Islamic Republic of Afghanistan

Ministry of Public Health

National Public Nutrition Policy & Strategy

1388 – 1392 (2009-2013)

Acknowledgements

Improving the nutritional status of the Afghan population and in particular of pregnant women and young children has been part of the main objectives of the MOPH since 2002. Progress has been made in lowering acute malnutrition, but over 50% of Afghan children under 5 are still stunted and between 5 and 10% suffer from acute malnutrition. An estimated 70% suffer from micronutrient deficiencies. A revised Infant and Young Child Feeding Policy and Strategy was published in October 2009, and the revised Child and Adolescent Health Policy and Strategy of 2010 stress the importance of appropriate nutrition interventions, aligned with other public health activities in order to reach Afghanistan's Millennium Development Goals. The MOPH is acutely aware that without addressing the still prevailing nutrition problems, only limited progress can be made in improving the general health of the Afghan population, and in particular of its most vulnerable groups, women and children.

We would like to extend our thanks to all those who contributed in the revision of the policy and strategy: the Public Nutrition Policy and Strategy Revision Task Force under the leadership of the Public Nutrition Department, the General Director Preventive Medicine, for their continued support throughout the policy and strategy revision process. We are also grateful for the suggestions presented by participants in the National Consultative Workshop on the Public Nutrition Policy and Strategy Revision held in Kabul on 29th July 2009. Their recommendations have been incorporated in the present document. We also appreciate the support provided by the MoPH Policy and Planning General Directorate, the Consultative Group on Health and Nutrition, the Technical Advisory Group and the Executive Board.

This Public Nutrition Policy and Strategy was prepared by the MoPH Public Nutrition Department, with technical assistance from USAID/BASICS and in close collaboration with the Public Nutrition Policy and Strategy Revision Task Force, composed of representatives from the Public Nutrition Department, USAID/BASICS, FAO, Micronutrient Initiative, UNICEF, WFP, WHO and the World Bank.

We appeal to all our colleagues and partners to join efforts in translating this revised Public Nutrition Policy and Strategy into actions. Together we will succeed in achieving the objectives of the Afghanistan Health and Nutrition Sector Strategy and improve the health status of all Afghans.

Dr. Suraya Dalil
Acting Minister of Public Health
June 2010, Kabul, Afghanistan

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Acronyms

AHDS	Afghan Health and Development Services
AHS	Afghanistan Health Survey
AMI	Aide Médicale Internationale
ANSA	Afghan National Standards Authority
BCC	Behaviour Change Communication
BFHI	Baby-Friendly Hospital Initiative
BHC	Basic Health Centre
BMI	Body Mass Index
BMS	Breast Milk Substitutes
BPHS	Basic Package of Health Services
BPNI	Breastfeeding Promotion Network of India
C-GMP	Community-based Growth Monitoring and Promotion
CBHC	Community-Based Health Care
CDC	U.S. Centre for Disease Control and Prevention
CED	Chronic Energy Deficiency
CGHN	Consultative Group on Health and Nutrition
CHA	Coordination of Humanitarian Assistance
CHC	Comprehensive Health Centre
CHD	Child Health Days
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
CSO	Central Statistics Office
DAIL	(provincial) Department of Agriculture, Irrigation and Livestock
DoE	(provincial) Department of Education
DoPH	(provincial) Department of Public Health
DRRD	(provincial) Department of Rural Rehabilitation and Development
ENA	Essential Nutrition Actions
EPHS	Essential Package of Hospital Services
FAAHM	Food, Agriculture and Animal Husbandry Information Management Policy Unit
FAO	Food and Agriculture Organization of the United Nations
FEWSNET	Famine Early Warning Systems Network
FHAG	Family Health Action Group
GAM	Global Acute Malnutrition
GCMU	Grant Contracts Management Unit
GMP	Growth Monitoring and Promotion
HMIS	Health Management Information System
HNSS	Health and Nutrition Sector Strategy
HPD	Health Promotion Department
IBFAN	International Baby Food Action Network
IDD	Iodine Deficiency Disorders
IEC	Information, Education, Communication
IFE	Infant Feeding in Emergencies
IMCI	Integrated Management of Childhood Illnesses
IYCF	Infant and Young Child Feeding
JHU	Johns Hopkins University

LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MAIL	Ministry of Agriculture, Irrigation and Livestock
MAM	Moderate Acute Malnutrition
MCH	Maternal and Child Health
MDD	Micronutrient Deficiency Disorders
MDG	Millennium Development Goals
MI	Micronutrient Initiative
MICS	Multiple Indicator Cluster Survey
MoC	Ministry of Commerce
MoE	Ministry of Education
MoJ	Ministry of Justice
MoLSA	Ministry of Labour and Social Affairs
MoM	Ministry of Mines
MoPH	Ministry of Public Health
MoRA	Ministry of Religious Affairs
MoWA	Ministry of Women's Affairs
MRRD	Ministry of Rural Rehabilitation and Development
NID	National Immunization Days
NRVA	National Risk and Vulnerability Assessment
ORS	Oral Rehydration Solution
PHCC	Provincial Health Coordination Committee
PND	Public Nutrition Department
PRT	Provincial Reconstruction Team
RH	Reproductive Health
SAM	Severe Acute Malnutrition
SC-UK	Save the Children United Kingdom
SC-US	Save the Children United States
SFP	Supplementary Feeding Programme
TFU	Therapeutic Feeding Unit
UNICEF	United Nations Children's Fund
USI	Universal Salt Iodization
WABA	World Alliance for Breastfeeding Action
WFP	World Food Programme
WHO	World Health Organization

Section I: Background

Why revise the Public Nutrition Policy and Strategy?

The present policy and strategy builds on the Public Nutrition Policy and Strategy for 2003-2006, which was slightly modified in 2005 and has guided the work of the Ministry of Public Health (MoPH) in nutrition until 2008. In the first Public Nutrition Policy and Strategy, the Government of Afghanistan, and the MoPH in particular, affirmed its commitment "to promote, protect and fulfil the rights of all people to adequate food and nutrition as stated in the International Declarations and Conventions on Human Rights." The MoPH adopted a public nutrition approach, based on the Conceptual Framework of Malnutrition (developed by UNICEF in 1992), presented in Figure 1, on the next page.

Many of the objectives and activities described in the Public Nutrition Policy and Strategy for 2003-2006 have been achieved. Since then, new priorities and challenges have arisen which require new strategies. Furthermore, the Public Nutrition Policy and Strategy must be aligned with the Health and Nutrition Sector Strategy, which was finalised in 2008. The present document therefore provides an update of the nutritional situation in Afghanistan, and describes renewed policy priorities and key strategies, which build on the progress that has been achieved since 2003. Priorities have been selected that will contribute to achieving the objectives of the Health and Nutrition Sector Strategy for 2008-2013, namely:

- To reduce infant mortality by 32% from the 2000 baseline of 165 per 1000 live births to 111 per 1000 live births
- To reduce under 5s mortality by 38% from the 2000 baseline of 257 per 1000 live births to 160 per 1000 live births

Since 2003, the MoPH Public Nutrition Department has acquired greater experience and developed an evidence base, which was used to select the priorities and strategies presented here. The present strategy will enable the MoPH to prioritize the allocation of resources for nutrition. It will also provide a common framework for all nutrition partners and therefore support inter-ministerial and inter-agency coordination.

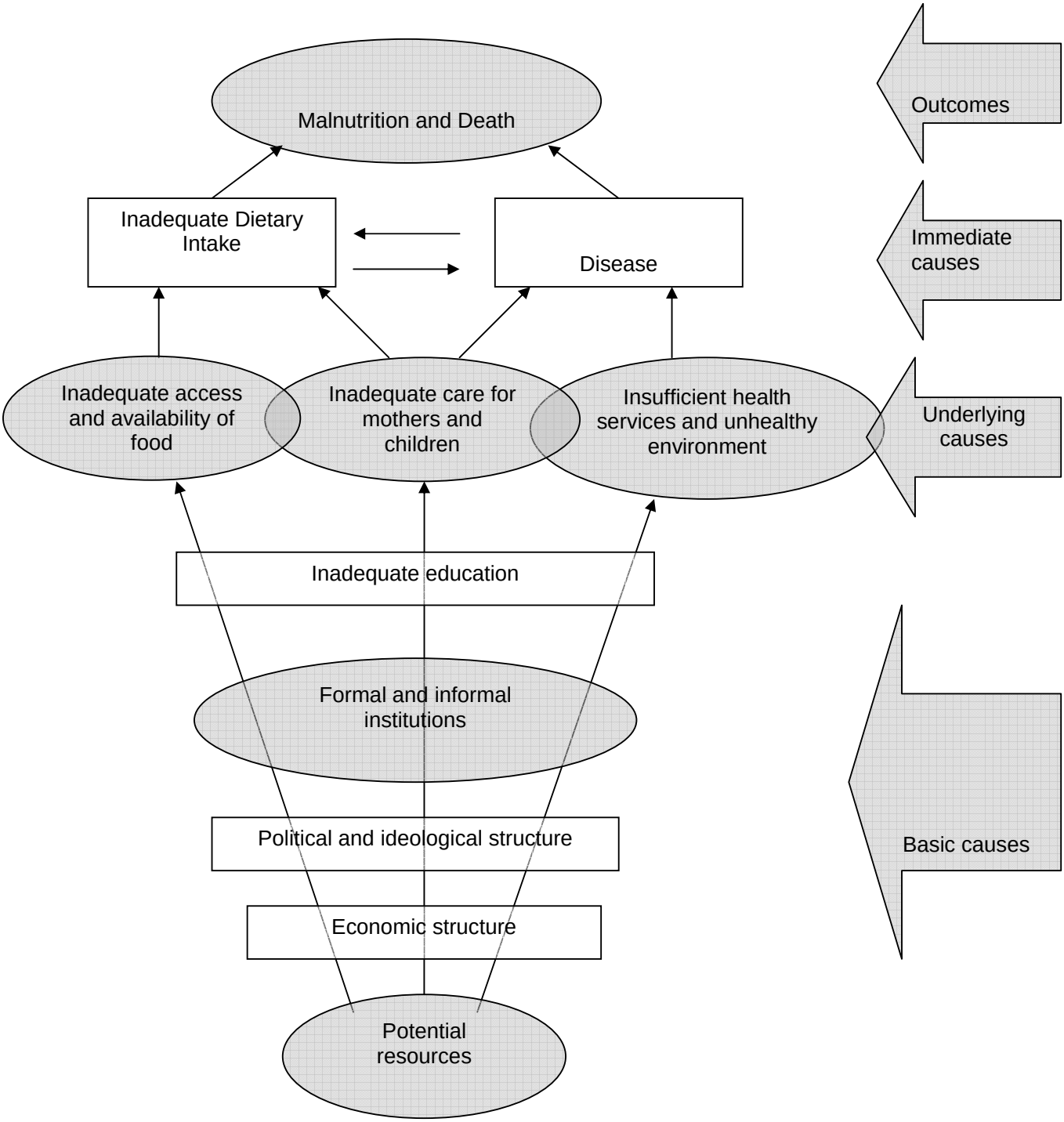


***Figure 1**: The Conceptual Framework of Malnutrition, adapted from UNICEF – 1992*

The Conceptual Framework of Malnutrition was elaborated by UNICEF in 1992 and highlights the immediate, underlying and basic causes of malnutrition. It highlights the need for multi-sectoral collaboration to effectively address malnutrition and provides a useful

foundation for joint planning and coordination. It is the backbone of the Public Nutrition approach, adopted by MoPH.

