

## PREREQUISITES FOR THE INITIATION OF "UNIVERSAL" VAC DISTRIBUTION: A POLICY THINK PIECE

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The short-term universal vitamin A capsule (VAC) distribution program in Bangladesh celebrates its twentieth anniversary now. The 1989 evaluation of the program found its coverage to have declined to 35% of children 6 months–6 years old, compared to the 1982 coverage of 46%. In 1989, 25% of infants under 6 months old (who were not supposed to receive VAC) had, in fact, been given a 200,000 IU dose in the previous round.

Is such a program short-term, universal, or anything to celebrate? Its greatest danger is that it pacifies government and donor alike into putting off finding better solutions more likely to reach the poor and vulnerable groups: "After all, we can put off the more difficult approaches as long as we have the capsule program to fall back on." Yet, with the increased publicity vitamin A is receiving for its apparent mortality-reducing potential, there is every risk that governments and donors will rush into starting "short-term" universal VAC distribution which in effect becomes "unethical" to ever stop.

This is not to deny that vitamin A is needed, that public awareness in many countries may demand that interventions be rapidly mobilized, even if imperfect, and that some way is needed to take advantage of the positive elements of such programs while minimizing the negative ones.

This paper proposes that governments and donors adopt a policy whereby universal VAC distribution is initiated *where needed* if, and only if, certain criteria are met:

1. A political commitment is made that universal VAC distribution is indeed to be a short-term measure.

2. A budget is established for pursuing a long-term (i.e., permanent, affordable, sustainable) approach which is at least as large as the one allocated for VAC distribution.

3. A surveillance system is set up to monitor the vitamin A status of the target population *and* the diet of the vulnerable groups (probably a simplified method can be developed based on frequency of use of a select number of high-carotene foods in sentinel population groups).

4. A technically determined, but politically agreed-upon, cut-off point must be established for dietary improvement, above which universal VAC distribution is no longer to continue.

5. When the surveillance system shows that a given area shows dietary improvement above the threshold, an intensified vitamin A status surveillance system is put in place and one round of VAC distribution is skipped.

6. If the surveillance system reveals dangerous increases in vitamin A deficiency, VAC distribution is resumed and the threshold reset to a higher level.

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A Report of the

XV International Vitamin A

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