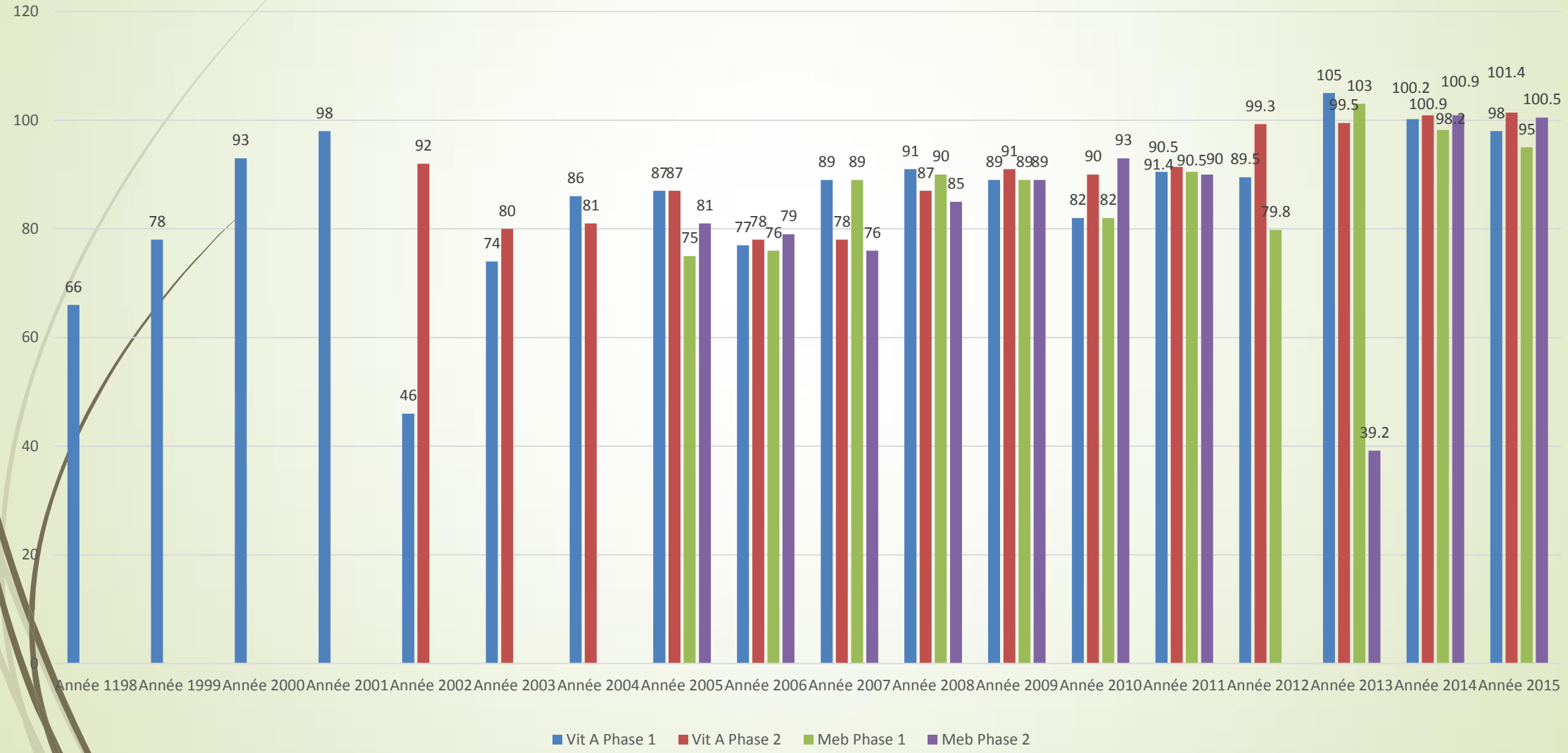
Forces	Défis
Use of pre school consultation card	Management of denominator and supplies
Revives pre school consultations in health zones	Create demand for pre school consultation
Implements 6 month contact point for VAS as routine	Proper management of VAS routine data
Existence des expériences pilotes SVA en routine	Maintain coverage at least at 60%

