

No.Z.28020/30/2003-CH  
Government of India  
Ministry of Health & Family Welfare  
Department of Family Welfare  
CHILD HEALTH DIVISION

Nirman Bhawan, New Delhi.  
Dated the 02<sup>nd</sup> November 2006.

To

- 1) The Secretary, Department of Health of All States/UTs
- 2) The Secretary, Department of Family Welfare of All States/UTs.
- 3) The Director of Family Welfare of All States/UTs
- 4) The Country Representative, UNICEF, Lodi Estate, New Delhi.
- 5) The Country Representative, WHO (India), Nirman Bhawan, New Delhi.
- 6) The Country Representative, USAID, Chanakyapuri, New Delhi.
- 7) The Country Representative, European Union, Chanakyapuri, New Delhi.

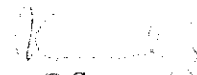
Subject: Vitamin A & IFA Supplementation -Regarding -

Sir,

I am directed to say that the Government of India for quite some time has been examining the issues on the policy decisions on the Vitamin A Supplementation Programme for the Children in the Country, and has also been reconsidering the recommendations of the WHO, UNICEF and Ministry of Women & Child Development, in this aspect. **It has been now decided to administer Vitamin A Supplement to all children nine months to five years of age.** A Policy Note on the subject is also enclosed herewith. As such you may kindly take further needful and necessary action in the matter please.

This issue with the approval of Secretary (Health & Family Welfare)

Yours faithfully,

  
(Smt P Sengupta)  
Under Secretary (CH)  
Tel No.23063875

Copy also for information to:

1. Secretary, Ministry of Women & Child Development, Shastri Bhawan, New Delhi.
2. DG, ICMR, Ansari Nagar, Ring Road, New Delhi.
3. Sr. Adviser (Health), Planning Commission, Yojana Bhawan, New Delhi.
4. Adviser (Nutrition), DGHS, Nirman Bhawan, New Delhi.

Copy for Information (Supply Section)

RUI (SMB)

7-1MA 1A9 ANF. RANI, NIPCO, NIKLE N. AIMS

## POLICY ON MICRO NUTRIENT -VITAMIN-A

- Regular consumption of dark green leafy vegetables or yellow fruits and vegetables prevents Vitamin-A deficiency.
- Breast feeding protects against vitamin A deficiency colostrums rich in Vitamin A.
- Oral Prophylactic dose of vitamin A
  - one dose of 100,000 IU to infants( 6-11 months).
  - six months dose of 200,000 IU to children 1-5 years of age.
- Treatment of vitamin A deficient cases
  - single oral dose of 200,000 IU of vitamin A immediately at diagnosis.
  - Follow up dose of 200,000 IU, one four weeks later.

Vitamin A deficiency has been recognized to be a major controllable public health and nutritional problem. An estimated 5.7% children in India suffer from eye signs of vitamin A deficiency. Recent evidence suggests that even mild vitamin A deficiency probably increases morbidity and mortality in children, emphasizing the public health importance of this disorder. National Prophylaxis Programme for Prevention of Blindness due to Vitamin A Deficiency. The prophylaxis Programme comprises a long term and a short term strategy. While the short term intervention focuses on administration of mega doses of vitamin A on periodic basis, dietary improvement is the long term ultimate solution to the problem of vitamin A deficiency.

Vitamin A supplementation is to be implemented through the Primary Health Centers, its sub centers and the anganwadis. All health staff working with the Primary Health Centers are responsible for administering vitamin A concentrates to children under 5 years and for imparting nutrition education. The services of Integrated Child Development Services(ICDS) Programme, under the Department of Women and Child Development, Ministry of Welfare, is utilized for the distribution of vitamin A to children in the ICDS Blocks and for education of mothers and prevention of Vitamin A deficiency.

### A. PREVENTION OF VITAMIN A DEFICIENCY

#### i) PROMOTING CONSUMPTION OF VITAMIN A RICH FOOD

- Regular dietary intake of vitamin A rich foods by pregnant and lactating mothers and by children under 5 years of age I to be promoted.
- The mothers attending antenatal clinics and immunization sessions as well as mothers and children enrolled in the ICDS Programme are to be made aware of the importance of preventing vitamin A deficiency.
- Breastfeeding, including feeding of colostrums, to be encouraged.
- Feeding of locally available B-carotene(precursor of vitamin A) rich food and such as green leafy vegetables and yellow and orange vegetables and fruits like pumpkin, carrots, papaya, mango oranges along with cereal and

pulse to a weaning child to be promoted widely. In addition, whenever economically feasible, consumption of milk, cheese, paneer, dahi(yoghurt), ghee, eggs, liver etc. is to be promoted.

