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High vitamin A capsule coverage attained during the October 2001 *Garantisadong Pambata*

Vitamin A deficiency, which increases the risk of severe illness and death among children, is a public health problem in the Philippines. This is being addressed through a national vitamin A supplementation program in a twice-yearly campaign known as *Garantisadong Pambata* (GP). Helen Keller International (HKI) in collaboration with the Philippine Department of Health (DOH), Field Epidemiology Training Program (FETP), Center for Health Development (CHD) and the Local Government Units (LGUs) conducted a household survey in nine out of the country's 16 regions and found an 85.5% vitamin A capsule (VAC) coverage during the October 15-19, 2001 GP campaign.

Vitamin A is one of the most essential vitamins for maintaining the health of children and mothers. Studies have repeatedly shown that supplementation with vitamin A prevents severe illness. Vitamin A supplementation, especially among those who are vitamin A deficient, results in a reduction of severe child illnesses and deaths.

Vitamin A deficiency (VAD) is endemic in the Philippines. At least 38% of pre-school children and 20% of pregnant and lactating women have suboptimal serum retinol concentrations (<20µg/dl).[1] In response to this problem, the DOH, with technical assistance from HKI, has adopted a vitamin A supplementation program using high-dose VAC twice a year since 1993. These nationwide, twice-yearly campaigns have been given different names but starting in 1999, the campaigns were renamed *Garantisadong Pambata* (GP). These campaigns support various health programs to reduce childhood illnesses and deaths by promoting positive childcare behaviors and by providing specific health services.

To assess VAC coverage during the GP campaign conducted on October 15-19, 2001, HKI and the DOH conducted a multistage, cluster survey during November 2001 in nine of the country's 16 regions. These nine regions were assisted by USAID-HKI in implementing the GP. *Barangays* (the smallest administrative unit of governance) in all the provinces and selected cities in these nine regions were considered clusters. A total of 1,539 clusters were selected from 38 provinces and 28 cities in the nine regions, based on a probability-proportionate-to-size sampling scheme. Whenever reasonably complete lists of households (census records, voter's lists, etc.) were available, these were used as sampling frames in the random selection of ten households per cluster. The mother or principal caretaker of children 12-59 months of

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Figure 1. Vitamin A capsule coverage by region in 1998 and 2001.

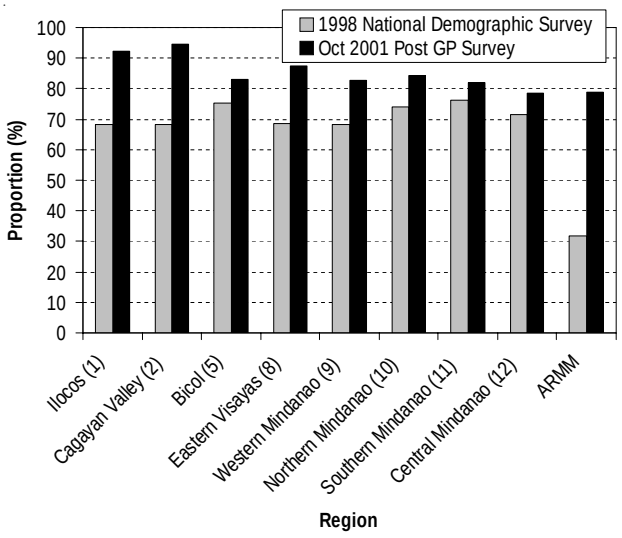
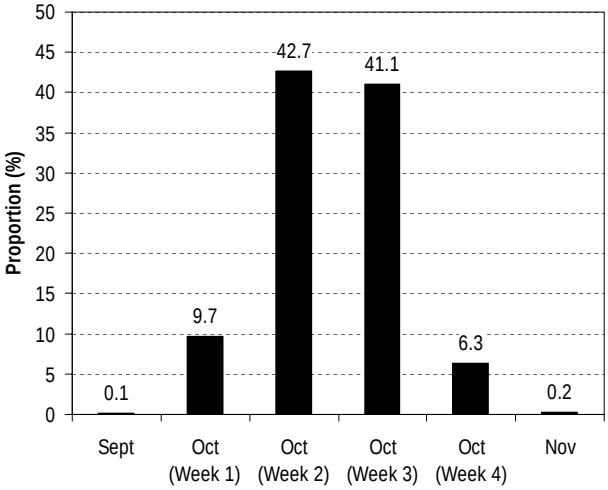


Figure 2. Distribution of when vitamin A capsule was received (*Garantisadong Pambata*, October 2001).



age in the selected households was interviewed to gather data on awareness of GP, vitamin A capsule coverage, use of iodized salt and other services received during the October 2001 GP. In the absence of sampling frames, the central location of a barangay (cluster) was chosen as the starting point to prepare a complete list of households with underfive children. The first household was then randomly selected from this list for participation in the survey. The nine neighboring households were also surveyed. The total sample size of 15,374 respondents allowed for coverage estimates per region with a 95% confidence interval (CI) of +/-10%.

Interviews with key informants (municipal and barangay level GP coordinators) were also conducted to obtain a better description of the field activities during GP. A total of 513 GP coordinators were interviewed.

Given that the survey was limited to the nine USAID-HKI assisted regions shown in Figure 1, the results are not representative of the whole country; however, the major findings would likely reflect the situation in most of the other regions of the country.

The overall VAC coverage in the nine regions was 85.5% (95% CI = 84.9-86.1), with each region attaining a VAC coverage significantly higher than those measured in the 1998 National Demographic Survey (see Figure 1).