Definitions of malnutrition[1]

Malnutrition: 'Malnutrition' is a term that comprises all forms of 'bad' nutrition, including 'undernutrition' and 'overnutrition'.

"Overnutrition" is due to an excessive intake of fat and energy and leads to overweight or obesity. It is measured using the Body Mass Index (BMI). BMI is equal to the Weight divided by the height squared (W/H^2); see Table 1 for degrees of overweight. Overnutrition is associated with increased risks of chronic disease (diabetes, cardiovascular disease). Overweight individuals can also suffer from specific nutrient deficiencies (in particular micronutrients) if they have an imbalanced diet.

The term '**undernutrition**' is increasingly used to designate malnutrition that is due to a lack of food or nutrients (N.B. in this document, the term 'malnutrition' is still used to refer to 'undernutrition'). Undernutrition is the most common form of malnutrition in Afghanistan. It is present under several forms, described below.

- **Chronic malnutrition (or stunting):** Children who suffer from chronic malnutrition fail to grow to their full genetic potential, both mentally and physically. The main symptom of this is stunting - shortness in height compared to others of the same age group- and it is measured with 'height-for-age' (H/A). See table 1 for the classification of degrees of chronic malnutrition.

- **Acute malnutrition (or wasting/oedematous form):** Children who suffer from acute malnutrition lose weight as a result of acute lack of food or disease. The main symptom of acute malnutrition is wasting – a loss of weight compared to children of the same height- and it is measured with 'weight-for-height' (W/H), and/or presence of Oedema. See Table 1 for the classification of degrees of acute malnutrition.

- **Underweight**: underweight refers to children who have a low weight compared to others of the same age and is measured by 'weight-for-age' (W/A). Underweight can either be a sign of stunting or wasting, or a combination of both.

- **Micronutrient Deficiency Disorders (MDDs):** MDDs encompass a wide range of disorders that are due to a low intake or utilization of micronutrients. Different symptoms and disorders are associated with each micronutrient. For example, iron deficiency can cause anaemia, iodine deficiency can cause goitre and cretinism, vitamin A deficiency night-blindness, and vitamin C scurvy. Each deficiency can cause a range of symptoms according to the severity of the deficiency.

- **Low Birth Weight (LBW)**: Low Birth Weight Babies are born with a weight inferior to 2,5 kg. LBW babies are at higher risk of malnutrition and a wide range of disorders.

- **Chronic Energy Deficiency (CED):** Chronic Energy Deficiency is the term used to

[1] Adapted from FAO, 2005 *Nutrition Indicators for Development* and WHO, 2006 *Child Growth Standards* and www.who.int.

designate adult undernutrition due to a lack of energy (as opposed to micronutrients), and which is indicated by weight loss. CED is also measured using the Body Mass Index (BMI). See Table 1 for the degrees of CED.

Table 1: Classification of malnutrition (adapted from WHO 1997)

Children malnutrition (undernutrition)				
Degree Type	Normal (not malnourished)	Global	Moderate	Severe
Chronic malnutrition (U5)	H/A >-2 SD* (also called Z-scores)	H/A <-2SD	H/A <-2SD & >-3SD	H/A <-3SD
Acute malnutrition (U5)	W/H >-2 SD	W/H <-2SD	W/H <-2SD & >-3SD	W/H <-3SD
Underweight (U5)	W/A > -2SD	W/A <-2SD	W/A <-2SD & >-3SD	W/A <-3SD
Adult malnutrition (undernutrition)				
Degree		CED Grade I	CED Grade II	CED Grade III
Chronic Energy Deficiency (adults)	BMI > 18,5	BMI <18,5 & >17	BMI <17 & >16	BMI <16
Adult overnutrition				
Degree	Normal	Overweight	Obesity	
Overweight/obesity	BMI >18,5 and <25	BMI>25 and <30	BMI>30	

* SD = Standard Deviation (also called Z-score) = (observed value - median value of the reference population)/ standard deviation value of reference population

***Nota Bene*:** There is a **critical window for a child's optimal physical and mental growth and development**, from when **it is still in its mother's womb and during its first two years of life**. Efforts to counter the effects of malnutrition during that time can prevent, or even reverse, the negative impacts of malnutrition. But **if the opportunity is missed, the child will suffer the negative consequences of malnutrition for the rest of his/her life**.

Section II: The nutrition situation in Afghanistan

Prevalence, consequences and causes of malnutrition in Afghanistan

The consequences of malnutrition for the Afghan population

Afghanistan has the 3rd highest child mortality rate (children <5 years of age) in the world, with 191 children under 5 dying out of 1,000 live births). Malnutrition is a major underlying cause of child mortality and morbidity in Afghanistan, because poor nutritional status compromises a child's ability to resist and recover from infections. According to the international studies (Pelletier, 1994; Lancet Series, 2008), 35% to 52% of children dying before the age of five would survive if they had been adequately nourished to support a strong immune system to fight infections. Malnutrition also impairs children's mental and physical development, ability to learn in school, and adult work capacity. Furthermore, prevention of malnutrition and associated diseases would significantly reduce households' health care costs. The economic costs of malnutrition to households and to the country undermine development efforts. and can reduce GDP by 2 to 3%[2].

Prevalence of different types of malnutrition

The majority of children under five years of age suffer from malnutrition. Prevalence of chronic malnutrition amongst children from 6 to 59 months (which manifests as low height for age—linear growth stunting) ranges from 39% to 60% depending on the region and time of year. Prevalence of acute malnutrition ranges from 5 to 10%, with rare reports of prevalence above 15% (MoPH, 2005; see Table 2 for summary of available data). Recent trends suggest that the prevalence of acute malnutrition is increasing in some ares (HMIS, 2008; MoPH, 2008) as a result of the rising food prices, prolonged drought, and very harsh winter of 2007-2008, which have ravaged livestock and agricultural resources.

Nutritional survey results show that children under the age of 29 months are most affected by malnutrition. A recent survey conducted by Save the Children in Jawzjan province revealed that 11.4% of children under 6 months were suffering from acute malnutrition, compared to 6.8% in children 6-59 months. This is largely due to inadequate infant and young child feeding practices (see below) and vulnerability to infection and illness. It is a common pattern, worldwide, that the prevalence of stunting, wasting and underweight increases dramatically during the first two years of life. It is absolutely essential to address malnutrition in this age group, because stunting, and the effects of certain micronutrient deficiency disorders, are frequently irreversible, especially after the age of two, when the pace of growth and psycho-motor development slows.

Micronutrient deficiencies are even more widespread. According to the National Nutrition Survey carried out by the MoPH in 2004, 48% of non-pregnant women are iron deficient and 25% suffer from anaemia, while over 72% of children 6- 59 months are iron deficient and nearly 38% anaemic. Iodine Deficiency Disorders (IDD) are also a major public health issue, in particular in mountainous provinces in the north and central highlands. The National Nutrition Survey found that 75% of women of reproductive age and 72% of children are iodine deficient.

2 World Bank, Repositioning Nutrition as Central to Development (2006)

There is hope that the prevalence of iodine deficiency has decreased since these data were collected, with improved access and use of iodized salt: During 2001/2, access to iodized salt was estimated to be less than 1% while coverage of household with iodized salt reached to 41% in 2005 and 53% in 2007/08 (NRVA, 2005 and 2007/08)[3].

Other vitamin deficiencies include vitamins A and C. In a sample of preschool children in Kabul, it was found that close to 30% of less than 5 years olds in that city may be vitamin A deficient[4]. The prevalence of paediatric vitamin A deficiency is likely to be higher in rural areas. The National Nutrition Survey also found that 10% of pregnant women in Afghanistan suffered from night-blindness. Vitamin C deficiency occurs in highly food insecure areas where dietary diversity is very poor, as indicated by occasional scurvy epidemics. Up to 10% of the population was found to have scurvy in areas severely affected by drought in 2002 and 2003[5]. Finally, international studies have demonstrated that where chronic malnutrition rates are high, zinc deficiency rates are also high. This suggests that zinc deficiency is likely to affect a large number of Afghan children U5.

Table 2. Data on malnutrition in Afghanistan[6]

	Children (6-59 mos.)	**Women (15-49y)**	**Men (18-60y)**	**Households**
Underweight (<-2 z-score, wt/age)	39%			
Chronic malnutrition[7] (<-2 z-score, ht/age)	54% (39,9 - 60%)			
Acute malnutrition (<-2 z-score, wt/ht)[6]	7% (6-10%) (2004 NNS), 16.7% in 2008 RNA in 22 provinces.			
Adult Chronic energy deficiency (Body Mass Index < 18.5)		21%		
Anemia (hemoglobin < ll g/dL)	38% (50% for 6-24m)	25% (non-pregnant)	7%	
Iron deficiency (Zn protoporphyrin)[8]	72% (90% in U3s)[9]	48% (non-pregnant)	18%	
Iodine deficiency (urinary I< 100µg/L)	72%	75%		
Vitamin A deficiency (Night blindness)		20%		
Vitamin C deficiency (scurvy)[10]				Up to 10%

[3] The National Risk and Vulnerability Assessment, 2005 & 2007/08

[4] personal communication, Mr. Laird Ruth, CDC, Atlanta

[5] Cheung et al (2003). An epidemic of scurvy in Afghanistan: assessment and response. Food and Nutrition Bulletin, 24(3): 247-255

[6] Data are derived mostly from the MoPH 2004 National Nutrition Survey except where noted.

[7] Figures in brackets are the range of results from various surveys carried out between 2000 and 2005

[8] For children 6-59 months, cutoffs were used of zinc protoporphyrin >61µmol/mol haeme; for non-pregnant women, cutoffs of zinc protoporphyrin >70 µmol/mol haeme were used.

[9] UNICEF. (2003). Multiple Indicator Cluster Survey (MICS). Kabul: UNICEF.

[10] Cheung et al (2003). An epidemic of scurvy in Afghanistan: assessment and response. Food and Nutrition Bulletin, 24 (3): 247-255.

There is very little data available on overnutrition, but experience and surveys suggests that overnutrition is much less common than undernutrition in Afghanistan. Several surveys conducted have shown that around 10% of women of reproductive age living in urban areas were overweight (ACF, 2000). While national nutrition survey revealed (12%) overweight and 3% obesity among same group of women national wide. This can be due to women's limited movement and physical activity, and also to mental health issues (depression) that contribute to unhealthy eating habits. Furthermore, fat consumption can be excessive in certain households and population groups compared to their dietary needs (e.g. affluent urban households; pastoralists for whom animal fat is a large component of the diet), and this increases the risks of chronic disease such as cardiovascular problems, diabetes and cancer.

