

NUTRITION BULLETIN**Improvement in vitamin A capsule coverage in Cambodia:
The success of village health volunteers as social mobilizers**

Vitamin A capsule (VAC) coverage for children 6-59 months of age is still very low in most provinces of Cambodia. To find solutions to improve coverage, Helen Keller International (HKI) and the Ministry of Health (MOH) started a pilot project in August 2001. The project aims to create awareness and demand for vitamin A capsules through social mobilization, training, supervision, logistics and other support for health center outreach. Social mobilization was found to be among the most important factors for increasing vitamin A capsule coverage in the three project areas. Coverage increased from 22%, 47% and 39% in March 2001, the last distribution before the pilot project started, to 82%, 89% and 95% in November 2001.

Background

Vitamin A deficiency is still a serious public health problem in many areas of Cambodia and remains a preventable cause of childhood morbidity and mortality. For children 6-59 months of age, chances of survival are increased by 20-25% when vitamin A status is improved through twice yearly distribution of high-dose vitamin A capsules. However, results from HKI's 2000 National Micronutrient Survey show that vitamin A coverage is still low among children 6-59 months of age (10-55%) and postpartum women (1-13%). The National Vitamin A Program was fully integrated with routine immunization outreach in 1998. Besides special campaigns, vitamin A capsule distribution occurs twice yearly in March and November. The 2000 Assessment of the National Vitamin A Capsule Distribution Program, conducted by HKI, found that there are various factors related to poor

VAC coverage. These include low staff knowledge about vitamin A and the National Vitamin A Policy. Some health center staff do not take vitamin A capsules with them during outreach or do not know they should distribute VACs in the community or with immunizations. These misunderstandings are related to the fact that there is a high turnover of staff at the health center level and while trainings have been conducted, new personnel had not yet benefited.

Despite these constraints, health center outreach is now considered to be the best mechanism for vitamin A distribution. The Cambodia National Micronutrient Survey (CNMS) found that vitamin A capsule coverage and measles immunization coverage correlate well. This is because it is one of the few programs that reach all communities throughout the country on



Important factors to improve vitamin A capsule coverage

According to the results from the assessment of the November 2001 VAC distribution, the main factors that contributed improved VAC coverage are:

- 1) Village Health Volunteers (VHVs) and social mobilization – VHVs were found to contribute the most to raising awareness among community members and mobilizing them to the vitamin A distribution sites. VHVs know people in their community well; they visited all households in their village, identified and listed the target groups, conducted nutrition education sessions among villagers, and mobilized the population. They were also able to follow up on those villagers who did not show up at the distribution site. The training, BCC materials and supervision given to VHVs contributed to improving their knowledge, and their confidence in conducting educational sessions among villagers
- 2) Health center staff motivation and support for outreach activities – The main factors that helped improve HC staff motivation during the November 2001 distribution included: training for HC staff, technical and logistical support, per diem for training and outreach, monitoring and supervision, reinforcement of good performances, and constructive feedback. Furthermore, HC staff mentioned that the involvement of VHVs in the vitamin A program was very useful, they thought VHVs were instrumental in providing assistance with the preparation and distribution of vitamin A capsules.

a regular basis. However, vitamin A coverage consistently remains lower than immunization coverage. To improve coverage, it is important to improve the delivery of VAC, the demand for VAC, and the health care system in general. This bulletin reports on first round results from the HKI/MOH vitamin A capsule distribution pilot activities to improve coverage, in three operational districts (OD).