Other modeles

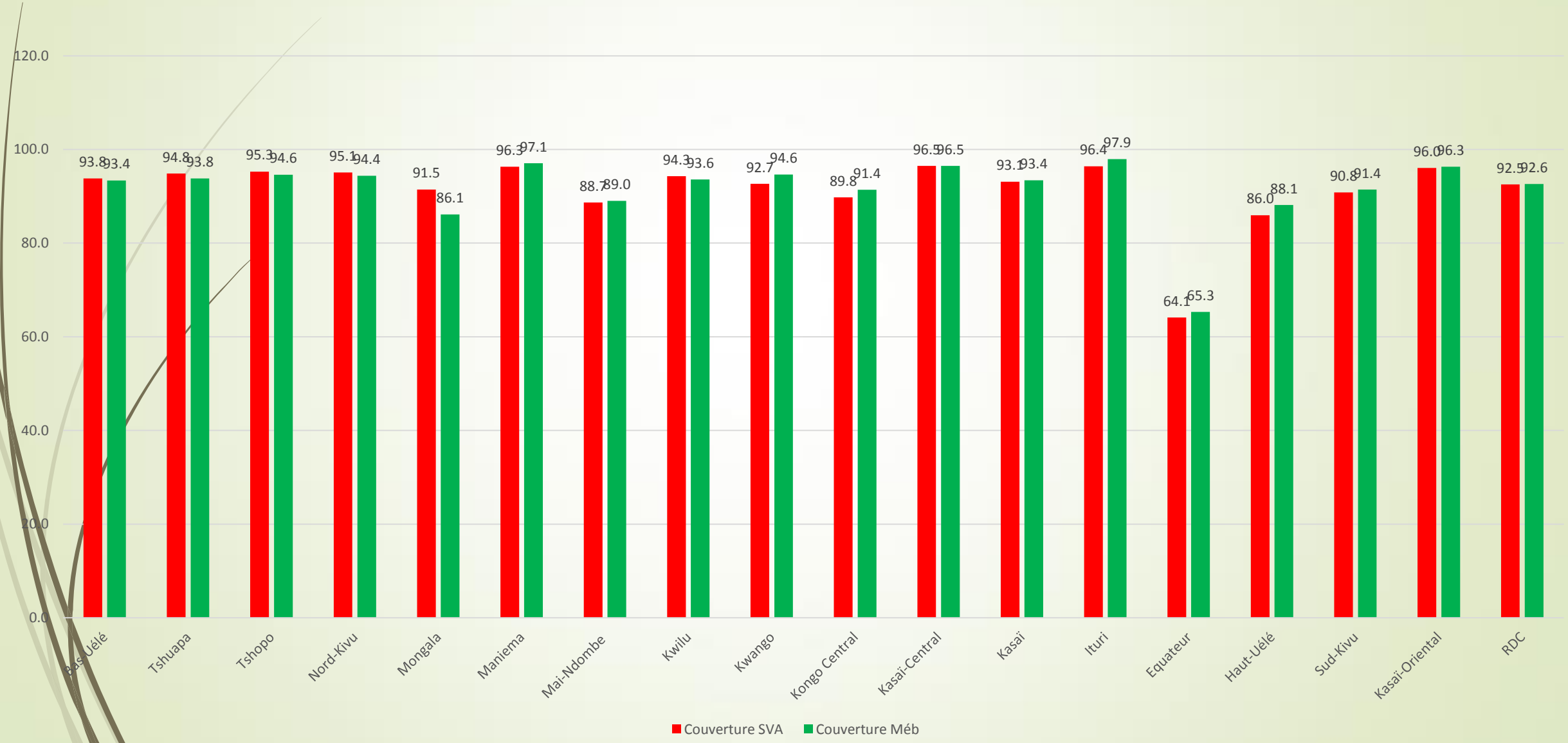
Other models

- VAS intergated with measles immunization in fixed and outreach strategy in some health zones
- VAS integred with community based ivermectine treatment: community distributors distribute VAS, deworming and ivermectine in a door to door strategy in endemic health zones.
    - Vitamin A
    - Deworming
    - Ivermectin