Underlying causes of Malnutrition

Food insecurity and poverty: Widespread poverty, lack of access to food, lack of availability of food and poor diet are major causes of malnutrition in Afghanistan, and micronutrient deficiencies in particular. The results of the NRVA 2007/2008 show that 32% of households do not meet their caloric needs (2,100 kcal/person/day), and further analysis by WFP Vulnerability Analysis and Mapping Unit found that 35% of households had poor food consumption. The NRVA 2007/8 also found that 36% of the Afghan population, or 9 million people (CSO 2007), lives below the poverty line set at 1,255 Afghani per person per month ($0.84/person/day). The drastic increase in food prices in 2007-2008 (over 100% between 2007 and 2008 on some markets[11]), the very harsh winter (2007-2008) that led to 10% livestock losses, and drought have also contributed to severely worsen an already alarming food security and economic situation. The growing political insecurity in a number of regions poses ongoing challenges to local food production and market access, and limits humanitarian agencies' abilities to deliver assistance in the most insecure areas. Limited knowledge about nutrition principles further affects food choices and child feeding practices.

Health services & Health environment: The most common causes of under five mortality in Afghanistan include neonatal deaths (26% of U5 deaths), acute respiratory infections (ARI; 25%), diarrhoea (19%), measles (6%), malaria (1%)[12]. The 2006 Afghanistan Health Survey found 47% of U5s had diarrhoea during the previous month. Malnutrition is very commonly a consequence of these diseases as well as a contributing factor to disease. Data from therapeutic and supplementary feeding centres, for example show that acute malnutrition rates vary seasonally and are notably linked to diarrhoeal disease trends, as indicated by sharp increases in admission rates in the summer months. Cases of acute malnutrition in winter months are very often associated with ARI.

Poor hygiene, sanitation and limited potable water supply are major causes of infections. According to UNICEF (2006), only 22% of the population is using improved drinking water sources (17% in rural areas) and 30% of the population is using improved sanitation services. Hygiene conditions inside homes and neighbourhoods are often poor (presence of animals, open latrines in the street…). Hand washing with soap is not a routine practice. Furthermore, though access to health services has greatly improved in recent years, with an estimated 9% of households having nearby access to primary health care services in 2000 and 65% in 2006

[11] Prices have then decreased by 40% between 2008 and 2009, but remain volatile and above pre-crisis norms.
[12] Afghanistan Health Survey, 2006.

(ANDS, 2008), many households still do not have the means to make optimal use of these facilities, and the quality of care needs to be greatly improved.

Food safety and hygiene are also major problems in Afghanistan. The majority of households are concerned with problems of food hygiene in their homes, due to inappropriate environmental hygiene, poor storage and conservation, exposure to insects, pests and other animals, and unhygienic food preparation. This is a major cause of gastro-intestinal infections and, consequently, of malnutrition. Urban populations are also exposed to unhygienic practices amongst food retailers (in particular butchers), street food vendors, and restaurants. The food quality control systems are extremely weak (absence of recognized standards, legislation, regular inspection systems, border controls) such that food quality control of imported foods and locally processed products is most often absent.

***Feeding and caring practices**:* Therapeutic Feeding Unit (TFU) monitoring data show that 40% of admitted children are under 6 months, and nutritional survey results show that acute malnutrition rates are highest in the 6-29 months age group. These data point to inadequate infant feeding and caring practices as a major cause of malnutrition. The rate of exclusive breastfeeding was estimated at 70% in a 2006 study, but qualitative field studies have found that true exclusive breastfeeding from 0-6 months is extremely rare. Introduction of solid/semi-solid foods also occurs later than the recommended 6 months of age and with foods of inadequate nutrient density. Many mothers report suffering from 'breast milk insufficiency', which is often a misperception since the lack of milk may be due to mixed feeding leading to less demand by the infant which leads to less breast milk production (a vicious circle). Early cessation of breastfeeding often occurs during a consequent pregnancy or illness, due to cultural beliefs about not breastfeeding while pregnant or when the mother or child is ill. Breastfeeding difficulties can also be associated with stress or other mental health issues. Infant and Young Child Feeding (IYCF) practices are negatively affected by emotional and mental health problems amongst mothers; low knowledge & skills on IYCF; traditional beliefs and food taboos; lack of peer support to mothers; limited resources (time, food...); emotional and mental health problems amongst mothers; early marriage and pregnancy; mothers' workload; and short birth intervals (< 3 years). In urban and semi-urban areas, the influence of commercial products (in particular Breast Milk Substitutes and commercial complementary feeding porridges) adds to the problem.

The three sets of underlying causes described above are clearly inter-connected. For example, food insecurity obliges women to priorities participating in the income generation activities over caring practices. It is therefore important to address malnutrition in a holistic manner.

The Inter-generational cycle of malnutrition

A very important factor explaining high child malnutrition rates is the high prevalence of maternal malnutrition. Poor maternal nutritional status will contribute to poor intrauterine growth and low birth weight. Poor complementary feeding practices and micronutrient deficiencies coupled with a high incidence of diarrhoea and subsequent inadequate quality of food lead to malnutrition and growth failure (in particular amongst under twos), which in turn leads to another generation of malnourished mothers - who will replicate this cycle (Figure 2). This inter-generational cycle of malnutrition will only be broken by comprehensive public health and food security interventions that effectively address these underlying causes, and that are delivered in such a way as to reach the important target group, women.

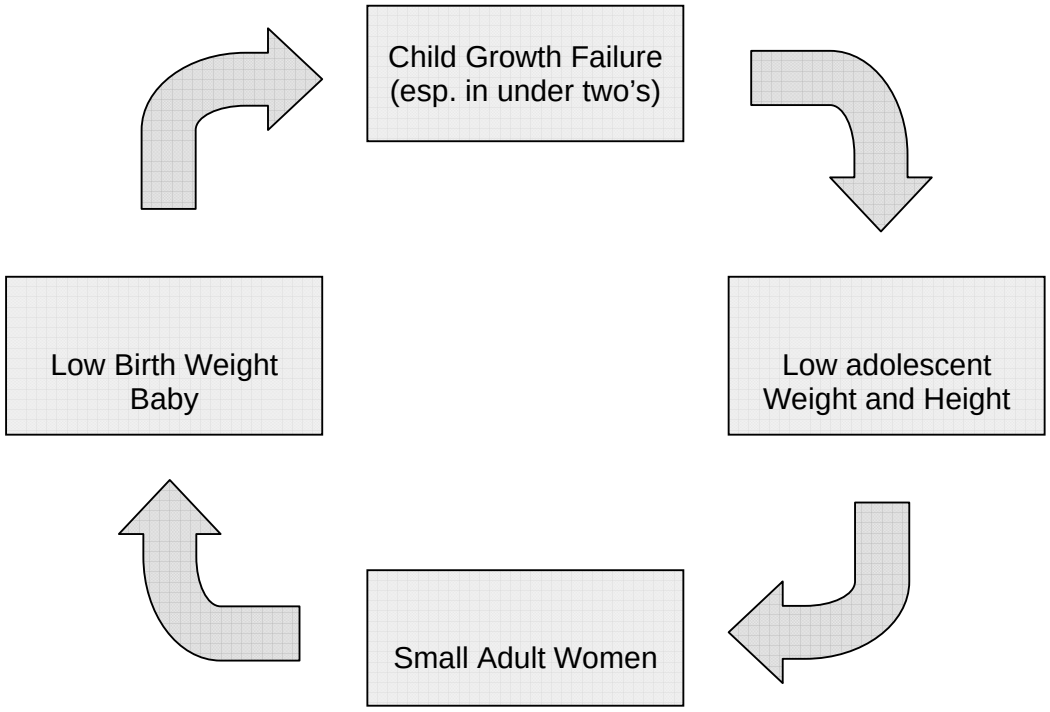


Figure 2: Inter-generational Cycle of Malnutrition

Challenges to be addressed through the Public Nutrition Policy and Strategy

The analysis of the nutrition situation in Afghanistan and of nutrition interventions implemented since 2002 has led to the identification of the following eight priority challenges:

1. Inadequate knowledge & skills for achieving good health nutrition
2. Inadequate IYCF and limited community outreach of current IYCF counselling and support;
3. Low micronutrient intake & poor dietary diversity, associated with low coverage and limited quality of current micronutrient interventions;
4. Presence of severe acute malnutrition and limited access to quality treatment;
5. Exposure to unsafe foods and unhygienic food conservation and preparation;
6. Low availability of reliable nutrition data;
7. Recurrent crises / emergencies and low assessment and response capacity;
8. Limited capacity in public nutrition amongst health practitioners and professionals from other nutrition-related sectors (agriculture, education, social affairs, etc.)

The Public Nutrition Policy and Strategy for 2009-2013 is designed to address these challenges by building upon current achievements and interventions.

Malnutrition can best be prevented during gestation and the first two years of life. The Public Nutrition Policy and Strategy will therefore focus primarily on interventions targeting children under 2 years of age and mothers to prevent the inter-generational cycle of malnutrition.

Section III: Public Nutrition Policy

Vision of the Public Nutrition Policy and Strategy

All Afghans are protected from all forms of malnutrition, by benefiting from optimal food intake, feeding and caring practices and health, nutrition and hygiene services.

Policy Statement

The MoPH is committed to reducing malnutrition of all types, including micronutrient deficiency disorders, through integrated and coordinated programming. In collaboration with development partners, the Ministry will take the lead in preventing, identifying, and reducing malnutrition, using a public nutrition approach.

Goal and operational objective of the Public Nutrition Policy & Strategy

The PNPS will contribute to the achievement of the Health and Nutrition Sector Strategy Goal by aiming to achieve the following goal and overall objective:

Goal: To reduce nutrition related mortality amongst mothers and children by protecting and promoting healthy nutrition for all Afghans, and by preventing chronic malnutrition and associated micronutrient deficiency disorders.

Operational objective: To increase access to and utilization of quality preventive and curative nutrition services provided at community level and through health facilities.

Public Nutrition Policy priorities

In order to achieve the vision of the Public Nutrition Policy and Strategy, the MoPH will focus its efforts on the following policy priorities, targeting primarily children under five years of age, pregnant women and mothers.

1. **Nutrition promotion**

Healthy nutrition practices shall be promoted through awareness raising, counselling, participatory demonstrations and community support activities implemented through health facilities, media and a variety of community development interventions (literacy, schools, agricultural projects, etc.). Nutrition promotion messages must be harmonized and cleared by the MoPH Public Nutrition Department before dissemination.

2. **Infant and Young Child Feeding**

IYCF is an essential priority for public nutrition in Afghanistan. A full Policy and Strategy has therefore been developed on this topic. Please refer to the full document for details.

All Afghan infants and young children have the right t o benefit from optimal breastfeeding and complementary feeding practices to protect them from all forms of malnutrition and its adverse consequences.

The IYCF Policy and Strategy elaborates on the following 9 policy priorities:

- Early initiation of breastfeeding

- Exclusive breastfeeding until 6 months
- Restricted use of commercial formula and respect of the Code of Marketing of Breast Milk Substitutes
- Continued breastfeeding until 2 years and beyond
- Introduction of solid/semi-solid foods at six months
- Promotion of micronutrient-rich foods and appropriate supplementation
- Maternal health and nutrition
- Children facing high health and nutritional risks
- IYCF in emergencies (respect of the Code of Marketing of Breast Milk Substitutes (BMS) and prohibition of BMS donations in emergency situations)

3. Micronutrients

The intake of micronutrients shall be promoted and increased through: nutrition education; adequate fortification of staple foods implemented through partnerships with the private sector; and micronutrient supplementation as part of routine health services and preventive distributions in high-risk populations.

