



The Global
Alliance
for Vitamin A

VITAMIN A SUPPLEMENTATION IN THE CONTEXT OF COVID-19

FREQUENTLY ASKED QUESTIONS (FAQ)

The COVID-19 pandemic has impacted health systems around the world, and many countries are trying to find the right balance between preventing the spread of COVID-19 and minimizing disruptions to essential child health and nutrition services such as vitamin A supplementation (VAS). The Global Alliance for Vitamin A (GAVA) developed a [consensus statement](#) and [operational guide](#) to support countries and program managers in determining the best course of action for VAS programming in the context of the pandemic [1, 2]. These FAQ were developed to complement those resources.

The FAQ are organized by topic:

- Vitamin A and COVID-19
- Mass campaigns vs. routine delivery
- Household level (door-to-door) vs. fixed site distribution
- Health worker vs. caregiver administration model
- Preparing for VAS delivery
- Integrating VAS delivery with other health services
- Screening for COVID-19
- Personal Protective Equipment (masks, gloves, etc.)
- Caregiver administration model
- Delivering VAS using vitamin A syrup
- Task-shifting to community health workers/volunteers
- Supervision of health workers

VITAMIN A AND COVID-19

What is the role of vitamin A in the prevention and treatment of COVID-19?

Vitamin A is essential to support growth and help combat infections in childhood. Clinical trials have demonstrated that VAS is a life-saving intervention that is vital to reduce the risk of child mortality, morbidity, and malnutrition in countries with high levels of vitamin A deficiency (VAD). Although there is currently no evidence on the effectiveness of high-dose VAS for the treatment of COVID-19 or the reduction in severity of the specific illness it causes, VAS is especially important for vulnerable children during an infectious disease outbreak when access to health services is limited.

MASS CAMPAIGNS VS. ROUTINE DELIVERY

The GAVA Consensus Statement recommends that the decision to deliver VAS through mass campaigns be based on an analysis that weighs the risks and benefits. If a country has already done the risk analysis for a polio campaign, do they need to do a separate risk analysis for VAS?

Yes, they do. The administration of the oral polio vaccine is similar to that of VAS, so many of the same risks for COVID-19 transmission during service delivery exist for both services. However, the benefits of conducting a polio campaign will be different than the benefits of conducting a VAS campaign, so a separate risk benefit analysis should be completed for VAS.



Our country decided to suspend VAS campaigns during the pandemic and integrate VAS into routine health service delivery. How do we select the most appropriate platform to reach children with VAS? Many routine health services, like immunization, often only focus on children 6-11 months of age. How can we optimize the integration of VAS to improve coverage for children 12-59 months of age in the context of COVID-19?

The first step in planning VAS delivery through routine health services is to map all potential platforms where children aged 6-11 months and children aged 12-59 months can be reached. The following steps and criteria will help complete this task:

1. Create a list of potential platforms, including important details like how often each child participates in the platform and the age group covered by the platform. Look at a broad range of services for potential contact points (e.g. health, education, social welfare), including those that were established during the COVID-19 pandemic, such as community-based COVID-19 surveillance activities.
 - a. e.g. the Extended Programme on Immunization (EPI) is attended every day by children aged 6-11 months, growth monitoring program is attended every month by children aged 6-23 months, kindergarten/preschool is attended daily by children over 36 months of age.
2. Weigh the performance/level of attendance of each of the platforms by children, by age group, to decide whether to use each platform.
 - a. e.g. 80% of children aged 9 -11 months received measles vaccine through EPI.
3. Decide which delivery platform(s) is/are best suited to cover all children aged 6-59 months, keeping in mind that multiple platforms may be required to reach children of different ages.
4. Conduct a monthly review of performance by delivery platform to assess the extent to which each selected delivery platform is reaching children in each age group. Use this data to decide if each selected delivery platform should continue to be used to deliver VAS, to decide if any rapid course correction is necessary, or to decide whether to add other platforms to reach the target population. Pay special attention to the 12-59-month age group to ensure they are being reached and to identify if action is needed to employ different delivery platforms.
5. Plan for intensified, catch-up delivery of VAS when the COVID-19 situation allows. This catch-up plan might be at the national level or be limited to specific regions within the country.

Should countries accelerate the transition from campaign to routine delivery of VAS in light of the COVID-19 pandemic?

Restrictions on large gatherings have forced countries to make a rapid shift to routine delivery of VAS to ensure the continuity of VAS during the COVID-19 pandemic. However, countries should not accelerate a permanent policy shift towards routine delivery.

