Implementing calcium supplementation projects based on lessons learned

Guidance for prenatal calcium supplementation programming based on experiences with iron and folic acid supplementation

1. Are lessons learned from iron and folic acid supplementation (IFA) applicable to calcium supplementation?

Calcium supplementation, like IFA supplementation, involves daily micronutrient supplements for women to take during pregnancy and these will likely be distributed through prenatal or antenatal care (ANC). Pregnancy is thought to be a time when women can be motivated to take nutritional supplements to benefit the health of both mother and child and similar strategies might be used to promote both IFA and calcium supplements. Calcium supplementation programs are likely to face barriers similar to those of IFA programs with regard to supplies, coverage, and adherence. Because of these similarities, a great deal can be learned from past IFA experience and applied to future calcium supplementation initiatives.

There are also important differences. Calcium supplementation is intended to help prevent preeclampsia/eclampsia (PE/E), a dangerous condition but one that is uncommon relative to the anemia prevented by IFA. In addition, calcium supplements will not alleviate symptoms that are noticeable to the consumer, in contrast to IFA supplements which often remedy symptoms such as fatigue. As a result, promoting adherence to calcium supplementation may require different behavior change communication (BCC) approaches.

2. What policies are in place for preventive IFA and calcium supplementation during pregnancy?

Dietary intakes of iron and calcium are low for the majority of pregnant women in many countries. As a result, the WHO recommends a policy of supplementation for all women, rather than screening to target supplementation based on nutritional status.

**WHO Recommendations:**

- **IFA:** 30-60mg iron and 400ug folic acid daily during pregnancy and 3 months postpartum
- **Calcium:** 1.5-2 g of elemental calcium daily for all pregnant women in populations with usual calcium intakes averaging less than 900 mg per day.

Although not sufficient to guarantee success, governmental support of supplementation programs through development of national policy is an important and necessary step toward ensuring supplementation. Many countries have adopted either part or all of the WHO’s recommendations for IFA supplementation. Iron supplementation is included in antenatal care policies universally but programs to improve folate nutrition have only been introduced in about 40 countries.
The WHO issued the recommendation on calcium supplementation in 2011 so there has been little opportunity to put in place national health policies on prenatal calcium supplementation for preventing PE/E. However, a number of countries are investigating the possibility of implementing such actions.

### How much progress has been made on ensuring that pregnant women receive adequate IFA supplementation?

Progress has been made, but due to the varying measures used to evaluate IFA coverage and adherence, it is difficult to quantify. Large variation in IFA supplementation coverage is reported both within and among countries; national Demographic and Health Survey (DHS) data on the number of pregnant women who receive iron supplements range from 17% in Ethiopia to 93% in the Dominican Republic.

Despite significant gains in low income countries, the percent of pregnant women who receive and consume supplements at appropriate doses and timing remains unsatisfactory, partly because many women don’t start taking the pills until their second trimester. As a result, even women who report taking the pills are often not supplemented long enough to attain the full benefits of IFA supplementation. Lack of early and regular attendance at ANC and inadequate supplies of supplements remain important barriers to successful IFA supplementation. It is imperative that countries sustain positive momentum to increase coverage of IFA supplementation and facilitate progress in similar programs, such as calcium supplementation.

### What are the most important barriers to successful supplementation?

The primary barriers to successful supplementation during pregnancy involve:

- Inadequate availability, quality and early and regular use of antenatal care (ANC)
- Poor supply of supplements due to ineffective procurement and distribution within the health care system

It is often assumed that poor adherence on the part of women is a major obstacle but while this can sometimes be a problem, experience has shown that the most important stumbling blocks occur even before women get their supplements. Barriers related to ANC and supplies of supplements are discussed in more detail below, followed by a discussion of barriers for adherence.

### Why is early and regular ANC attendance important for nutritional supplementation?

Ensuring access to good quality ANC is an important component of Millennium Development Goal 5, “improve maternal health,” because it is a key entry point for pregnant women to receive multiple health promotion and preventive services including immunization, nutrition education and supplement distribution.

In the context of prenatal supplementation, early and regular ANC visits during which women are provided appropriate supplement doses and information are vital for ensuring adequate duration of supplementation and for promoting adherence to the prescribed regimen.

The WHO recommends an approach known as focused antenatal care (FANC), consisting of four ANC visits, starting in the first trimester, and emphasizing quality and individualized care.

Unfortunately, implementation of this strategy is far from universal and antenatal health services are severely underutilized. In low-income countries during 2005-2012, only 37% of pregnant women attended ANC four or more times, and trend data indicate little improvement in the past decade. The majority of women who do access services do so only in their late second or third trimesters, too late to fully benefit from many of the preventive interventions available or to identify early risk factors.