4. Adequate care during severe acute malnutrition

Afghan children suffering from severe acute malnutrition should have access to quality treatment through in-patient care in hospitals for complicated cases, and outpatient care from hospitals or Comprehensive Health Centres for non-complicated cases. The management of severe acute malnutrition must be systematically associated with prevention activities so as to prevent relapses or other cases of acute malnutrition occurring in the same households.

5. Food safety and quality control

All foods made available to Afghan consumers, whether produced by the households, purchased on local markets, or imported, should be safe for consumption and respect national food safety and food quality standards.

6. Effective nutritional surveillance and monitoring

Information on the nutrition situation and on the results and impacts of nutrition interventions should be regularly collected and analysed as part of relevant surveillance and monitoring and evaluation (M&E) systems (in particular the Health Information System and food security surveillance systems). This information shall be regularly shared with relevant stakeholders and used to inform development and emergency programming.

7. **Adequate prevention and response to moderate acute malnutrition and/ or chronic malnutrition.**

Nutrition interventions in situations of emergency, shock or at times of Global Acute Malnutrition (GAM) greater than 10% (or lower with aggravating factors), shall be designed according to an adequate assessment of the nutritional impact of the crisis and an analysis of the underlying causes of malnutrition.

Such emergency feeding programmes shall be implemented where and when there is a demonstrated elevated GAM rate, using the following criteria:

- If GAM is greater than 10% (or GAM is >5% with aggravating factors): SAM treatment services should be expanded if required, and targeted Supplementary Feeding Programmes (SFP) should be established for the management of moderate acute malnutrition in children 6-59 months of age and pregnant and lactating women. Blanket

supplementary feeding for children aged 6-24 months may also be considered on a case by case basis with a preventative aim.

- If GAM is greater than 15% (or GAM is >10% with aggravating factors): SAM treatment services should be expanded if required, and blanket Supplementary Feeding Programmes should be established for children under 6-59 months of age and pregnant and lactating women.

Nutrition counselling including the promotion of local recipes based on locally available foods should be an integral part of all emergency programmes.

All forms of food assistance shall be safe, nutritionally adequate, culturally acceptable and targeted at the most vulnerable sections of the population.

8. Capacity development for public nutrition

Public nutrition training should be part of pre-service and in-service training for all health workers, and relevant staff working in the fields of agriculture, education, women's and youth affairs, economics and social affairs.

Linkages to other relevant Government Policies and Strategies

Food Security and food safety

Ensuring adequate food security is absolutely essential to enable the Afghan population to meet its nutritional requirements. A priority is to decentralise and focus support to most vulnerable population groups, diversifying household food production and processing, income generation in particular for rural women, combined with educational support to ensure an effective use of household resources. The responsibility for food based strategies is shared by several ministries, namely the Ministry of Agriculture (MoA), Irrigation and Livestock (MAIL), regarding food production, and the Ministries of Rural Rehabilitation and Development (MRRD), Labour and Social Affairs (MoLSA), and Commerce (MoC), for generating employment and income.

Ensuring food security lies beyond the MoPH's mandate and capacity, and therefore is not included as one of the policy priorities in the present strategy. However, the MoPH has a clear role in promoting the consumption of safe, nutritious and diverse foods (as indicated in policy priorities 1, 2, 3 and 4), and in advocating for stakeholders involved in food production (namely MAIL and the private sector) to produce and develop access to the foods required for healthy nutrition. Mechanisms for coordination with other ministries are described in Section IV. Furthermore, many activities listed in the Public Nutrition Strategy (section III) are to be jointly implemented with other ministries and partners which are listed in Table 3 (Section IV).

Food safety is also an area requiring strong inter-ministerial collaboration, as it is under the joint responsibility of the MoPH, MAIL, and MoC. Furthermore, in Afghanistan, the Afghan National Standards Authority, an independent authority, aims to protect the health of the Afghan population, by developing national food standards.

Ministry of Public Health Policies and Strategies

Infectious diseases and poor hygiene practices, including the failure to wash hands frequently with soap are a major cause of malnutrition. All measures designed to reduce the prevalence of and treat these diseases and improve hygiene practices are an essential part of the Public Nutrition Policy and Strategy. However, they are not detailed here, because the policy priorities and strategies designed to address them are described in the general MoPH Policy and Strategy

and in the policies and strategies for Child and Adolescent Health and for Reproductive Health. Hygiene promotion activities are also included in the Health Promotion Strategy. The present Public Nutrition Policy and Strategy is designed to complement these strategies by detailing specific nutrition interventions required to achieve the HNSS 2008-2013 objectives.

Guiding policy principles

These guiding policy principles are inspired by the **public nutrition approach**, which was adopted in the first Public Nutrition Policy and Strategy 2003-2006, as well as the guiding principles in the general MoPH Policy and Strategy (2005).

Addressing the multiple underlying causes of malnutrition: The causes of malnutrition are multi-fold and context-specific. Reducing malnutrition requires treating symptoms, while also addressing underlying causes (food insecurity, poor feeding and caring practices, poor health and hygiene) by implementing preventive interventions.

Understanding of political, economic, social and cultural factors: The categories of underlying causes are determined by economic, agricultural, and trade policies. Additionally, cultural and social norms influence people's ability to access food as well as their food consumption patterns. The MoPH shall advocate for policies that protect the population's nutritional status, and design interventions that are adapted to cultural and social norms.

Multi-sectoral collaboration: Malnutrition cannot be effectively addressed through health interventions alone. Professionals from a broad range of sectors –such as health, agriculture, economy, education, rural development- should contribute to the design and implementation of programmes in public nutrition.

Community-based interventions and civil society participation: Participation of local communities and civil society stakeholders, including private sector, is essential for effectiveness and sustainability. The Public Nutrition Strategy prioritizes interventions that should be implemented at the community level, targeted at vulnerable population groups and households.

Sustainability and use of local resources: Nutrition interventions should as far as possible be based on the promotion of locally available resources, so as to reduce the risk of dependency on foreign products. Interventions should be designed so as to be sustainable and replicable by local communities Food-based approaches, in particular, will be given high priority.

Integration in all levels of the health system: nutrition interventions that are implemented through the health system need to be integrated at all levels of health care, from community-level with CHWs and community support groups to provincial hospitals. All health personnel have a responsibility for promoting good nutrition practices.

Evidence-based interventions and action-oriented strategies: Assessments to describe the extent and severity of the problem of malnutrition, including a description of the risks and causes, must be conducted in order to inform the design or revision of interventions. A process of learning is required, which is evidence-based, involves wide dissemination of lessons learned and demonstration of translating policies into practice.

Section IV: Public Nutrition Strategy 2009-2013

Specific objectives of the Public Nutrition Strategy 2009-2013

The following **specific objectives** will contribute to the realization of the goal and overall objective described in Section II, above. (See targets in Table 4, in the Monitoring and Evaluation section):

1. To increase the awareness about nutrition amongst the general population, and provide caregivers with the knowledge, skills and support that is required to adopt healthy nutrition practices, using food-based approaches.

2. To increase the percentage of child caregivers adopting appropriate infant and young child feeding practices.

3. To reduce the prevalence of major micronutrient deficiency disorders, in particular iron, folic acid, iodine, vitamin A, and zinc, throughout the country and prevent possible outbreaks of vitamin C.

4. To strengthen case management and increase access to quality therapeutic feeding and care at health facility and community levels.

5. To ensure that all commercial and home-produced foods are safe for consumption.

6. To monitor changes in the nutritional situation in Afghanistan and evaluate the impact of nutrition strategies and programs, in order to inform development planning and emergency responses.

7. To ensure that responses to treat or to prevent moderate acute and/or chronic malnutrition are timely and appropriate, and that increases in global acute malnutrition rates are effectively managed.

8. To strengthen in-country capacity to assess the nutrition situation, and design, implement, monitor and evaluate public nutrition interventions.

The strategies designed to achieve these objectives will be primarily targeted at **women, adolescent girls** and **children**. Tackling maternal nutrition is particularly important to transform the vicious inter-generational cycle of malnutrition into a positive inter-generational cycle of healthy nutrition. Furthermore, there is a critical window for a child's optimal physical and mental growth and development, from **when it is still in its mother's womb and during its first two years of life**. Efforts to counter the effects of malnutrition during that time can prevent, or even reverse, the negative impacts of malnutrition. But if the opportunity is missed, the child will suffer the negative consequences of malnutrition for the rest of his/her life.

1. Strategies for Nutrition Promotion at National, Provincial and Community levels

Objective 1: To increase the awareness about nutrition amongst the general population, and provide caregivers with the knowledge, skills and support that are required to adopt healthy nutrition practices, using food-based approaches.

The promotion of healthy nutrition practices is the foundation for fighting against all types of malnutrition, including chronic and acute malnutrition, micronutrient deficiency diseases (MDD), and over-nutrition. However, the priority for this policy and strategy is on reduction of maternal and child mortality.

Current nutrition promotion interventions: achievements and limitations

Since 2002, the Public Nutrition Department and its partners have produced a wide range of nutrition education materials. These materials have been used to introduce nutrition promotion through the media (radio, TV), health facilities, literacy classes, schools (in particular through the MAIL and MoE school garden project), and agricultural projects (home gardens, poultry, food processing).

Interventions implemented to date have unfortunately often been limited to awareness raising. But behaviour change requires proper counselling, adaptation of messages to caregivers' circumstances, transfer of skills and peer support. Various stakeholders are testing community-based nutrition promotion interventions, such as: promoting healthy nutrition through participatory nutrition activities, including and promotion of appropriate use of local products and participatory cooking sessions, linked to household food security interventions; application of the Positive Deviance (Hearth) model; and piloting of community-based Growth Monitoring and Promotion (C-GMP). The C-GMP pilot notably attempts to establish a mechanism to mobilize communities to support various health promotion activities (by linking CHWs to Family Health Action Groups). But these interventions have had so far limited coverage and they need to be developed further.

Strategy 1.1: Advocacy and sensitization on the importance of promoting healthy nutrition

Given the extent of malnutrition problems, there is a need for strong multi-sectoral collaboration and commitment of several ministries and senior levels of Government for success of public nutrition approaches. Therefore, the following activities should be undertaken:

1. Regular advocacy and sensitization of senior government officials and donors on the importance of public nutrition interventions.
2. Strengthen / develop ownership of the Public Nutrition Policy and Strategy amongst other ministries (in particular senior management levels in MAIL, MRRD, MoE, MoWA, and MoC); explore the possibility of developing an inter-ministerial plan addressing nutrition and food security, building on the Public Nutrition Policy and Strategy, ANDS Health and Nutrition Sector Strategy and Agriculture and Rural Development Sector Strategies, and develop the plan if determined possible.
3. Facilitate regular inter-ministerial and inter-agency coordination to support the implementation of the Public Nutrition Policy and Strategy. (see Section V, on institutional mechanisms).