This temporary shift to routine VAS delivery during the pandemic may highlight some best practices and lessons learned, but a permanent policy shift to routine requires a comprehensive, systems approach and a well-articulated plan that is ideally implemented in a stepwise manner, where countries roll out the transition gradually across districts/states/provinces. It should not be rushed or implemented during a pandemic when the health system is not functioning as usual.

HOUSEHOLD LEVEL (DOOR-TO-DOOR) VS. FIXED SITE DISTRIBUTION

Should household-level (i.e. door-to-door) distribution of VAS be avoided during the COVID-19 pandemic?

Household-level distribution of VAS can be executed safely in the context of COVID-19 by respecting key infection prevention and control (IPC) measures. When possible, VAS should be administered outside the dwelling or in a well-ventilated area, and health workers should maintain physical distancing by remaining 1-2m away from caregivers, children, and other family members. Sections 3.2 and 4.1 of the [GAVA guide](#) detail the IPC measures required to safely distribute VAS at the household level.

In countries where VAS was typically distributed through door-to-door campaigns but where household-level distribution is prohibited due to the COVID-19 pandemic, what delivery method can be used to distribute VAS safely to young children?

If household-level distribution is prohibited, VAS can be delivered at fixed sites such as health posts, health centres, health system outreach sites, or other places within the community. Guidance on how to carry out the delivery of VAS at fixed sites can be found in Section 4.2 of the [GAVA guide](#).



In areas with high population density, physical distancing can be challenging. What is the safest way to distribute VAS in these areas?

In densely populated areas where physical distancing is difficult to maintain, it is crucial that health workers are provided with the appropriate personal protective equipment (PPE) for distributing VAS (i.e. medical masks). Program managers should also consider ways to reduce the risk of crowding during distribution. This might include reducing the number of people expected to attend each distribution event, integrating VAS delivery with other health services, or increasing the number of days and distribution sites for VAS delivery. Additional recommendations on how to reduce the risk of crowding can be found in Section 4.2.1 of the [GAVA guide](#).

HEALTH WORKER VS. CAREGIVER ADMINISTRATION MODEL

How should countries decide between the health worker or caregiver administration models?

The choice between the health worker or caregiver administration model is based on the availability of personal protective equipment (PPE) for health workers. GAVA recommends that VAS be administered by trained health workers wearing medical masks, incorporating additional steps into the usual VAS administration protocol as described in the [GAVA guide](#). However, where medical masks are not available in sufficient quantities, health workers should maintain 1-2m distance from caregivers and children. In this scenario, the caregiver administration model must be employed to allow the health worker to maintain physical distancing from the child and caregiver.

In the past, caregivers have not been permitted to administer vitamin A capsules to their children. Why is GAVA now recommending this administration model?

The caregiver administration model is a mitigation strategy during the COVID-19 pandemic in settings where personal protective equipment (PPE) is not available for health workers.

Typically, GAVA recommends health worker administration because health workers are well trained to handle the challenges associated with VAS administration (e.g. handling the small capsule and cutting the tip off of the capsule, ensuring that each child receives the correct dose). However, during VAS administration the health worker must get close enough to the child and caregiver to squeeze the contents of the capsule into the child's mouth. In the COVID-19 context, this close contact could put the health worker, caregiver, and child at risk of COVID-19 transmission as physical distancing cannot be maintained. For this reason, health workers should wear a medical mask while administering VAS.

The caregiver administration model is recommended in contexts where medical masks are not available for use by health workers, as it allows the health worker to maintain physical distancing, so VAS distribution continues in the absence of PPE. When weighing the benefit of the child receiving their VAS versus the challenges involved in the caregiver administering the VAS, it is better that the child receives their age-appropriate dose of VAS using the caregiver administration model.

PREPARING FOR VAS DELIVERY

Is it necessary to adjust the number of days allotted for VAS distribution in the context of COVID-19 to accommodate for extra steps related to infection prevention and control (IPC) measures?

Yes, it will likely be necessary to add additional days for VAS distribution during COVID-19 to be able to reach the same coverage levels as before the pandemic. The additional IPC steps incorporated into the VAS administration protocol might mean that each administration will take more time, so with the goal of reaching the same number of children, this will likely require additional days (or, alternatively, additional health workers). This applies to VAS distribution through mass campaigns or routine delivery, whether VAS is distributed at the household level or at fixed sites.