### What are the barriers to early and regular ANC attendance?

Even among women who do attend ANC, few book as early or as often as recommended for FANC, limiting timely access to micronutrient supplementation. Societal norms mean that pregnancy often is not acknowledged until the second or third trimester, presenting cultural and psychological barriers to attending ANC earlier in pregnancy.

The reasons for underutilization of ANC are multi-factorial and include the following:

- A belief that ANC services are unnecessary or of poor quality
- Preference for consulting traditional birth attendants (TBAs) or family members
- Distance, lack of transportation or other geographic barriers (ANC use is often lower in rural areas)
- Financial constraints
- Concerns about long wait times
- Anxieties about communicating and interacting with health care providers
- Discomfort or religious restrictions related to examination by male providers
- Women’s lack of control over their own health care decisions
- Lack of support from the husband or family
- Hesitancy about acknowledging pregnancy in first trimester combined with the public nature of clinic attendance in many communities

### What are the successful strategies for improving utilization of ANC?

Improving utilization depends in part on ensuring the availability of good quality ANC. Recommendations for increasing the quality of care include increased availability and quality of equipment and supplies, well-trained staff, evaluating and rewarding employee performance, improving communication at all levels and cultivating good patient-provider relationships.

Access to ANC can be enhanced by eliminating user fees, bringing basic ANC services to women in rural areas, expanding ANC services to help reduce waiting lines, providing child care services, offering services in multiple languages, and bringing basic services to the home and workplace.

Another strategy is to increase awareness of the importance of seeking timely ANC and find ways to increase comfort and willingness to disclose pregnancy earlier. In numerous countries, community health workers, traditional birth attendants, or trained midwives have been able to identify women early in their pregnancy and encourage them to seek ANC early and regularly, as discussed below (See FAQ 10).
Do women who attend ANC receive IFA supplementation?

Even if women attend ANC regularly during pregnancy, it does not guarantee that they will receive supplements or adequate information about their administration. For this to happen, the health system must ensure that (1) supplies of supplements are available in facilities, (2) staff provide adequate amounts of supplements to women during their ANC visit, and (3) staff provide effective counseling to help women remember to take supplements and to prepare them for possible side effects.

The multiple challenges that confront efforts to ensure adequate supplies of the appropriate micronutrient supplements at the facility level are discussed below (See FAQ 9 & 10). Once facility-level supply is ensured, provision of supplements and information during an ANC visit depends on staff training, supervision, and setting priorities. Health staff may not be adequately trained on the supplementation protocol or effective counseling techniques. Due to workload or motivational factors, health staff may not have the time necessary to counsel women properly. Without supportive supervision, supplementation will not be fully implemented within ANC.

Therefore it is common for pregnant women seeking care to receive inadequate doses of supplements and improper or no information about them. Those women who visit prenatal health services are often familiar with iron supplements, but commonly do not know why they are prescribed, are not told about possible side effects, and receive conflicting information about dosage. These challenges will also need to be addressed for successful promotion of calcium supplementation.

Why is the supply of supplements a barrier?

Ensuring adequate and reliable supplies depends on multiple people, organizations, and regulations and is therefore one of the major challenges facing efforts to increase coverage of supplementation programs. At the national level, responsibility for procurement of IFA may be unclear due to lack of coordination among government departments and in some cases, among international organizations who provide supplements on an interim basis.

Confusion about the most appropriate formulations and dosages for preventive supplementation can mean that the proper supplements are not included on a country’s list of essential drugs. Formulations must of course be clinically-effective, but there are other factors to consider. It is also important that the supplies procured are acceptable to women, thereby avoiding barriers related to supplement appearance, taste, shelf life and packaging. Limited funding for supplements in national budgets is another hurdle for IFA and calcium supplementation and cost can influence which formulations are procured.

The supply problem is not limited to inadequate procurement at the national level, but also includes uneven distribution of tablets. Poor communication between facilities, imprecise targeting and lack of a demand-based supply system (see FAQ 10) lead to sporadic and inadequate supplementation coverage.

What are successful strategies for improving the supply of supplements?

A number of strategies are suggested for ensuring a continuous supply and effective delivery systems for supplements. An effective management system requires listing IFA (or other micronutrient) supplements as essential medicines and ensuring adequate buffer stocks. Many countries use a “push” or centralized supply-driven system for supplement distribution, meaning that supplies at the national level determine what will be distributed. However, it is recommended to also include a “pull” or demand-driven component in which distribution is based on regular monitoring of needs at the facility level.

This requires communicating local needs to regional or national levels so that supplies can be procured in advance. In addition, to maintain supplies at the local level, quality control must be in place in each facility, and tablets must be stored properly and monitored regularly to ensure timely restocking.