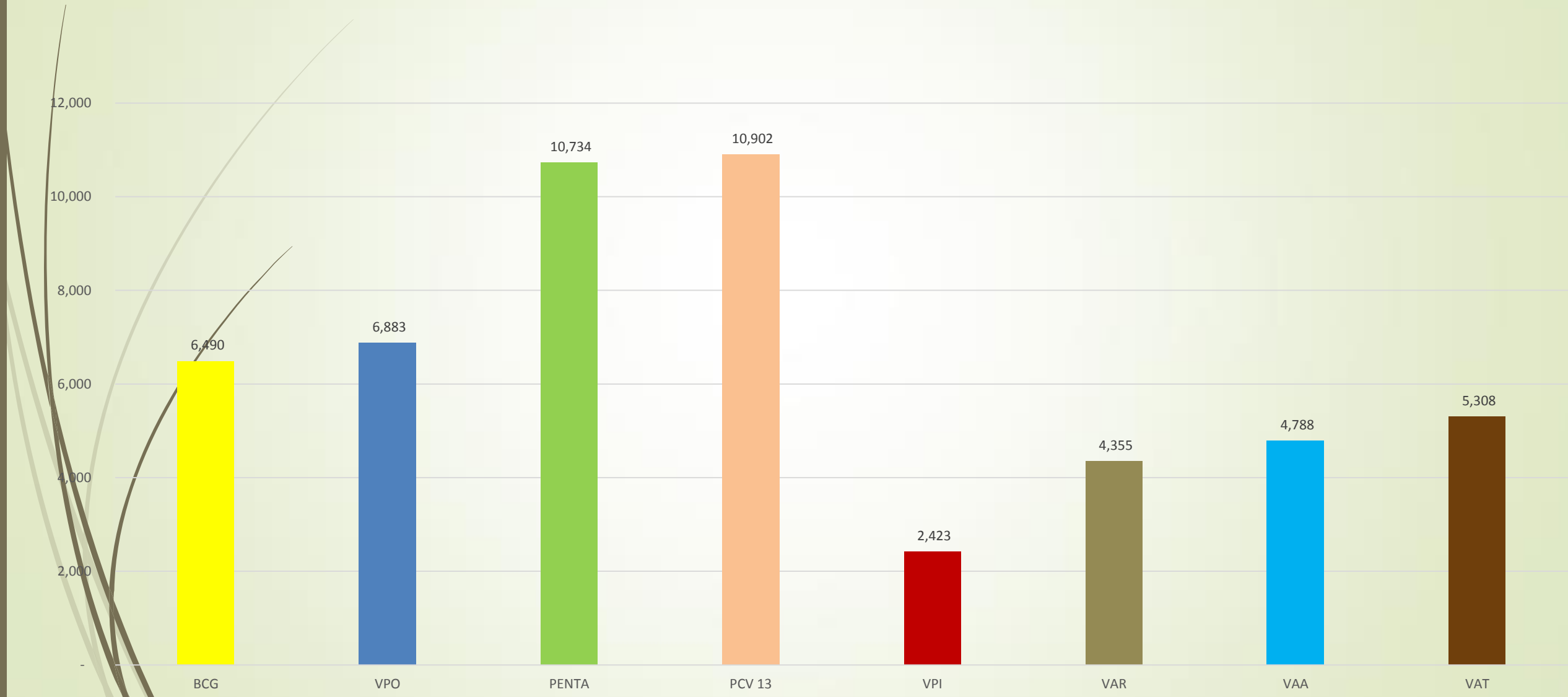
Evolution of VAS administrative coverage and deworming between 1998 and 2015