4. Explore the possibility of establishing a High-level Nutrition Committee at the Cabinet, President's Office, and/or Parliament levels to support and supervise the implementation of inter-ministerial work on nutrition and food security, and establish this committee if feasible.

Strategy 1.2: Harmonized Nutrition Promotion across sectors

Nutrition Promotion activities will follow the general approaches developed in the Health Promotion Strategy of MoPH. The following interventions should be carried out:

5. Review existing nutrition promotion activities, so as to identify initiatives that can be strengthened / up-scaled and gaps that should be filled. On the basis of this analysis, define and implement a comprehensive nutrition promotion strategy involving various sectors, that could build on current initiatives by:
   - Expanding the dissemination of nutrition education messages through public media, such as television and radio, as part of regular programmes
   - Improving the quality of nutrition education sessions as part of health service delivery, at all levels of BPHS and EPHS facilities, and including, where possible, breastfeeding counselling and participatory food preparation sessions.
   - Integrating nutrition education messages as part of literacy and school curricula.
   - Integrating nutrition education messages as part of agriculture and community development programmes, in partnership with MAIL and MRRD.
   - Disseminating nutrition messages in partnership with religious leaders.
6. Review formative research results and existing nutrition promotion materials to ensure that: messages are adapted to current practices and nutrition policy priorities (including the importance of a balanced diet to prevent both under- and overnutrition); messages and materials are adapted to the various user groups (e.g. for some groups, it may be recommended to use less oil to prevent chronic disease but others may need more oil – such as pregnant and lactating women and young children); messages are standardized / consistent across materials; identify gaps in existing materials and prepare the development of new materials.
7. According to the results of the material review, reprint existing materials, or develop new materials, according to need.
8. Develop a training strategy for the relevant staff (e.g. EPHS and BPHS health staff, literacy and school teachers, agricultural extension workers, etc.)
9. Nutrition promotion activities should be designed to reach women and adolescent girls, in particular, and emphasize the importance of healthy nutrition for women and children under two years of age.
10. Supervise and monitor the implementation of nationwide nutrition promotion activities through various sectors (including in the BPHS/EPHS).

Nutrition promotion will require close collaboration with other ministries, namely MAIL, MoE, MoWA, MRRD, MoRA, etc. It is absolutely essential that messages are standardized across ministries to avoid undermining MoPH's nutrition promotion activities. For this reason, MoPH will liaise with other ministries to ensure that any nutrition messages they disseminate are cleared by the MoPH Public Nutrition Department before dissemination.

Strategy 1.3: Strengthening of community-based nutrition promotion activities

Community-based approaches for nutrition promotion (including practical demonstrations and participatory food preparation sessions), should be strengthened and expanded by implementing the following activities:

11. Review the lessons learned from the various community-based activities implemented to date, including the C-GMP pilot (BASICS), PD/Hearth model (Save the Children US), and MAIL/FAO promotion of food based approaches and diversified food production.
12. Strengthen nutrition education provided at community-level through the BPHS and develop / strengthen partnerships between MoPH, technical assistance agencies and NGOs so as to expand successful community-based nutrition promotion activities. Develop linkages between nutrition promotion activities and other community development activities (literacy, agriculture, income generation, schools, etc.) to create synergies, enhance effectiveness and sustainability. Partnerships with youth organisations, in particular, can be explored and developed.
13. Develop a training strategy to train the relevant staff on participatory nutrition promotion and develop nutrition promotion activities at community-level (including breastfeeding counselling and participatory food preparation sessions). Women staff, in particular, should be trained to ensure access to women in communities.
14. Develop materials required to support community-level nutrition promotion activities. These materials should be accessible to women and emphasize the importance of maternal nutrition.
15. Provide supervision and on the job support to practitioners providing nutrition promotion at community level. Conduct, where possible, participatory food preparation sessions.
16. Document lessons learned so as to improve community-based nutrition promotion and inform future scale-up.

Strategy 1.4: Nutrition promotion through schools and literacy courses

Education programmes for children and adults provide very promising opportunities for promoting nutrition and mobilizing the future generation to adopt and disseminate healthy nutrition practices. This can notably be done through the National Healthy Schools Initiative and Functional Literacy Initiatives. The following activities have been initiated and should be expanded / continued:

17. Working with the relevant MoE Departments and education programmes, review school and literacy course curricula and effectively integrate practical nutrition skills, adapted to learners' level and areas of interest.
18. Develop appropriate learning aids to be used by school students and literacy learners. This can notably entail integrating nutrition lessons in wider learning materials and textbooks.
19. Develop appropriate training of trainers materials and train the appropriate teacher trainers on conducting practical nutrition promotion activities.
20. In collaboration with MAIL and FAO, advocate for the expansion and institutionalisation of school gardens as part of schools, and where possible literacy classes.

Strategy 1.5: Linkages to food security interventions

In most cases, increased access to diverse foods and/or income is required to enable families to apply nutrition messages. While it is not directly in the mandate of MoPH to improve food security, the MoPH can engage in the following activities:

21. Prioritise food-based approaches in all actions related to improving nutrition, and ensure the promotion of healthy foods is part of nutrition education conducted through the BPHS and EPHS (including, where possible, through participatory food preparation sessions).
22. Advocate for the production, processing and storage of diverse foods responding to local nutritional requirements with stakeholders involved in food production, namely MAIL, private sector, donors and NGOs. Interventions that should be promoted include: home gardening, poultry raising, dairy production, and home-based food processing. Production and consumption of vitamin C rich foods (e.g. germinated wheat, samanak) should particularly be promoted in scurvy-prone areas. Food production and processing as well as income generation that involve and benefit women should particularly be encouraged.
23. Develop partnerships between health service providers (e.g. BPHS NGOs) and stakeholders working in the agricultural sector, in order to develop food security interventions, particularly in areas with high rates of malnutrition and for families of malnourished children (in particular families with children under two years of age).

2. Strategies for Infant and Young Child Feeding

Objective: To increase the percentage of child caregivers adopting appropriate infant and young child feeding practices.

A National IYCF Policy and Strategy has been developed in 2009 to support this objective. The strategies presented here are extracts from the full document. (*Please refer to full document for full details*).

Current IYCF interventions: achievements and limitations

Interventions implemented to date related to IYCF include:

- Formative research on infant and young child feeding practices, including Trials of Improved Practices (TIPS) and recipes;
- Breastfeeding counselling: development of breastfeeding counselling tools and training of 80 breastfeeding master trainers and 3000 counsellors in health facilities
- Celebration of World Breastfeeding Week every year, and launch of a National Breastfeeding Communication Campaign in 2009
- Introduction of re-lactation support as part of TFUs
- Endorsement of the Code of Marketing of BMS by the Ministry of Justice, Cabinet and President in 2009.
- Introduction of the Baby-Friendly Hospital Initiative (BFHI) in four hospitals
- Development of improved family and complementary feeding recipes (MAIL/MoPH)
- Introduction of improved cooking demonstrations in health, literacy and agricultural

projects

The effectiveness of these interventions has been limited by: limited community outreach and coverage; low staff counselling skills; limited support to families to make practical changes. The following strategic components have been designed to address these weaknesses.

Strategy 2.1: Advocacy, regulations, guidelines.

The following activities should be undertaken under this component:

24. The National IYCF Policy and Strategy should be disseminated, advocacy should be carried out and resources mobilized to support its implementation.
25. Measures required to enforce the Code on the Marketing of BMS need to be defined and taken.
26. Measures to support the application of the Maternity Protection Act need to be implemented.
27. A comprehensive set of harmonized guidelines on IYCF needs to be developed and disseminated.
28. These guidelines should include a section on Infant Feeding in Emergencies, which need to be applied in all emergency responses.

Strategy 2.2: Behaviour change through awareness raising, counselling and community support

This strategic component includes the following activities:

29. Harmonized Public Awareness Raising, through national campaigns and regular nutrition education programmes. The IYCF messages should include messages regarding the importance of maternal nutrition.
30. Establishment of community support groups and interventions, through which breastfeeding counselling, complementary feeding demonstrations and participatory cooking sessions, can be associated to other health and food security interventions to enable families to improve the care they give to children. Such support groups can be established with existing community groups (e.g. literacy circles, community health groups, etc.). They should be primarily organised to support mothers and other caregivers.
31. Integration of IYCF in non-health community-level interventions, such as the introduction of IYCF counselling in literacy classes for women, and agricultural projects targeted at women (such as poultry rearing and vegetable gardening).

This component is closely related to nutrition promotion activities described in section 3.1.

Strategy 2.3: Infant and Young Child Feeding in health facilities.

The following activities are planned under this component:

32. Expansion of the Baby-Friendly Hospital Initiative to more health facilities.
33. Integration of IYCF counselling in all health facilities, notably as part of Integrated Mother and Child Health activities.

34. Training of health staff on IYCF, through in-service and pre-service training adapted to the various levels of skills and job descriptions.

3. Strategies to address Micronutrient Deficiency Disorders

Objective 3: To reduce the prevalence of major micronutrient deficiency disorders, in particular iron, folic acid, iodine, vitamin A, and zinc, throughout the country, and prevent possible outbreaks of vitamin C deficiency.

Current micronutrient interventions: achievements and limitations

Promotion of micronutrient-rich foods: Micronutrient-rich foods are currently being promoted through general nutrition education activities described under objective 1. However, these activities have had limited coverage and scope. Furthermore more efforts are required to increase the population's knowledge about the nutritional value of different foods and skills for producing and optimally utilizing micronutrient-rich foods.

Universal Salt Iodization (USI): Since 2003, 25 iodised salt factories have been established through partnerships with the private sector, and the Ministry of Mines (MoM), making Afghanistan self-sufficient in iodised salt. A nationwide campaign has been implemented to promote the use of iodized salt, and regulatory frameworks and legislation on iodised salt has been elaborated. They are currently pending enactment by the Ministry of Justice. An Afghan Salt Producers Association has been established and is committed to manufacturing adequately iodized salt provided that they can procure sufficient good quality raw salt at a reasonable price. Finally, a school-based household iodized salt coverage monitoring system has recently been established, but needs additional support.

The limitations of the USI programme include the following:

- Although Afghan salt production has great potential and should be promoted, the quality of raw salt is currently limited due to contamination with dirt and mud (and maybe lead). Salt iodization factories have no capacity to clean the salt. Consumers therefore prefer imported salt.
- There is no systematic external and legal quality control process, and compliance with standards and official MoPH logo is low (e.g. use of logo for non-iodized salt).
- There are no officially endorsed supportive legislation and enforcement mechanisms
- Awareness amongst the population about the importance of iodized salt is low and there is no systematic monitoring of iodized salt coverage.
- Salt iodization factories currently rely on UNICEF and MI for supplies of KIO3 fortificant; an independent, sustainable fortificant supply should be established.
- Importation of foreign salt (raw and processed) is now illegal, but still occurs illegally and is thus not subject to any quality control mechanisms.

