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Vitamin A capsule coverage improves between the August 1999 and February 2002 vitamin A distribution months

In 1999, the national policy on vitamin A supplementation changed to include 6-11 mo old infants as a new target group for routine supplementation. Data from the Government of Indonesia/Helen Keller International (GOI/HKI) Nutrition and Health Surveillance System (NSS) following the February 2002 vitamin A distribution month show that capsule coverage rates have increased among all children 6-59 mo of age since late 1999 and that the most dramatic improvement has occurred among the new target group.

The NSS, which is conducted as a collaborative effort between the Ministry of Health (MOH) and HKI, routinely provides information about a variety of socioeconomic, demographic, health, and nutrition indicators. Vitamin A capsule (VAC) coverage rates among children 6-11 mo and 12-59 mo of age are two of the key indicators that were reported for each province separately as part of the 2000[1] and 2001[2] provincial bulletin series.

This bulletin presents VAC coverage rates for children in all of the NSS data collection sites following the August 1999 and February 2002 vitamin A distribution months in order to examine progress made over this time period. Coverage rates are presented to the nearest 1% for all of the urban poor and rural sites included in the Sep '99 – Feb '00 and Mar-Apr '02 data collection rounds.

How is vitamin A capsule coverage calculated?

Vitamin A capsule (VAC) coverage is calculated as the proportion of children who reportedly received a VAC in the 6 months prior to the NSS data collection round divided by the total number of children in the same age group. Results are calculated only for those children who were eligible for supplementation (i.e. 6-59 mo old) during the most recent VAC distribution month. Coverage rates may vary from 0% (none of the children received vitamin A) to 100% (all of the children received vitamin A).

NSS VAC coverage data

Since 1999, NSS data collection has taken place on a quarterly basis in both rural and urban areas.[3] Households with children under five years of age are eligible to participate and the mother in each household is invited to be interviewed. Currently, approximately 40,000 households participate in each round (10,000 in the urban areas combined and 30,000 in the rural areas combined). In the urban areas, around 275 younger

[1] Helen Keller International/Indonesia (2000). Nutrition and Health Surveillance System (NSS). *Monitoring the Economic Crisis: Impact and Transition, 1998-2000*. Jakarta: Helen Keller Worldwide.

[2] Helen Keller International/Indonesia (2002). *New Insight on the Health & Nutrition Situation in Indonesia through Data Sharing*. Nutrition & Health Surveillance System Annual Report 2000-2001. Jakarta: Helen Keller Worldwide.

[3] Helen Keller International/Indonesia (2000). *Nutrition Surveillance: How does it work?* HKI Technical Programs Series. Indonesia Crisis Bulletin. Year 2, Issue 2. Jakarta: Helen Keller Worldwide.

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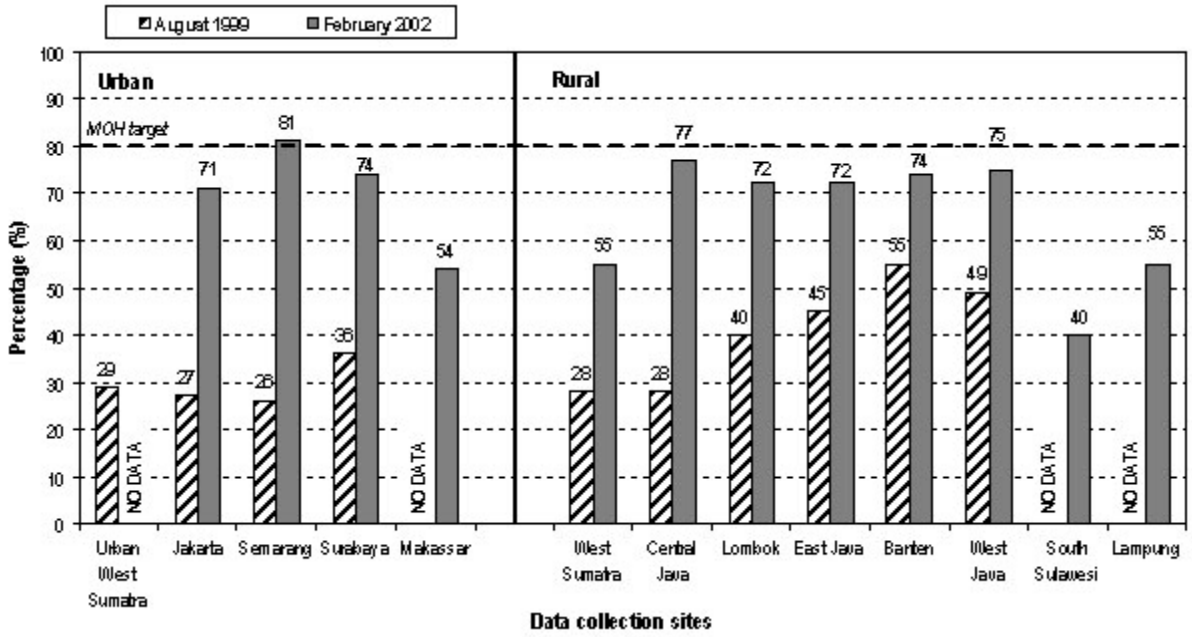
Figure 1. VAC coverage among 6-11 mo-old children in urban poor and rural areas in August 1999 and February 2002.



