

What are the implications of the current concern/debate on national efforts to prevent vitamin A deficiency in Zambia?

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The rate of reduction in vitamin A deficiency among population groups is linked to the type of interventions; target population and scale at which interventions are implemented. In Zambia, vitamin A deficiency is still of public health significance despite the country putting in place several interventions. Interventions in the country include mandatory fortification of sugar with Vitamin A targeting the general population, vitamin A capsule supplementation targeting children aged between 6-59 months old and bio fortification of maize and sweet potato with pro vitamin A for the general population. Nutrition education programmes are particularly considered critical in encouraging population to demand vitamin A related services, thus diet diversification with focus on promotion of foods rich in Vitamin A using Behaviour Change Communication approaches has been very important.

A debate on whether the country should implement multiple interventions to improve vitamin A status in children and women has arisen. This is because supplementation and fortification interventions both use preformed vitamin A, which can lead to hypervitaminosis A as it is efficiently absorbed and stored. There is however no consensus on this as there are also some questions on whether the country is doing enough or above what should be done to address vitamin A deficiencies. This is also because when multiple interventions are in place vitamin A intakes can easily exceed requirements. A number of questions are therefore being raised as in the country there (i) is no updated information on the scale of implementing other vitamin A related initiatives; (ii) the absence of updated prevalence data on vitamin A deficiency among different population groups is also a source of concern? Should the country continue with Vitamin A capsule supplementation among under-five children when vitamin A supplementation does not seem to positively influence morbidity and mortality national estimates among children; (iii) which methodology should be used to estimate population vitamin A status? Others have proposed that evaluating population vitamin A status needs to move beyond the measurement of serum retinol concentrations, and have since proposed that much more sensitive methods using the retinol isotope dilution test method which uses the deuterium or ¹³C, for excessive range of liver reserves be used, still there is no consensus on this. What are the capacity issues? (iv) Is the monitoring framework adequate to track the delivery of interventions? (v) Are the capacity issues well addressed to allow for adequate monitoring and evaluation in the delivery of interventions?, (vi) Are the policy and regulatory factors adequate to support the delivery of vitamin A interventions in the country? (v) Can Zambia continue implementing all these initiatives when there are so many unanswered questions?

The debate on these questions have several implications for both research and policy.

Key words: Multiple interventions, hypervitaminosis A, regulatory, Policy