Flour fortification: A pilot of small-scale flour fortification through village mills was conducted between 2003 and 2005. Conclusions showed small-scale flour fortification to be extremely difficult and costly to implement due to the challenge of ensuring quality control, monitoring and supplies for a large number of spread out mills. The decision was therefore made to focus on large-scale fortification through public-private partnerships with large

commercial mills. Flour fortification has now been established in 8 flour factories and a communication campaign promoting fortified flour has been implemented in 2008.

The limitations of the current flour fortification programme include the following:

- The Afghan government has not yet issued national flour fortification standards. Thus, the type of premix is determined and provided by the donor agency, although in coordination with the MoPH and using international standards.
- The quality assurance capabilities of the flour mills is not fully developed, nor is there a national capacity to perform legal quality control checks on fortified flour.
- The private industrial milling sector is only a few years old, and the existing industry association is still weak; this makes it more difficult for the public sector to collectively communicate with the industry.
- Commercially imported flour is not fortified; the importers are unaware of the importance of fortified flour, and there is no national regulation requiring importation of fortified flour even though all the exporting countries have the capacity to fortify flour sent to Afghanistan.
- There is no system to monitor household coverage of fortified flour in urban populations.
- The vast majority of the rural population of Afghanistan would not benefit nutritionally from fortification of industrially milled flour, as they often rely on their own wheat production, milled in village mills.

Supplementation

Supplementation of key micronutrients is now part of the BPHS and EPHS. Iron/folic acid supplements are given to mothers as part of ante-natal and post-natal care and vitamin A supplements are given post-partum. Children receive vitamin A supplements as part of National Immunization Days (NID). Furthermore, preventive distributions of vitamin C tablets are done in scurvy-prone areas (remote, drought-prone districts). Finally, iodine supplements have been distributed in areas with high prevalence of MDDs.

The limitations of the current interventions are:

- The majority of the population does not routinely access health facilities for preventive services (including ante- and post-natal care) and most deliveries are at home, such that the coverage of supplementation is low.
- Limited compliance with MoPH supplementation protocols due to limited capacity and inadequate supplement supplies in many health facilities. Furthermore, the BPHS guidance does not include operational procedures to standardize the delivery of preventive or therapeutic vitamin and mineral supplements.
- Absence of coverage data for supplementation through the HMIS.
- Vitamin A supplementation for children is entirely dependent on NIDs, and no plan has been prepared for vitamin A supplementation post-NID.

Strategy 3.1: Public education on micronutrients

35. Micronutrient-rich foods and healthy feeding practices should be actively promoted through the nutrition promotion activities described under objective 1. Specific nutrition education messages regarding micronutrient intakes and utilization should be developed and widely disseminated. Messages should notably include:

- The importance of eating a diversified diet and promotion of micro-nutrient rich foods
- The impact of tea consumption on iron utilization
- The importance of exposure to sunlight to prevent vitamin D deficiency
- The importance of complying with regular micronutrient supplementation
- The importance of iodised salt and fortified flour

36. All health staff responsible for micronutrient supplementation should provide nutrition advice together with the supplements.
37. The promotion of micronutrient-rich foods should be part of agricultural, rural development, and education programmes, as described under objective 1, above.

Strategy 3.2: Universal Salt Iodization

The target of the MoPH USI campaign is to ensure that > 90% of households have access and consume iodized salt throughout the country. To achieve this target, it is necessary to build upon the achievements of the USI programme implemented since 2002, by taking the following steps:

Advocacy, management and coordination:

38. Establish the National Iodine Deficiency Disorders (IDD) Elimination Committee, led by MoPH and composed of other ministries, private sector representatives, UN and NGOs, to effectively oversee the implementation of the USI strategy at central and provincial levels. (N.B. there are 28 provincial levels committees that should be strengthened). If deemed necessary to generate support for the Committee, organise a High Level meeting to advocate for greater attention and commitment to USI amongst relevant ministries.
39. Establish sustainable and effective mechanisms to monitor household coverage of iodized salt.
40. Establish a schedule for ending the public sector financing of KIO3; encourage the Afghan Salt Producers Association to establish a revolving fund that would cover the costs of a joint purchase of KIO3 to meet the needs of all iodized salt production.

Production of quality iodised salt

41. Advocate with the MoM, private sector representatives and other relevant Government entities to support (financially and technically) the establishment of a national salt processing plant to supply clean and dryer raw salt to the iodization plants.
42. Provide technical and logistics assistance to salt producers (training, spare parts, maintenance support…)
43. Strengthen coordination between different partners involved in salt production

Quality control and supervision:

44. Establish an effective quality control system to monitor the quality of iodized salt at all stages of production, packaging, and marketing, to ensure conformity with the quality standards defined by MoPH and prevailing legislation and respect of the Government logo. This will entail partnerships with private producers, the MoM, MoC, and ANSA.
45. Carry out a study to determine whether domestic rock salt is contaminated with heavy metals, especially lead.

Legislation:

46. Ensure that national legislation for regulating universal salt iodization for human and animal consumption is finalized, enacted and enforced.

Promotion of iodized salt

47. Build the awareness of wholesalers and retailers regarding the importance of iodised salt and develop partnerships with retailers to promote the sale of iodised salt. Provide retailers with the means to test iodised salt.
48. Conduct social mobilization, advocacy and communication activities to explain the causes and consequences of iodine deficiency and promote iodized salt through various media, in schools, health facilities and at community level. Encourage women, in particular, to use iodized salt for their own consumption and their families'.
49. Promote the use of iodized salt in all food processing industries and food aid programmes implemented through schools, health facilities and communities.
50. Expand the school-based iodized salt monitoring project (testing of iodized salt in school classes)

Research

51. Explore the feasibility of double fortification of salt with iodine and iron.

Promotion of iodized salt for animals

52. Promote the use of iodized salt for animal consumption in partnership with existing iodized salt factories. Advocate with MAIL to establish linkages between iodised salt factories and livestock projects.

Strategy 3.3: Flour Fortification

Current efforts to develop flour fortification in Afghanistan should be pursued, by undertaking the following initiatives:

Management and coordination

53. Update and disseminate the national action plan for the implementation of large-scale flour fortification in partnership with the private sector and other ministries, namely, MAIL and the MoC.
54. Strengthen the flour millers' association and establish a coordination system to support flour fortification activities.
55. Establish a schedule for ending the public sector financing of premix for flour fortification; encourage the wheat milling companies to establish a revolving fund to cover the cost of joint premix procurement.
56. Establish a monitoring system to track the coverage and impact of fortified flour.

Scale-up

57. Continue the public-private sector partnership with the industrial wheat flourmills and encourage and enable them to fortify all (low and high extraction) flour.
58. Encourage flour importers across the country to order only fortified flour from neighbouring countries.
59. Collaborate with the government flourmills so that they will also adopt fortification if they start milling wheat again.
60. The new premix will contain iron, zinc, folic acid, vitamin B12 and vitamin A. Explore the possibility to include vitamins vitamin B1, B2 and B3 in the future.

Quality Control

61. Establish an effective quality control system to ensure that all flour millers respect food fortification standards in conformity with food fortification legislation and ANSA and MoPH standards. This will entail partnerships with private producers, the MoC and ANSA.

Legislation

62. Develop, enact and enforce national legislation for regulating flour fortification for local and imported food products.

Promotion:

63. Increase awareness amongst wholesalers and retailers regarding the benefits of fortified flour and develop partnerships to encourage them to sell fortified flour.
64. Advocate and promote fortification of other industrially processed foods such as biscuits, breads, etc.
65. Promote the use of fortified flour in all food processing industries and food aid programmes implemented through schools, health facilities and communities including in emergency situations.
66. Conduct social mobilization, advocacy and communication activities to explain the benefits of fortified flour through various media, in schools, health facilities and at community level. Encourage women, in particular, to use fortified flour for their own consumption and their families'.

Strategy 3.4: Ghee and Cooking Oil Fortification

Fortifying ghee and cooking oil with vitamin A (and possibly vitamin D) is an effective way of increasing vitamin A intake in the general population, especially as about 36% of Afghan households purchase liquid vegetable cooking oil and about 75% purchase ghee (National Nutrition Survey, 2004)13. Between 85% and 90% of the brands were labelled as "Vitamin A Fortified", but upon testing, only about 10% of the labelled products contained any vitamin A. This shows that it is possible for Afghan importers to order vitamin A (and possibly vitamin D) fortified vegetable oils and ghee with correct labelling, but that this will require awareness raising, supportive legislation and quality control mechanisms. The following steps should therefore be taken:

67. Actively engage Afghan importers to order only vitamin A fortified cooking oil and ghee with appropriate labelling.
68. Promulgate and enforce national regulations requiring that all vegetable oil and ghee be fortified with vitamin A (and possibly vitamin D).
69. Support the ANSA and the Customs Authority to establish a monitoring system to ensure that all imported cooking oil and ghee are fortified according to government standards.

[13] CDC. Summary report of the national nutrition survey: Afghanistan, 2004. Atlanta, Georgia, May 2005.

Strategy 3.5: Fortification of complementary foods

Complementary foods as currently prepared by Afghan households often fail to meet the nutritional requirements of young children. Their nutritional content should be primarily improved through the introduction of micronutrient-rich foods (c.f. section 3.2 on IYCF). However, in circumstances where the availability of micronutrient-rich foods is particularly low, the fortification of complementary foods should be envisaged, either through commercial production of fortified complementary foods, or through home-based fortification using special premixes. These should only be promoted alongside with local micronutrient-rich foods. The following can be undertaken:

70. Develop national standards on fortification of complementary foods for children 6 – 24 months of age.
71. Engage local entrepreneurs, businesses and NGO's to produce and/or import easy-to-use, hygienic and appropriately priced complementary foods for children 6 – 24 months of age that could be marketed across the country, or at least within urban and peri-urban settings.
72. In acute food security crisis situations, where access to micronutrient-rich foods is exceptionally low, micronutrient powders can be distributed for use with complementary foods.
73. Explore the feasibility and appropriateness of importing and marketing multi-vitamin and mineral powders for use in complementary foods, through public-private partnerships. The potential for future local production should also be assessed.
74. Ensure that complementary fortified foods and micronutrient powders are not promoted without simultaneously promoting locally available micronutrient-rich foods, fortified staples, and routine supplementation.

Strategy 3.6: Micronutrient Supplementation

Current supplementation efforts must be strengthened to improve compliance with national protocols, quality and coverage.

75. Finalize the revised guidelines and protocols for the diagnosis, prevention and treatment of micronutrient deficiency disorders (in particular on iron, folic acid, vitamin A and vitamin C). Ensure that staff are trained and the guidelines used in all EPHS and BPHS health facilities, in private health practitioners and at community level. These guidelines should notably specify that:
    - all women attending antenatal care are given preventive and curative iron folic acid supplementation at least for the last two trimesters of pregnancy, and as part of postnatal care within the first three months of delivery.
    - all postpartum women receive one dose of 200,000 IU of vitamin A within eight weeks of delivery through maternity health facilities, immunization clinics and communities.
76. Explore the feasibility, and develop protocols and guidelines accordingly, for iron and folic acid supplementation for children (6-23 months, 24-59 months, school age children), in particular in areas where the prevalence of anaemia is above 40%. Iron and folic acid supplementation should also be considered for adolescent girls and women of reproductive age given the importance of iron and folic acid in the very early stages of pregnancy.
77. Administer 100,000 IU dose to all children of 6-11 months and 200,000 IU to all children of 12-59 months every six months through NIDs.