For VAS distribution at fixed sites, the addition of extra days for VAS distribution can also help to reduce the risk of crowding and reduce the risk of COVID-19 transmission between families attending the event. Section 4.2.1 of the [GAVA guide](#) provides some suggestions on how to plan for fixed site VAS distribution to reduce the risk of crowding.



During the COVID-19 pandemic, caregivers may be hesitant to access health services, especially for preventive services such as VAS. What can be done to help improve care-seeking for VAS in these settings?

Good communication is an important part of planning for the delivery of VAS and other essential health and nutrition services. In addition to informing caregivers of the benefits of VAS for young children, a well-designed communication strategy can help community members feel at ease seeking health and nutrition services, by providing up-to-date, accurate information on where and when VAS is available, basic preventive measures put in place to prevent infection and how VAS is being delivered safely to children. Information should be disseminated through trusted information sources, using multiple communication approaches. Section 2.2 of the [GAVA guide](#) provides additional details on the recommended actions to be taken to communicate and engage with communities in the context of COVID-19.

What extra steps need to be taken when preparing for the caregiver administration model?

In the caregiver administration model, the VAS administration is managed by the health worker (i.e. she or he instructs and supervises), but the steps are carried out by the caregiver. This model is a significant deviation to many countries' VAS policies. After deciding to proceed with the caregiver administration model, there may be the need to revise national and subnational VAS policies to allow for capsule administration by caregivers. The VAS program communication strategy should be revised to include messages informing caregivers of the change and emphasizing that caregivers will be supported by health workers during the process. Training materials and protocols will also need to be updated to reflect this change in policy. Given the challenges associated with engaging caregivers to administer the capsule, GAVA recommends training health workers on how to carefully instruct the caregiver to carry out the administration, and to provide close supervision and guidance.

The caregiver administration model requires proper communication beforehand. Are there communication materials available to support implementation of the caregiver model?

The [GAVA guide](#) provides some images and step-by-step instructions to support the proper administration of VAS by caregivers, but additional communication materials will be required to conduct community engagement and disseminate information to communities.

INTEGRATING VAS DELIVERY WITH OTHER HEALTH SERVICES

In many countries, VAS distribution is conducted alongside other health services, like deworming or screening for acute malnutrition. Considering GAVA's operational guidance, can this still be done?

GAVA's [operational guidance](#) is focused on the process of administering vitamin A capsules, but this does not mean that VAS must be delivered on its own. We recommend that VAS be co-delivered with other services. While our [guide](#) does not cover the logistics of handling the deworming tablet or conducting nutrition screening, many of the same infection prevention and control (IPC) measures apply when carrying out those activities.

Can high-dose VAS be given to young children on the same day/at the same visit as iron syrup or micronutrient powders (MNP)?

Yes. There is no safety risk in giving high-dose VAS to young children on the same day/at the same time as iron syrup or vitamin A-containing MNP.

SCREENING FOR COVID-19

In areas where systematic COVID-19 testing is not taking place, can VAS still be distributed?

Yes, VAS can still be distributed in areas where there is limited access to COVID-19 testing. The [GAVA guide](#) recommends that screening be conducted prior to VAS administration, allowing for additional infection prevention and control (IPC) measures to be put in place to protect health workers from infection. Furthermore, the IPC measures described in the [GAVA guide](#) are meant to reduce the risk of COVID-19 transmission between health workers and community members and within communities, understanding that screening may not be sensitive enough to detect all cases.



The GAVA guide recommends regular screening of health workers for COVID-19. Given that many countries do not have enough COVID-19 tests, how can this be accomplished?

The screening advised in the [GAVA guide](#) does not require the use of COVID-19 tests; rather, it considers the common symptoms and risk factors for COVID-19 infection. This advice is to ensure that health workers who are suspected or presumed cases of COVID-19 are not involved in the distribution of VAS until they no longer meet the criteria of a suspected or presumed case.

Why do you advise that children who are suspected or confirmed COVID-19 cases still be given VAS? Is there any reason not to give VAS to a child during COVID-19?

There are no sicknesses or illnesses that prevent a child from receiving their age-appropriate dose of VAS. All children aged 6-59 months should be given twice-yearly VAS, even if they are suspected or confirmed cases of COVID-19. If a child is a suspected or confirmed case, appropriate measures should be taken to protect health workers during VAS administration; these measures are outlined in section 3.2.1 of the [GAVA guide](#). Children are exposed to morbidity and mortality risks related to other health problems including measles that may re-emerge due to decreased vaccination coverage resulting from the impact of COVID-19 on essential health services. Although there is no evidence that VAS decreases or increases morbidity or mortality due to COVID-19, VAS is especially important during the pandemic to protect children from preventable morbidity and mortality in settings where vitamin A deficiency is a public health problem.