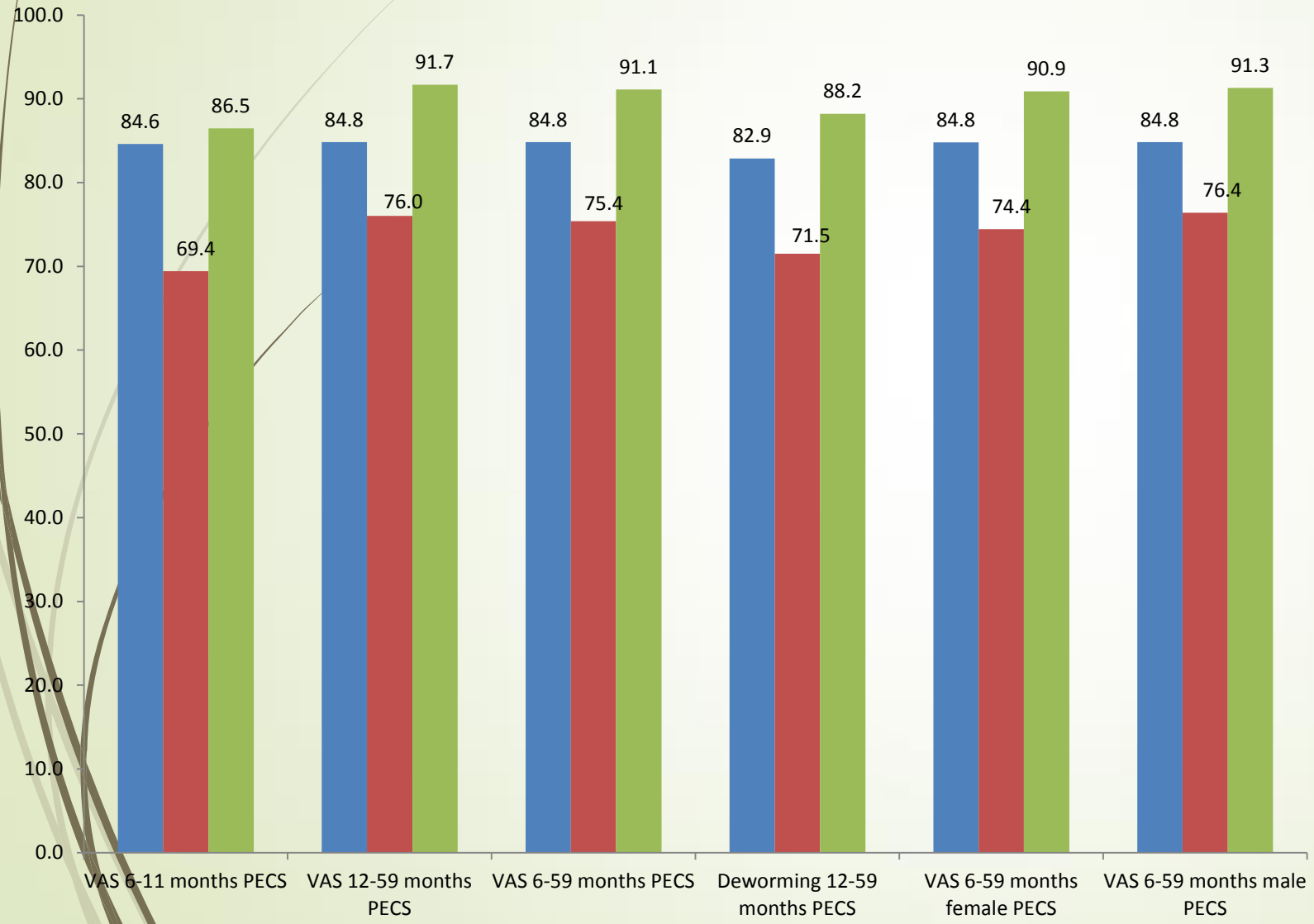
VAS and deworming administrative coverage during CHD in 2015



Number of children and pregnant women immunized during CHD



VAS and deworming coverage in specific provinces 2012 – 2014



Perspectives

- Extend CHD in all provinces and respect implementation processes to ensure high coverage
- Institutionnalize CHD through ministry of health directives
- Revive pre school consultations in all health zones in order to extend VAS 6 months contact point through routine services
  - and to support growth monitoring
- Transition to routine
- Ensure supervision, coordination and data management in integrated manner with EPI and nutrition

Conclusion

- Various models used to deliver VAS in DRC allowed coverage beyond 95% for children 6 to 59 months
- Post event coverage surveys (PECS) conducted between 2012-2014 in some provinces did not show significative difference between survey and administrative coverage
- Pockets of low coverage remain (< 80%) so programs for hard to reach children are required for low performing health zones
- Routine Vas (1st contact at 6 months) needs to be scaled up and strengthened