(6-11 mo old) and 1,500 older (12-59 mo old) children per site were eligible for vitamin A supplementation and contributed data to this report. In the rural areas, around 650 younger and 2,850 older children were eligible per site and contributed data to this report. These sample sizes allowed for 95% confidence estimates of VAC coverage rates to within ±5% (for younger children) and ±3% (for older children).

Urban poor data collection sites

In August 1999, capsule coverage rates among the new target group of 6-11 mo old children were uniformly low (26-36%) in all urban areas (see Figure 1). Not surprisingly, coverage rates were much higher (35-75%) for the well-established target group of 12-59 mo old children (see Figure 2). None of the urban sites had achieved the 80% target set by the MOH for either the younger or older target group.

By the February 2002 distribution round, VAC coverage rates had increased dramatically for both age groups. Coverage rates among the younger (6-11 mo old) children had doubled or tripled. Among 12-59 mo old children, coverage rates doubled in Jakarta and increased in Surabaya and Semarang by 11-13% points. Semarang was the only site that achieved 80% coverage for both 6-11 and 12-59 mo old children, while in Surabaya, the coverage rate exceeded 80% in the 12-59 mo age group.

Rural data collection sites

In August 1999, VAC coverage rates among the new target group of 6-11 mo old children were low (28-55%) in the rural areas surveyed (see Figure 1). Not surprisingly, coverage rates were somewhat higher (46-74%) for the well-established target group of 12-59 mo old children (see Figure 2). West Sumatra and Central Java had the lowest coverage rates for younger children, while Banten and West Java had the highest.

By the February 2002 distribution round, VAC coverage rates had increased for both age groups. In February 2002, coverage rates among the younger (6-11 mo old) children were 40-77%, while rates of 49-86% were reached in the older (12-59 mo old) age group. Although none of the sites achieved coverage rates that exceeded 80% among younger children, three sites (Central Java, Lombok and West Java) achieved coverage rates of 80% or higher among the older children.

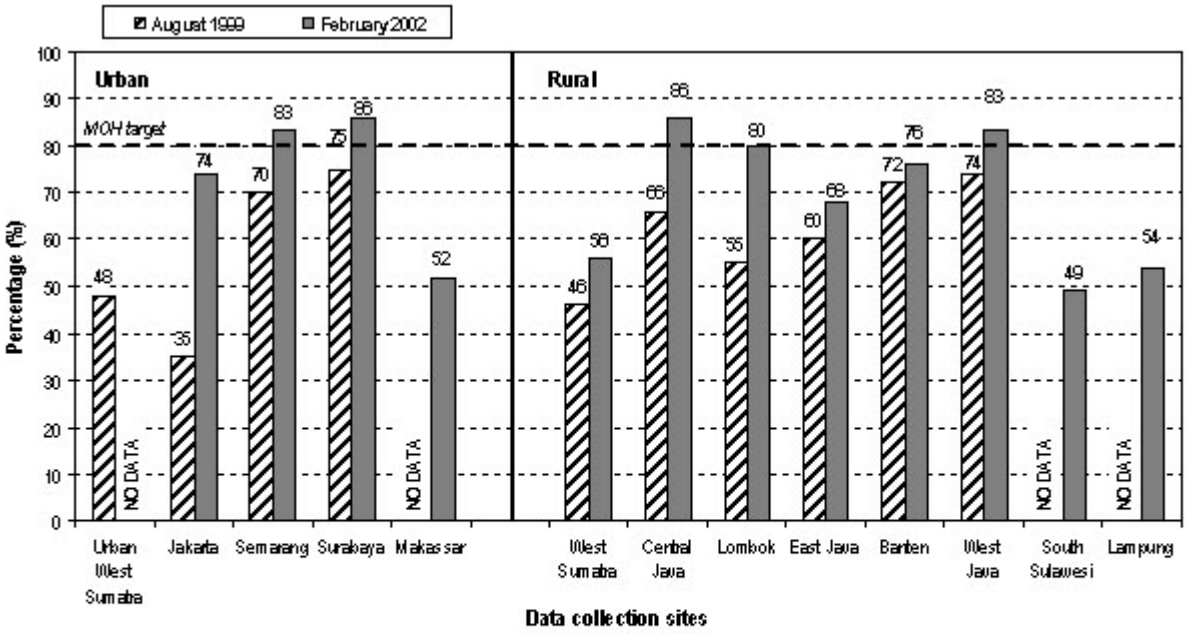
Factors influencing the vitamin A program since 1999