What symptoms or signs should we look for when screening caregivers and children prior to VAS distribution?

Screening for COVID-19 typically involves looking for symptoms such as fever, cough or shortness of breath, as well as a history of travel to a location with known COVID-19 transmission or contact with a confirmed or probable case [3]. Screening should be conducted in accordance with local policy on COVID-19 surveillance. For more guidance on screening, up-to-date case definitions are available from WHO [4].

Do health workers need to be equipped with digital thermometers to conduct screening for COVID-19?

Ideally health workers have access to necessary tools such as digital thermometers to conduct screening for COVID-19, but this has financial implications and may not be feasible in all contexts. As such, it is recommended that as a minimum, screening be based on symptoms rather than the actual measurement of body temperature.

PERSONAL PROTECTIVE EQUIPMENT (MASKS, GLOVES, ETC.)

Should health workers wear medical gloves during VAS administration? What about medical gowns?

Health workers should always follow national and local guidelines on appropriate personal protective equipment (PPE). Guidance from WHO and UNICEF describes the appropriate infection prevention and control (IPC) precautions—including PPE such as medical masks, gowns and gloves—required for different health care activities. While the guidance does not specifically mention VAS, it explains that health workers are not required to wear medical gloves and gowns when conducting activities similar to VAS administration [3]. For this reason, GAVA did not include a recommendation for the use of medical gowns or gloves by health workers administering VAS. In accordance with global guidance, the [GAVA guide](#) emphasizes the importance of frequent hand hygiene for health workers during the COVID-19 pandemic as a critical IPC measure to reduce the risk of COVID-19 transmission. Section 3.1 of the [GAVA guide](#) details the critical times for hand hygiene during VAS administration.

The GAVA guide only discusses the use of medical masks for health workers, even though we are witnessing more and more use of alternative masks manufactured according to standards set by the WHO. Why does GAVA focus exclusively on medical masks for health workers? If VAS distribution is carried out at the community level, are locally made masks sufficient for use by health workers?

In accordance with WHO guidance on the rational use of personal protective equipment (PPE) [5], the [GAVA guide](#) recommends that health workers wear medical masks during VAS administration. Although cloth masks may be appropriate for use by healthy members of the general public, the use of cloth masks as an alternative to medical masks is not considered appropriate for the protection of health workers [5], whether distribution occurs at the community level or at higher administrative levels.



In communities where there is not sufficient availability of medical masks for VAS administrators, can VAS be distributed?

As per the [GAVA guide](#), where medical masks are not available for use by health workers, the caregiver administration method can be employed to distribute VAS. This method is described in Section 3.2.4 of the [GAVA guide](#).

Is it necessary for caregivers to wear a mask when they attend VAS distribution events at fixed sites (e.g. health posts, health centres)?

The [GAVA guide](#) does not make specific recommendations on the use of masks by caregivers. Caregivers and other community members should follow local policies regarding the use of masks by the general public.

CAREGIVER ADMINISTRATION MODEL

In the caregiver administration model, can the health worker cut open the capsule before transferring the capsule to the caregiver?

No. The health worker must not cut open the capsule in the caregiver administration model because the health worker and the caregiver would come in close contact when the open capsule is transferred to the caregiver by hand. This would defeat the requirement for physical distancing that the caregiver administration model is being implemented to address.

Will it be difficult to manage wastage of the capsule contents with caregivers cutting open the vitamin A capsule?

Although the opening of the capsule might be a new skill for the caregiver to learn, wastage of capsule contents can be minimized by providing the caregiver with clear guidance and close supervision. The health worker should provide step-by-step guidance to the caregiver during the entire VAS administration, including providing instruction on how to cut open the capsule without applying too much pressure to the capsule. If there is wastage of the capsule contents, the caregiver should discard the open capsule and the health worker should give them a new capsule to repeat the steps. The increased risk of capsule loss when using the caregiver administration method is a consideration to keep in mind during the planning stages.

The caregiver administration model requires a tray or container. What other objects can we use to function like the tray or container mentioned in the GAVA guide?

A tray or container is required for the health worker to pass the vitamin A capsule to the caregiver while maintaining physical distancing, so that they don't have to pass it by hand through close contact. Many objects can be used to serve this purpose. The object should be dry and clean and must have raised edges to prevent the capsule from falling off. It should be made from a material that can be cleaned easily such as plastic or metal. Although the terms "tray" and "container" are used throughout the [GAVA guide](#), the instrument can be any shape, such as a plate, saucer, or cup.