78. Develop a strategy for vitamin A supplementation after NIDs are phased out, for example by including vitamin A supplementation as part of Child Health Days (CHDs) whenever applicable, or integrating vitamin A supplementation for children of 6-59 months of age in routine health service facilities (ensuring that each dose is recorded in a child's card).
79. Zinc supplementation is now officially part of the treatment of diarrhoeal diseases but is only implemented in selected provinces (provinces where the Integrated Maternal and Child Health and Nutrition package is implemented). Efforts are required to ensure that zinc is effectively part of diarrhoeal treatment in all health facilities and at community level.
80. Promote utilization of multiple micronutrients for prevention of MDDs in pregnant and lactating women and young children in emergency and other required situations, ensuring that wherever they are promoted and utilized routine supplementation (iron, folic acid, vitamin A) should be continued.
81. Administer preventive vitamin C doses to communities identified at high risk for vitamin C deficiency (scurvy) outbreaks for 2-3 months during winter.

Note about iodine supplementation: in the past, distributions of iodine capsules were done in high-prevalence areas. These are no longer necessary given the greater availability and access to iodised salt.

4. Strategies for Adequate Management of Severe Acute Malnutrition

Objective 4: To reduce mortality from severe acute malnutrition through strengthened case management and increased access to quality therapeutic feeding and care at health facility and community levels.

Current interventions: achievements and limitations

Since 2002, 47 TFUs have been established as part of provincial hospitals and selected district hospitals in 32 provinces. However, the coverage of TFU's remained limited given access difficulties between provincial or district hospitals and villages. Furthermore, defaulter rates were high, because few mothers are able to stay for the entire length of treatment in the TFU. For these reasons, a simplified version of Community-based Management of Acute Malnutrition (CMAM) was piloted in partnership with BPHS NGOs in 9 provinces[14]. A Supplementary Feeding Programme (SFP) component was added in early 2009 to the CMAM pilot in selected areas for the management of moderate acute malnutrition and follow-up of treated SAM patients.

The results of the experience with TFU's and CMAM pilot showed that:

- The coverage of treatment is significantly higher with an outpatient component than with TFUs alone.
- It is difficult to conduct thorough community mobilization and active case finding from community screening sites, due to weak functional community network, work load of

[14] The community-mobilization and active case finding components of CMAM were limited / sometimes absent due to access constraints. SFPs were not part of the main pilot.

CHW, turnover of CHW and security constraints. However, it is possible to integrate screening and referral of SAM patients as part of CHWs and health staff's regular work.

- Complicated cases should be managed in hospital or CHC-based TFUs (equivalent to stabilization centres).
- It is possible to integrate an out-patient treatment component for non-complicated and stabilized cases in health facilities, in particular comprehensive health centers (doctors can follow-up the SAM patients and patients can receive RUTF rations from the pharmacy).
- The SFP component if included will likely need additional resources and capacity when implemented as part of CMAM.
- The quality of treatment provided in TFUs, and in CMAM pilots has proved variable and often poor, due to low staff training, limited staff, poor staff mobilization and weak supervision.
- The cost of SAM treatment per child is very expensive. Out-patient treatment is less expensive then in-patient treatment.
- Prevention activities, such as IYCF counselling, are rarely associated with treatment of SAM, making patients vulnerable to relapse.

The proposed strategy for the treatment of SAM combines elements from the TFU and CMAM approaches to maximize opportunities and limit the weaknesses identified to date. The strategy described below shall be applied as part of BPHS. Interventions may differ in emergency situations where global acute malnutrition rates exceed 10% or 5% in presence of aggravating factors (*see section on response to moderate acute and chronic malnutrition*).

Guidelines supporting the implementation of the present strategy need to be developed, as well as an adequate training programme for all health staff involved in the management of SAM. Special attention should be paid for programme monitoring and evaluation.

Strategy 4.1: Improved Community Mobilization and Screening of Acute Malnutrition at Health Facility and Community Levels.

The detection of children suffering from severe acute malnutrition is essential to refer them rapidly to the appropriate service and provide them with treatment as soon as possible. It is particularly important to rapidly refer children under two suffering from SAM, since the consequences of malnutrition can be irreversible beyond two years of age. The following is required:

82. Establish and strengthen systematic screening of children in health facilities (both out-patients, in-patients), and establish a system of referral with the nearest treatment facility (TFU for complicated cases, health facilities with outpatient treatment services for non-complicated cases).
83. Build the capacity of CHWs to screen children at household and basic health post levels, using MUAC. They should refer children with MUAC <11.5 cm to the nearest Basic Health Centre for a complete diagnosis and referral to the appropriate treatment facility. The screening of SAM by CHWs can be associated to other health-related community mobilization activities and groups, such as Community-based Growth Monitoring and Promotion and Family Health Action Groups.
84. Establish a follow-up system whereby cured children are referred to the CHW and Family Health Action Groups for support in preventing relapse. Absentees should be

followed up by CHWs and referred back to the health facility for therapeutic food and care. Reasons for defaulting should be identified and traced.

Strategy 4.2: strengthen network of Therapeutic Feeding Units for complicated cases

Currently, TFUs have been established in provincial and selected district hospitals. However, the quality of care, and coverage of TFU's need to be expanded, in particular for children suffering from SAM with medical complications. Specific attention must be given to children under two years of age. The following activities must be implemented:

85. Expand the number of TFUs to more district hospitals, in particular in areas where high numbers of children suffering from acute malnutrition are reported.
86. Ensure that children suffering from SAM with medical complications are referred to TFUs for in-patient care during the stabilization phase.
87. Establish a system of referral for stabilized cases and patients without medical complications to the nearest facility providing out-patient care.
88. Ensure that MoPH guidelines for health facility based management of SAM are applied in all paediatric facilities.
89. Provide in-depth training and regular technical support to staff working in TFUs.
90. Ensure that appropriate therapeutic feeding supplies [F75, F100, RUTF, ReSoMal, Complex Mineral and Vitamins (CMV)] are included in MoPH central/provincial stock procurement, distribution and control system with an appropriate monitoring system.
91. Provide health and nutrition counselling and education to caregivers of children admitted with SAM in paediatric facilities, in particular on infant and young child feeding practices, and good hygiene. Mothers should be counselled on the preparation of improved complementary feeding recipes and practices using local resources, and should be encouraged to give them as part of the treatment and thereafter.
92. Integrate psychosocial care in all paediatrics facilities managing SAM cases in order to stimulate the children and support caregivers in maintaining good caring and feeding practices.
93. Wherever possible, put patients' families in contact with organizations providing food security interventions (e.g. home gardening, poultry programmes) to support households in preventing the relapse of the child or future cases of malnutrition. For example, vegetable gardens can be established in local hospitals as demonstration plots.
94. Keep records of all admitted cases of SAM in all health facilities, together with treatment outcomes (cured, died, defaulter, non cured, weight gain and length of stay, etc.) and report figures to the Public Nutrition Department central level on a monthly basis.

Strategy 4.3: Out-patient treatment of SAM for non-complicated cases

Children suffering from SAM without medical complications can be treated and followed through out-patient care, in facilities where staff have received adequate training and supplies are available. Specific attention should be given to children under two years of age.

95. Establish out-patient care based on the CMAM guideline for SAM patients without medical complications in provincial and district hospitals as well as Comprehensive Health Centres in areas where there is a high caseload of children suffering from SAM. Explore the feasibility of establishing quality out-patient care as part of Basic Health Centres.

96. Ensure that patients are followed-up regularly and referred to the nearest TFU should they suffer from medical complications.
97. Develop guidelines for out-patient management of SAM and ensure they are applied in all paediatric facilities providing out-patient care.
98. Provide in-depth training and regular technical support and supervision for staff working in facilities providing out-patient care.
99. Ensure that appropriate therapeutic feeding supplies such as RUTF, are included in the pharmacy and that an appropriate distribution and quality control system is in place.
100. Provide health and nutrition counselling and education to caregivers of SAM patients, in particular regarding infant and young child feeding practices and good hygiene. Mothers should be counselled on the preparation of improved complementary feeding recipes and practices using local resources, and should be encouraged to give them as part of the treatment and thereafter.
101. Wherever possible, put patients' families in contact with organizations providing food security interventions and support (e.g. home gardening, poultry programmes) to support households in preventing the relapse of the child or future cases of malnutrition. For example, vegetable gardens can be established in CHCs as demonstration plots.
102. Keep records of all cases of SAM followed through out-patient care, together with treatment outcomes (cured, died, defaulters, non cured, weight gain, length of stay, etc.) and report figures to the Public Nutrition Department central level on a monthly basis.

5. Strategies for Food Safety and Quality Control

Objective 5: To ensure that all commercial and home-produced foods are safe for consumption.

Current initiatives: Achievements and limitations

Ensuring food safety and developing national food quality control capacity is a complex task involving education and training of the public, but also of a wide range of professionals in the public and private sectors. It also requires strong inter-sectoral collaboration involving health, agriculture and commerce (see Annex 3 for common sharing of responsibilities between relevant ministries). To date several achievements have taken place:

- In MoPH: Establishment of the Food and Drug Quality Control Department in the Afghan Public Health Institute, and refurbishment and equipment of laboratories to conduct analyses of water quality, iodised salt, fortified flour and other food stuff. This department runs a food control lab (which is currently poorly equipped and staffed), organizes food inspections in the local bazaars, and delivers certificates for certain products (e.g. water).

- In MAIL: food safety and quality control issues are managed by the Quality Control Department and relevant technical departments. Several donor-supported projects are contributing to the development of quality control systems related to specific products, in particular animal food products (meat and dairy), horticulture products, and to pesticide use. Each of these projects is working on the development of legislation, regulatory frameworks, standards and procedures, refurbishing and equipping laboratories, training technicians, and laying the foundations for certification systems. They are working closely

with associations representing the private sector stakeholders involved in the industry (e.g. Afghan Veterinarian Association (AVA), the National Union of Horticulture Development in Afghanistan (NUHDA), which are foreseen (in the draft legislation) to become certifying agencies for their respective fields. The USAID funded RAMP project had also established a laboratory in the Raisins and Other Dry and Fresh Fruits and Vegetables Promotion Institute.

- Through the MoC, the Afghan National Standards Authority was established as the official authority to issue standards and certificates. ANSA is also planning to set-up a central laboratory, which would include food quality control facilities.

Given the risk of duplication, FAO has undertaken several activities to encourage inter-ministerial and inter-donor coordination. These included supporting Afghanistan in becoming a member of Codex Alimentarius, and, together with WHO, has supported representatives of MAIL and MoPH in attending several Codex Alimentarius conferences and trainings on food safety management. FAO also facilitated a food safety steering committee in 2006 and 2007 and organized several workshops to support inter-ministerial planning and decision-making and inform strategic planning related to food safety. Its activities unfortunately ceased due to a lack of dedicated human resources to support the coordination process.