- For increasing availability of vitamin A rich food, growing of vitamin A rich food, growing of vitamin A rich foods in home gardens and consumption of these must be promoted.

## ii) ADMINISTERING SUPPLEMENTAL DOSE OF VITAMIN A

- Unlike most other micronutrients, vitamin A is stored in the body for prolonged periods and hence periodic administration of massive dose ensures adequate vitamin A.
- Administration of supplemental dose of vitamin A to pre school children at periodic intervals is a simple, effective and most direct intervention strategy. This is a short term strategy.
- Under this strategy, every infant 6-11 months and children 1-5 years is to be administered vitamin A every 6 months. The recommended schedule is as follows:
  - 6-11 months - one dose of 100,000 IU
  - 1-5 years - 200,000 IU/6 monthsA child must receive a total of 9 oral doses of vitamin A by its fifth birthday.
- The contact with an infant during administration of measles vaccine between the age of 9-12 months is considered a practical time for administering the vitamin A supplement – 100,000 IU for infants.
- A biannual approach may be used for administering vitamin A to children 1-3 years and 3-5 years. However, the DPT/OPV booster in mid-second year to a child is a suitable time for the second dose of vitamin A (200,000 IU). Wherever, ICDS Programme is functioning, AWW should be involved in the distribution and administration of Vitamin A.
- The joint Mother-Child Health Card should be used to record and monitor the administration of vitamin A dose to children under 5 years.
- In addition, records of under-fives maintained under the MCH Services and the ICDS Programme, is recommended to be used for identifying as well as monitoring children for administration of a total of 9 oral doses of vitamin A per child.
- Communication strategy for creating awareness about Vitamin A must be in place.

## B. TREATMENT OF VITAMIN A DEFICIENT CHILDREN

- Mild deficiency of vitamin A leads to night blindness and conjunctival lesions, while more severe deficiency results in corneal damage. The term 'Xerophthalmia' is used to indicate the various types of eye lesions that result from vitamin A deficiency.

- Loss of luster, haziness and dryness are characteristics of corneal xerosis. This can be completely reversed with vitamin A therapy but in untreated cases it progresses rapidly to keratomalacia( “wasting” of cornea) and blindness.
- Recurrent infections and parasitic infestations aggravate vitamin A deficiency, absorption, storage and utilization of vitamin A is adversely affected in such condition. Keratomalacia is often preceded by an episode of diarrhoea or respiratory infection. Measles is another important contributory cause of vitamin A deficiency and childhood blindness.
- Night blindness and conjunctival changes(such as Bitot’s spots) and corneal xerosis /ulceration are indication for immediate vitamin A Supplementaton. Corneal damage due to vitamin A deficiency(chanes in the normally clear central part of the eye) threatens sight and is a medical emergency.
- All children with clinical signs of vitamin A deficiency must be treated as early as possible. Treatment schedule is to administer 200,000 IU of vitamin A immediately after diagnosis. This must be followed by another dose of 200,000 IU 1-4 weeks later.
- Children with eye lesions must be treated immediately with vitamin A even if they are being referred for special care.
- Infants and young children suffering from diarrhoea, measles or acute respiratory infection must be monitored closely and encouraged to consume vitamin A rich food. In case, early signs of vitamin A deficiency are observed, the above treatment schedule must be followed.

### C. CONCENTRATED VITAMIN A SOLUTION – IMPORTANT GUIDELINES

- Vitamin A concentrate is available at primary health centers and sub health centers in the form of flavored syrup at a concentration of 100,000 IU/ml or 100,000 IU / capsule.
- Vitamin A syrup should be administered using the 2 ml. Spoon/dispenser provided with each bottle of vitamin A . A marked level full 2 ml spoon of vitamin A contains 200,000 IU vitamin A.  
Vitamin A solution must be kept away from direct sunlight . It should be stored in a cold dark room temperature is stable for a minimum of one year.
- Vitamin A solution bottle once opened must be utilized within 6-8 weeks.