What is the purpose of the third chair used during caregiver administration of VAS at fixed sites?

During caregiver administration, a third space is required to facilitate the transfer of tools and materials between the health worker and caregiver, without requiring them to exchange the items directly through close contact, so that physical distancing can be maintained. For example, at the beginning of the process, the caregiver approaches the third space, leaves the child health card for the health worker, and returns to a 1-2m distance. The health worker can then approach the table to pick up the card, while maintaining physical distancing protocol with the caregiver or child.

How can we ensure that health workers provide sufficient supervision during caregiver administration of VAS?

To support the safe and effective administration of VAS by caregivers, the health worker must give the caregiver detailed guidance on the necessary steps. The health worker should watch the caregiver carefully throughout the VAS administration and observe the process closely while maintaining physical distancing.

During caregiver administration of VAS for infants, is the caregiver expected to cut open the vitamin A capsule and administer the dose while holding the baby?

In the case of infants and very young children, caregivers should ask for help from another household member if possible as it may be challenging for them to complete all the steps required for VAS administration on their own.



DELIVERING VAS USING VITAMIN A SYRUP

In areas where VAS is administered using a syrup, health workers use the same spoon to administer VAS to multiple children as the specific spoon measures the required dose to be administered. What can be done to ensure that this process is appropriate for the COVID-19 context?

In the context of COVID-19, GAVA does not recommend using the same spoon to deliver vitamin A syrup to more than one child. Following WHO guidance, equipment such as spoons should be single-use and disposable, or if one spoon is to be used for more than one child, it must be cleaned and disinfected between children (e.g. by using ethyl alcohol 70%) [6].

Where VAS is administered using a syrup, how can health workers maintain physical distancing while administering VAS?

It is impossible for health workers to administer vitamin A syrup while following physical distancing rules. Therefore, health workers should always wear medical masks when using vitamin A syrup to administer VAS. Unlike the capsule delivery method, syrup cannot be administered by caregivers, because even if the caregiver pours the syrup into their child's mouth, the health worker still needs to approach the caregiver to pour the syrup into the caregiver's spoon.

TASK-SHIFTING TO COMMUNITY HEALTH WORKERS/VOLUNTEERS

What do you advise regarding the use of community health workers/volunteers as administrators of VAS?

Large gatherings are prohibited or discouraged to reduce the risk of COVID-19 transmission within communities, so many countries are considering distributing VAS at the household level or through community-level distribution events. However, in most settings there are not enough trained health professionals available to distribute VAS to all children in their catchment area through community-level delivery methods. So, many governments are considering having community health workers/volunteers (CHW/V) distribute VAS during the COVID-19 pandemic.

In some countries, CHW/V already play a major role in VAS distribution. In some settings they assist with logistics and support health workers during VAS distribution events; in this role, they can be helpful to manage patient flow, provide information to caregivers and children, and help with crowd control. In other settings, CHW/V are responsible for administering the vitamin A capsules themselves. The administration of VAS is a relatively simple task that does not require a health diploma, so it is possible for CHW/V to administer VAS as long as they are trained.

What criteria should be applied for task-shifting of VAS administration to community health workers/volunteers?

The decision to shift the responsibility of VAS administration to community health workers/volunteers (CHW/V) is very context specific. Careful consideration should be taken before deciding on task-shifting of VAS admin to CHW/V, to ensure that they are well trained, well equipped and well supported.

SUPERVISION OF HEALTH WORKERS

How do we conduct supportive supervision in the context of COVID-19, especially where there are policies in place restricting movement?

To limit movement between communities and where movement restrictions are in place, alternative methods must be employed to provide supportive supervision to health facilities and health workers. Subnational health management teams should consider conducting remote supervision over the phone or with mobile platforms and should only carry out field visits when necessary. Countries will need to assess mobile phone connectivity and set up agreements and partnerships with mobile network providers to ensure that some cost efficiencies can be achieved while increasing mobile phone coverage to remote communities. If the local COVID-19 response strategies do not impede movement and it's possible to follow the necessary infection prevention and control (IPC) measures, in-person supervision can be considered in contexts where communication over the phone is not possible or if one-on-one supervision is necessary.

While there is no specific guidance available on supportive supervision of VAS programs in the context of COVID-19, GAVA is collecting examples of best practices of effective methods. In the meantime, guidance on supportive supervision is available in various COVID-19-related documents developed by WHO and other partners [7, 3, 8, 9].



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