Pilot project to improve vitamin A capsule coverage

Using results from the CNMS, the National Vitamin A Capsule Program Assessment, and building upon the current National Vitamin A Capsule Distribution Program, HKI and the MOH designed a pilot project to improve vitamin A capsule coverage. Three operational districts of three provinces – Kampot in

Kampot Province, Chhlong in Kratie Province, and Prey Kabas in Takeo Province – were chosen for this pilot project. This choice was made according to various factors: ODs' vitamin A coverage rates; the differences between the support each OD receives from the government and from NGOs with regard to budget, technical (training, supervision) and logistical (transport) assistance to conduct outreach activities; and their different geographical locations. The objective of the pilot project is to improve vitamin A capsule coverage among children aged 6-59 months and postpartum women within 8 weeks of delivery. A three-pronged approach was used to achieve this objective:

1. *Improve health center staff knowledge.* A 2-day training for HC staff was provided. The training covered such topics as: vitamin A deficiency disorders (VADD); logistics of vitamin A capsule distribution; communication methods to raise awareness among target groups; use of vitamin A specific behavior change and communications (BCC) materials; recording information onto the Child Health Card; and reporting to the Provincial Health Department (PHD) and OD level on the vitamin A distribution.
2. *Support to health center outreach activities.* Technical and logistical support was provided. This included helping HC staff develop a schedule for vitamin A capsule distribution; training on how to keep a record of vitamin A capsule supplies and ensure sufficient stocks for the distribution day and how to estimate the size of the target population; and providing per diem to HC staff for the distribution day. Monitoring and supervision by PHD and OD levels for the preparation and the vitamin A capsule distribution was conducted to record successes and constraints during the distribution process. Village Health Volunteers (VHVs) were responsible for supporting HC staff in developing a target group list, and following up on villagers who had not come to the distribution site, and ensuring that those who had not come also received a capsule. Both VHVs and HC staff were provided with materials (a promotional t-shirt and cap, BCC materials) to improve their motivation in raising awareness among villagers and to mobilize them.
3. *Raise community awareness.* A 1-day training was provided to VHVs on topics such as VADD, vitamin A distribution, how to identify and list target groups (children under the age of 5 and postpartum women) before the distribution day,

social mobilization, providing support to HC staff and dissemination of messages to target groups. A social marketing campaign which included broadcasting two television and radio spots on VADD and vitamin A capsules, one month prior to distribution, was conducted in the target ODs.

In order to assess whether the objective was met, program monitoring and evaluation is crucial for the assessment of the pilot project. A baseline survey was conducted at the onset of the project, in October 2001 that enquired about the last distribution in March 2001. A post-distribution mini-survey was conducted in December 2001 to assess the November vitamin A capsule distribution.

Results from the November 2001 vitamin A capsule distribution

Figure 1 shows VAC coverage in the March 2001 distribution round and in November 2001, after the start of the pilot program, by OD. As seen from the figure, VAC coverage improved in all ODs. In Kampot, coverage increased from 22% to 82%; in Chhlong, coverage increased from 47% to 89%; and in Prey Kabas, coverage increased from 39% to 95%. Furthermore, it was found that VAC coverage did not differ significantly among child age groups (Figure. 2). This finding is similar to what was observed in the CNMS. Thus, all children are equally likely to present at the outreach and receive their VAC, regardless of their age. Figure 3 shows that among the various channels of information dissemination, most mothers heard about the VAC distribution through VHVs. VHVs can be very useful in mobilizing community members for the HC outreach services.

Conclusion

The results obtained from the first round of the vitamin A capsule distribution pilot project in November 2001 show that with minimal inputs to create awareness and demand for vitamin A capsules among households and communities, it is possible to significantly increase coverage. The social mobilization campaign, which involved the active participation of VHVs, appeared to play an important role in increasing demand for vitamin A capsules and in mobilizing the community to the distribution sites. These results are promising for the project’s objective of contributing to increased vitamin A capsule coverage in Cambodia.

Figure 1. Vitamin A capsule coverage in March and November 2001 distribution rounds, by operational district. Bars indicate 95% CI (Confidence Interval) corrected for design effect.

