Correspondence

Need to revisit vitamin A supplementation programme in India

Sir,

The guidelines issued by the World Health Organization (WHO)\(^1\) in 2011 reiterate their earlier recommendations supporting the use of high dose vitamin A supplements (VAS) to reduce child morbidity and mortality in populations where clinical and subclinical vitamin A deficiency (VAD) is a public health problem, \(i.e.\) where the prevalence of night blindness is 1 per cent or higher in children 24-59 months, or the prevalence of sub-clinical vitamin A deficiency (serum retinol 0.70 µmol/l or lower) is 20 per cent or higher in children 6-59 months of age.

The National Programme for Prophylaxis against Blindness in Children due to Vitamin A Deficiency, of the Government of India, has a provision for administering mega doses of vitamin A. It recommends for at least nine doses of vitamin A to be given to all children aged 9 to 59 months. The first dose of 100,000 International Unit (IU) is administered with measles vaccination at 9 months and subsequent doses of 200,000 IU each, every six months\(^{2,3}\). It also recommends for one dose of vitamin A on measles case identification, irrespective of whether it has previously been administered prophylactically or given as routine immunization\(^4\).

Biannual Child Health and Nutrition Promotion Months to be held six months apart would offer a package of child health and nutrition services; of which, vitamin A supplementation for children would be an integral part. These months would have activities where the sub-center level health workers, in close coordination with the workers of the Integrated Child Development Services Scheme, will allot one week per village for delivery of the services as per detailed micro-plans. Components of the package would be decided by the States themselves as per the needs and priorities of each State and will include other interventions such as distribution of iron and folic acid tablets to pregnant women, salt testing for iodization at household level and catch up immunization activities\(^5\).

Kapil and Sachdev\(^5\) presented a case for considering a targeted approach for the vitamin A supplementation programme, suggesting that targeting be based on demonstrated evidence of vitamin A deficiency, restricting it to geographical pockets or areas where clinical VAD is a significant public health problem rather than continuing universal prophylaxis. They also call for a primary focus on food based approaches to improve dietary intakes. We support the authors’ call for appropriate assessment of need, analysis and action, as our view is that all programmes being implemented, irrespective of their maturity or scale, must be informed by evidence of need, benefit/risk, and cost-effectiveness. The Micronutrient Initiative is a firm believer in this approach and we endorse the call for appropriate assessment to be undertaken to generate the necessary evidence as the best way forward for the vitamin A programme in India. We also agree with the authors that in the long run, dietary modifications to improve regular vitamin A intake is the ideal we should all strive for.

The Micronutrient Initiative and its global partners\(^6\) have been working on the development of an evidence based framework\(^6\) for scaling back VAS. This framework is being developed to assist governments of various countries to analyze available data, to plan for strategic data collection where there are gaps, and to take careful decisions on problems such as which pockets of the population perhaps no longer need twice yearly VAS, and which ones need to continue it so as not to unintentionally withhold a life saving intervention from vulnerable children. Developed primarily for countries where fortified foods are widely available and consumed by all segments of the population, and subclinical VAD among children has been significantly
reduced, we expect this framework to be tested and validated in field settings this year.

Adequate data are essential for guiding appropriate decision making, for which a more thorough assessment and analysis component would require at least State-level representative surveys. We see four aspects that merit early consideration: (i) the need to build policy level consensus on the indicators to be measured and the methodologies to be followed to assess VAD and so to arrive at an appropriate protocol for assessment; (ii) the institutional capacity to undertake these surveys; (iii) the cost of these surveys - significant if undertaken in all States; and (iv) development of a clear plan for the timing of these assessments, institutions responsible, budget requirement and sources of funding. Any decision to implement a more targeted approach in selected areas would need to involve the development of a plan including the development and dissemination of modified operational guidelines for health managers and workers at district, block and village levels; and modifications to current planning, training, communication, monitoring and supervision. It would be vital to roll out any targeted approach in a well planned manner, and assess progress closely over time.

With respect to approaches to improve dietary intake that could help improve vitamin A status in the long run, the twelfth five year plan of the Government of India, also envisages intensified action to improve health education with the aim to disseminate knowledge about VAD and its prevention as well as advocacy for food diversification to include vitamin A and carotenoid rich food regularly in the diet. We, therefore, call upon the research community to investigate this more systematically, so that proven approaches could be considered.

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