The observed improvement in VAC coverage rates over the past 2-3 years, particularly among the new target group, is attributable to a combination of factors that have influenced the national vitamin A supplementation program for children. Some of the key factors include:

Inter-agency and intersectoral collaboration: Since 1999, the MOH, HKI, UNICEF, and other groups (with financial support from USAID) have worked together to promote the newly introduced national policy to supplement 6-11 mo old children with vitamin A.

Information dissemination: Over time, information about the new national policy guidelines to supplement younger children reached program planners and health workers at the provincial, district and village levels.

Figure 2. VAC coverage among 12-59 mo-old children in urban poor and rural areas in August 1999 and February 2002.



Mass media campaigns: Large-scale mass media campaigns have taken place to raise public awareness about the vitamin A program and to remind families that the distribution month is approaching. Campaign activities have included TV and radio spots, press conferences, the distribution of printed media materials to *Puskesmas* (public health centers) and *Posyandu* across the country, and special activities, such as information booths and educational games at health fairs. More details about the activities conducted prior to the August 2001 vitamin A month are described in a separate bulletin.[4]

Pilot programs linking vitamin A supplementation and immunization: HKI collaborated with the MOH to sponsor a series of pilot projects linking mass measles immunization campaigns to vitamin A distribution among high-risk groups in the urban poor areas of Jakarta, Surabaya, Semarang and Makassar in Aug 2000,[5] in selected villages on Lombok in August 2001, and in two districts of West Sumatra in February 2002.

Increased availability of 100,000 IU VACs: UNICEF initially donated a supply of 100,000 IU VACs for distribution following the 1999 change in policy. In 2000, Kimia Farma also began producing 100,000 IU VACs in response to the demand for this new product. This new type of VAC has gradually become incorporated into the routine procurement and distribution system for the government-sponsored national supplementation program.

Conclusions

- The NSS is a useful tool for monitoring the vitamin A supplementation program.
- Between August 1999 and February 2002, VAC coverage rates improved for both target groups of children (6-11 and 12-59 mo old) in all sites.
- However, despite good progress, few of the sites had achieved the MOH goal of 80% capsule coverage rates.

Recommendations

- The NSS should continue to monitor the vitamin A supplementation program.
- Efforts should continue to try improving vitamin A capsule coverage rates by increasing public awareness about the supplementation program, by increasing promotion through mass media campaigns and close collaboration with technical support groups at the Central MOH, Provincial and District levels, and by increasing inter-agency and intersectoral collaboration.

[4] Helen Keller International/Indonesia (2001). *National Vitamin A Supplementation Campaign Activities: August 2001.* Indonesia Crisis Bulletin. Year 3, Issue 2. Jakarta: Helen Keller Worldwide.

[5] Helen Keller International/Indonesia (2000). *Mass Measles Immunization Campaign Successfully Linked to Vitamin A Supplementation Month in Urban Areas.* Indonesia Crisis Bulletin. Year 2, Issue 18. Jakarta: Helen Keller Worldwide.

All references are available online at *http://www.hkiasiapacific.org/Resources/Downloads/bulletins_indonesia.htm*

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