Nicaragua provides an example of how implementing these strategies to address the supply issues with IFA can increase supplement coverage and reduce anemia. Updated technical guidelines listing IFA supplements as essential medicines, efficient systems to procure and manage supplement stocks, and universal (no screening) distribution through several channels were successful in ensuring that women did not encounter difficulties in accessing iron supplements either at health posts or at local pharmacies. Similar systems will be needed to ensure adequate supplies of calcium supplements.

Are there other strategies for delivering micronutrient supplements to pregnant women outside of facility-based ANC?

There have been many successes in programs using alternative modes to reach women. Trained midwives, traditional birth attendants, and other community-based outreach workers can distribute IFA supplements, encourage women to attend ANC, and monitor their adherence with supplementation. For example, in the Philippines, Village Health Workers were trained to counsel women on iron pills and monitor compliance, partnering with professional health workers to distribute pills with great success. Nicaragua’s successful IFA supplementation program included distribution through multiple channels including ANC clinics, health posts, pharmacies, and community-based workers. Similar strategies were used in Thailand where pregnant women received IFA at ANC visits and village health volunteers helped to encourage compliance and visits to ANC. In Ethiopia’s Health Extension Program, local young women are trained to become Health Extension Workers who provide limited services within rural communities and successfully encourage model health behaviors including utilization of ANC services.

What are the barriers to adherence, once women receive their supplements?

Cultural beliefs and norms can hinder adherence to supplementation. Women may avoid supplements because they believe the pills can cause miscarriages, large babies and difficult deliveries, or they associate iron with more bleeding at delivery. Cultural norms may underlie preferences for herbal tonics and other home remedies and avoidance of pills during pregnancy. Motivation may be limited by lack of awareness of anemia (even among women who experience symptoms) and lack of explanation.
of the benefits of IFA. Symptoms of anemia may be seen as a natural part of pregnancy, lowering the demand for treatment. Similarly, symptoms of preeclampsia such as swelling of limbs are often seen as a normal part of pregnancy. Motivating women to take calcium supplements may be challenging if women and health workers do not view preeclampsia or eclampsia as risks or understand the role of supplements in preventing these conditions. In some countries, symptoms of eclampsia such as convulsions are believed to be due to evil spirits and thus unlikely to be seen as preventable with supplements.

Lack of adherence may result from forgetfulness, misunderstanding instructions, intentional overdosing, sharing the pills with family and friends or frustration about the frequency and number of pills prescribed. Once women start to feel better due to the effectiveness of IFA they may stop taking the supplements. Calcium supplementation differs in that women are unlikely to experience symptoms from which they will recover, however it is still possible that women may perceive changes in their health and decide that the supplements are no longer needed.

Physical and organoleptic qualities (taste, smell, etc.), the form of micronutrients, dosing, ease of use, packaging, and perceived health effects can affect adherence. Side effects can be a deterrent to adherence, particularly when one is not warned about them. Iron supplements may cause gastrointestinal side effects such as nausea, vomiting, constipation, diarrhea and abdominal distress. Calcium supplements can also cause mild gastrointestinal side-effects, such as constipation. However, the negative effect of side effects on adherence may be overestimated; with proper counseling women have been found to be willing to overcome any dissatisfaction with the side effects and continue to take IFA tablets. The same is expected to be true for calcium supplementation.

What strategies have been successful in improving adherence?

When women are given high quality supplements with correct information about health benefits and possible short-term side effects, and when they have the tangible experience of improved well-being from using the pills, they often are willing to continuously take the tablets.

Improving patient-provider relationships can aid in compliance to supplementation and it is important for health providers to use behavior change communication to give clear messages about the importance of taking the pills, directions for taking them, and warnings about possible side effects. Health care workers should be trained to use tested, culturally appropriate messages in all communication efforts.

Community-based health workers or volunteers can be valuable for bringing these messages to those who have limited access to health facilities. Including communities, community leaders, traditional healers, and families (especially husbands) in the discussion and promotion of the program can facilitate acceptance of supplements.

Motivating information about the importance of supplements can also come from other sources. Radio and bus advertisements have been successful in Nigeria and promotion materials like flyers and posters have been shown effective in the Philippines.

Memory aids and follow-up by health workers can also be helpful in reminding women to take the supplements regularly throughout pregnancy. For example, calendars used to mark daily intake of iron supplements have been successful for some women. It is essential that health staff, women, and other community members be consulted on their views and suggestions for the design of accessible programs and motivating health messages. Learning from successes in promoting IFA can be a starting point, but approaches will have to be adapted to calcium supplementation and to the contexts in which programs are implemented. Local input will be essential for this process.

REFERENCES

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