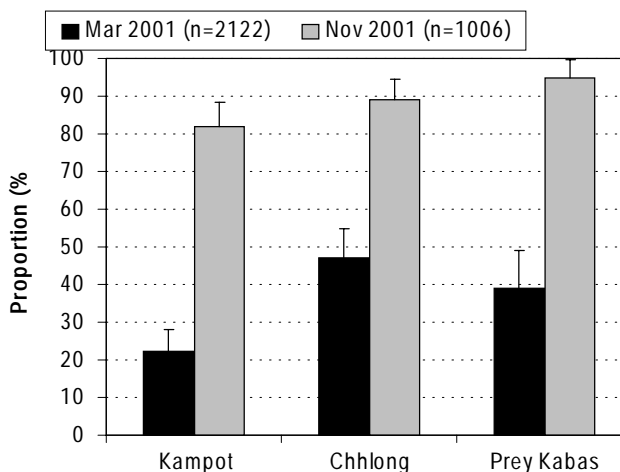


Figure 2. Vitamin A capsule coverage in November 2001, by operational district and child age group (n=1006). Bars indicate 95% CI corrected for design effect.

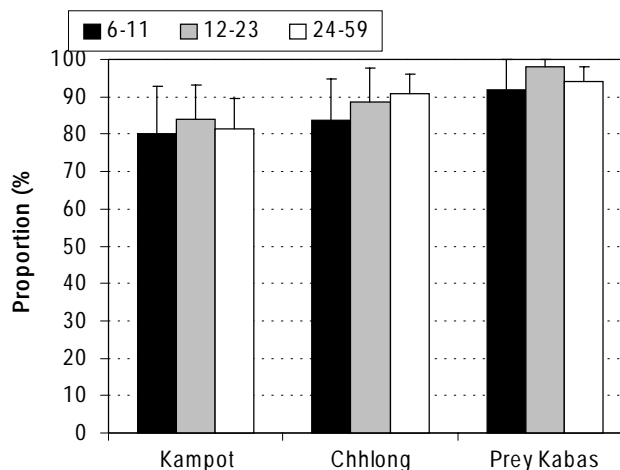
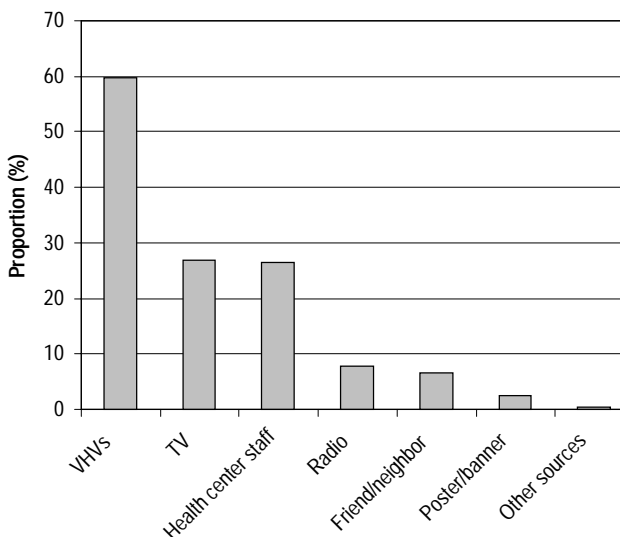


Figure 3. Source of information on vitamin A or vitamin A capsules for the mothers that reported to have heard about vitamin A (n = 804). Note that it was possible to mention more than one source of information.



Recommendations

To reach the goals of increasing demand for vitamin A capsules at the community level and of improving coverage nationally in the long-term, the following recommendations are made:

- Activities to improve vitamin A capsule coverage among preschool children and postpartum women need to be expanded nationally.
- Lessons learned from the vitamin A capsule distribution pilot project need to be disseminated to ensure commitment and collaboration in scaling up this pilot project for improved coverage at the national level.
- Further strengthen the cooperation between health center staff, local authorities and community-based workers such as the VHVs, to inform the community in advance about vitamin A capsule distribution to increase community mobilization and coverage.
- Strengthen and expand the monitoring and supervision systems for the vitamin A capsule distribution program as they have a direct impact on the performance of both HC staff and VHVs.
- Expand social marketing and social mobilization campaigns to continuously create demand for vitamin A capsules at the community level by increasing awareness of the importance of vitamin A.
- A pilot should be conducted to examine the possibility of including infants under 6 months of age as a target group for vitamin A capsule distribution, as recommended by international guidelines.

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