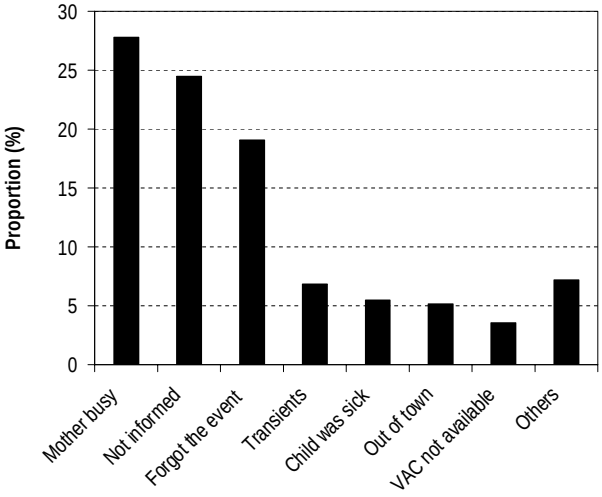
Across the nine survey regions, the health workers administered VAC by home visitation and by center administration, with different mixes of the two distribution sites and with varying VAC coverage. The VAC coverage was higher in areas with more center-based administration and lower in areas where more home-based administration took place.

Table 1. Proportion of children who received a VAC, by place and time of capsule administration. (*Garantisadong Pambata*, October 2001)

Place of administration of vitamin A capsule	Time of vitamin A capsule administration					
	Advance administration (Sept-2nd wk of Oct)		GP wk administration (3rd wk of Oct)		Post GP wk administration (4th wk of Oct-Nov)	
	N	%	N	%	N	%
Health Center	3527	51.1	2985	55.2	324	38.3
Home	2551	37.0	1643	30.4	426	50.4
Other*	409	5.9	483	8.9	44	5.2
Nutrition Post	378	5.5	267	4.9	45	5.3
Government Hospital/Clinic	16	0.2	19	0.4	3	0.4
Private Hospital/Clinic	17	0.2	8	0.1	4	0.5
Total	6898	100.0	5405	100.0	846	100.0

** The category 'Other' includes* barangay *health workers' houses, multipurpose halls, chapels, day care centers, barangay plaza, patak centers and purok centers.*

Figure 3. Reason that children did not receive a vitamin A capsule (*Garantisadong Pambata*, October 2001).



The highest coverage (94.4%) was found in Cagayan Valley (Region 2) where 77.6% of children received their capsules at a distribution center.

The VAC coverage of 85.5% (95% CI = 84.9-86.1) is a direct effect of the October 2001 GP activities. The survey showed that VAC coverage is 90.0% (95% CI = 89.4-90.6) among the children whose mothers had heard of GP. This is in contrast with the children whose mothers had not heard of GP, where VAC coverage was 75.7% (95% CI = 74.5-76.9).

The information campaign during the October 2001 GP week encouraged parents to bring their children to health centers and other designated GP sites for health services. Of the total number of children who were given VAC, 65% received the supplement from service centers, and the rest received it in their homes.

Almost all (99%) of the children brought to the centers were given vitamin A, while only 67% of those who were not brought to a center received the supplement.

While the October 2001 GP campaign was officially designated for the third week of October (15-19), some children received the supplement as early as September (see Figure 2). This happened because health workers in some Local Government Units (LGUs) started giving out VAC even before the third week of October. Early VAC distribution (termed advance implementation) is one of the best practices that the GP coordinators identified. By the end of the third week of October, which was the actual GP week, 94% of the total children covered had received the supplement (see Figure 2).

There was a significant association between the time and place of VAC distribution. VAC administration was higher in health centers during the advance administration (51%) and GP week administration (55%) compared to home administration. Of the children that received a VAC after the GP week, 50% received it at home. This was conducted for those caretakers who missed bringing their children in the health facilities during the GP week administration as a mop-up operation (see Table 1).

For the 14.5% of children who did not receive VAC during the October 2001 GP, the reasons for not receiving the supplement were primarily related to parent/caregiver factors and not having been informed (see Figure 3.)

Hospitals were rarely utilized as places for VAC administration during the October 2001 GP. Only 0.5% of all the children who received VAC got the supplement from hospitals. Given that hospitals are usually located in populated areas, and these facilities cater to both sick and well children, it is clear that utilization of hospitals as points of VAC supplementation can be improved.

CONCLUSIONS

High VAC coverage was attained as a result of the October 2001 GP campaign activities. The heightened awareness of GP, the resulting behavior of bringing children to health and other GP centers, advance implementation of VAC administration, and almost universal availability of VAC in the service sites were some of the main factors that led to an effective VAC coverage.

The goal to increase VAC coverage at health centers and clinics can be attained by making the information campaign even more effective. This should also lead to a reduction of home administration because a smaller mop-up would be required.

Endnotes

1. Philippine Nutrition: Facts & Figures. FNRI, 2001.

RECOMMENDATIONS

GP as a vehicle for attaining high VAC coverage needs to be continued nationwide, with the DOH and the LGUs taking the lead. Specific activities to be done or strengthened in future GP campaigns to further increase VAC coverage include the following:

- Widen the reach of and emphasize in the information campaign that children should be brought to health centers, including hospitals, for vitamin A and other services. Parents or guardians should be told exactly where to bring their children for services.
- Ensure the delivery of adequate supplies of VAC to the different health centers and other service points at least two weeks before GP week.
- Prepare VAC target client masterlists from the Target Client List that the Rural Health Midwives maintain in the health facilities. The masterlist is used to determine the adequate number of VAC to be requested. It is also used to identify those children who have not been brought to the health center and other centers. Once identified, they would be visited at home for mop-up VAC administration.
- The Local Government Units still need to strengthen advocacy and social mobilization activities for sustained high coverage through partnerships with NGOs and other civic organizations. Technical support on advocacy skills training and resource generation should continue.
- Process monitoring and evaluation of LGUs should be continued to improve service delivery.

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