Initiatives related to quality control and food safety implemented to date have been limited by the lack of an overall guiding regulatory framework and lack of institutional mechanisms to ensure coherence between different ministries' initiatives and donor-funded projects. This has limited the effectiveness of capacity-building activities. This also creates a risk of uncoordinated and inefficient quality management procedures and certification systems being established, which would create obstacles to marketing (domestic and international), increase the risk of corruption, and reduce the credibility of Afghan products. Most importantly, very little attention has been given to public education and training of food producers and retailers on basic food hygiene and food safety.

Strategy 5.1: Food safety education for consumers, food processors, retailers and traders

The foundation for any food safety and quality control system is the education of consumers, food producers, processors, retailers and traders. This is what can make foods safe for consumption. All other measures (described under strategy 5.2) are merely designed to control that food safety principles are applied; they do not, in themselves, make foods safe. For these reasons, the following activities are essential:

103. Public awareness campaign and regular education of Afghan households on food hygiene and food safety. This can notably be done as part of regular nutrition education sessions through BPHS facilities, as well as through nationwide campaigns using various media.
104. Support to MAIL efforts on the education of farmers and commercial food producers and processors regarding food safety. Note: these efforts are usually carried out through the agricultural sector, as part of regular agricultural extension activities and through the promotion of Good Agricultural Practices, using a "Farm-to-Fork" approach.
105. Sensitization and education sessions for food retailers and traders (including street food vendors) on food hygiene and food safety. This can be done in close

collaboration with MAIL (notably for meat quality, which usually falls under Public Veterinary Health), with the MoC and Municipalities.

Strategy 5.2: Establishment and strengthening of a food quality control system

The establishment of a food safety and quality control system is a complex enterprise requiring strong inter-ministerial collaboration, notably with MAIL, MoC, ANSA and the Private Sector. Several activities are required to establish such a system:

106. Together with other relevant government institutions and private sector representatives, define an effective management system for food safety and quality control, clarifying the respective roles of the various ministries and institutions involved. (See the graph in Annex 3, which can be a basis for discussion regarding the sharing of responsibilities between ministries)
107. Under the leadership of ANSA, and in collaboration with MAIL and relevant private sector representatives (e.g. producer associations) define food safety and quality standards and legislation, in line with international food safety standards (in particular Codex Alimentarius).
108. In collaboration with ANSA, MAIL, MoC, and private sector representatives, establish a system of certification and labelling of locally produced foodstuffs, guaranteeing they are safe for consumption and respect national food quality standards. Note: it is important that there is a coherent system of certification across ministries to avoid bureaucratic delays for producers, loss of competitiveness, and corruption (e.g. requests for under the table payments to receive certificates).
109. In collaboration with ANSA, MAIL, MoC and other relevant institutions, develop an effective inspection system to control the quality of foodstuffs that are sold in local markets, and at border controls, while avoiding duplication of efforts between different ministries. Train food inspectors on the application of national standards and on sampling and inspection techniques.
110. In collaboration with ANSA, MAIL and Universities (in particular Faculties of Agriculture, Medicine, and Pharmacy) develop national laboratory testing capacity. This entails establishing or strengthening existing labs, making sure they are properly equipped and staffed, and providing comprehensive trainings for lab technicians. Given the considerable investments involved, it is essential that duplication between ministries and faculties be avoided. Collaboration with the private sector should also be explored.

6. Strategies for Nutrition surveillance, Monitoring and Evaluation

Objective 6: To monitor changes in the nutritional situation in Afghanistan and evaluate the impact of nutrition strategies and programs, in order to inform development planning and emergency responses.

Current surveillance and Monitoring and Evaluation: achievements and limitations

Since 2002, the nutrition situation has been assessed and monitored using various tools and methodologies. Initially, provincial or district level surveys were carried out in selected areas, primarily by NGOs. Nutritional survey guidelines were developed to ensure the same methodology was used across surveys. In 2004, a nationwide National Nutrition Survey was carried out by MoPH with technical support from CDC, Tufts University and UNICEF.

Regular nutrition screening was introduced as part of routine information collection in health facilities and at community level (by CHWs using MUAC), through the Health Management Information system (HMIS). Nutrition indicators, such as household food consumption and coverage of iodised salt were introduced in the NRVA 2003, 2005 and 2007/08. Nutrition indicators are also included in Multiple Indicator Cluster Surveys (MICS), including the planned survey for 2009. *See annex 1 for a mapping of nutrition indicators currently collected*.

Limitations of current surveillance activities include the poor reliability of collected data and the variability of data quality. It is difficult to obtain representative data especially at provincial level, particularly with surveys (the sampling is not adequate to provide provincial and district-level estimates). Security problems and other access constraints make it very difficult to conduct nationwide surveys. It is therefore important to focus on obtaining good trend data through existing surveillance systems.

Monitoring and evaluation activities are currently weak. Very few monitoring indicators for nutrition interventions are collected as part of routine health service monitoring, such that data regarding the coverage of key interventions (e.g. micronutrient supplementation, breastfeeding counselling) is not available. Very few evaluations have been carried out (mainly one on SFPs in 2003), and there is no mechanism for effectively sharing lessons learned from M&E data.

Strategy 6.1: Strengthen nutrition surveillance

The nutritional situation should be regularly monitored, by integrating relevant nutrition indicators in existing government surveillance systems, notably food security surveillance system, the HMIS and the Disease Early Warning System (DEWS). The following activities should be undertaken:

111. Improve the quality and reliability of nutrition surveillance carried out in health facilities and at community level by CHWs as part of the HMIS and DEWS when/where relevant. If possible, collect the data disaggregated by age groups so as to monitor the prevalence of malnutrition amongst children under 6 months, 6-23 months, and 24-59 months. This entails providing adequate training to health staff and CHWs, developing appropriate job aids and supervision tools, conducting regular supervision visits, and conduct data quality control on HMIS data. Furthermore, the same case definitions should be used across all facilities to ensure comparability.
112. Ensure that appropriate indicators relating to malnutrition prevalence and underlying causes are collected as part of national health surveys, such as the Afghanistan Health Survey, MICS, and LQAS. Where possible, disaggregate the data by age group, as above. Indicators and case definitions should be consistent across surveys to ensure consistency. The Public Nutrition Department should be consulted in the validation of nutrition results.
113. Explore possibilities of integrating indicators of maternal nutritional status as part of regular health monitoring systems and surveys.
114. Ensure that indicators for nutritional risk are collected and interpreted as part of food security surveillance systems, in particular NRVA, FAAHM, and FEWSNET. This entails working with MAIL, MRRD, Central Statistics Office and other partners to review and complement existing indicators, and contribute to staff training, and data analysis to ensure data is reliable.

115. Maintain a database of all nutritional information collected through the various systems and surveys (health-related and food security-related). Use this information to produce an annual report describing the nutritional situation and progress on key indicators.
116. If circumstances are favourable (security, access) and resources are available, conduct a national nutrition survey before 2013. It is recommended practice to conduct such surveys every 3 – 5 years to monitor changes in national prevalence of acute and chronic malnutrition and underweight as well as the prevalence of micronutrient deficiency diseases and key indicators for IYCF.
117. If timely nutritional surveys are conducted at district or province levels, ensure that they respect the existing MoPH Guidelines on Nutritional Surveys (in line with international guidance); that data is disaggregated by age, and that findings are appropriately interpreted.

Strategy 6.2: Evidence-based action and Monitoring and Evaluation

The following actions should be applied to ensure that nutrition programmes are evidence-based and adapted to local circumstances:

118. Programme development is based on demonstrated context-specific analyses and understanding of underlying causes of malnutrition using adapted research methods.
119. Successes and failures of previous nutrition interventions in Afghanistan or other countries within the region, with similar nutritional problems and challenges, are applied appropriately.
120. An effective monitoring system is established and strengthened to monitor the implementation of the Public Nutrition Policy and Strategy. This entails integrating monitoring indicators for key nutrition interventions (supplementation, IYCF, SAM treatment, etc.) as part of the MoPH M&E system and other surveillance tools (see also section on Monitoring & Evaluation, below, and Annex 1 for recommended indicators).
121. Provincial Nutrition Officers should carry out regular monitoring visits to health facilities and communities to assess the quality of routine nutrition interventions. They should be supported by central level Public Nutrition Department staff and other health departments. Such visits should be coordinated with Provincial Health Officers and GCMU.
122. Programme evaluations and impact assessments are carried out regularly, shared and disseminated widely, in order to systematically document impact and justify use of limited resources.
123. Nutrition guidelines are developed on the basis of updated knowledge and regularly revised based on lessons learned.
124. Information sharing mechanisms are established with other ministries addressing malnutrition (notably MAIL, MRRD, MoWA, MoE, and MoRA) in order to jointly monitor progress in the fight against malnutrition, share lessons learned and design joint programmes.

7. Strategies for Adequate prevention and response to moderate acute malnutrition and/ or chronic malnutrition

Objective 7: To ensure that responses to treat or to prevent moderate acute and/or chronic malnutrition are timely and appropriate, and that increases in global acute malnutrition rates are effectively managed.

Since 2002, the MoPH Public Nutrition Department and its partners have largely been engaged in a transition from emergency interventions to longer-term, government-led development interventions. Furthermore, food assistance, the main emergency response, is managed by other ministries (MRRD, MAIL, and National Disaster Response Committee) and the World Food Programme (WFP). Emergency responses therefore represent a small portion of MoPH nutrition interventions, but it is important to maintain a response capacity, given Afghanistan's vulnerability to crises. Furthermore, nutrition partners can play a particularly important role through nutrition surveillance, as nutrition indicators provide information on the severity of a crisis, highlight worst-affected areas, and an analysis of underlying causes can inform the design of emergency responses in other sectors (e.g. are increases in malnutrition due to an increase in diarrhoea or acute food shortages).

Current emergency nutrition interventions: achievements and limitations

The main achievements carried out in relation to nutrition in emergencies include:

- On Supplementary Feeding Programmes:
  - Evaluation of SFPs in 2003
  - Development of guidelines on SFPs in 2003
  - New SFP pilot and training in 2009
  - Revision of SFP guidelines in 2009 as part of the CMAM guideline
- Piloting of Community-based Management of Acute Malnutrition (2007-2009)
- Establishment of the Nutrition Cluster in 2008
- Rapid Assessment in 22 provinces in 2008

Despite these achievements, the response capacity of nutrition partners remains limited, contributing to significant delays (e.g. the 2009 SFP pilot is in response to the 2008 food crisis, although the food prices, which remain well above pre-crisis norms, have decreased and the 2009 harvest is good, however not always translating to improved/diversified per person food intake). Needs assessment capacity remains limited, which makes it very difficult to obtain reliable estimates of crises' impacts. Furthermore, the underlying causes of malnutrition in emergency situations are rarely analysed, and interventions tend to be "supply-driven". They often fail to effectively meet the needs of crisis-affected populations. Finally, while the coordination between nutrition stakeholders has been greatly improved with the establishment of the nutrition cluster, coordination with other emergency stakeholders (namely food security and health and hygiene) needs to be strengthened.

Strategy 7.1: Appropriate Assessments, Design and Implementation of Timely and Relevant Interventions

Nutrition partners should aim to achieve the following in crisis situations:

125. When a crisis breaks out, a rapid assessment (where possible using participatory methods) is carried out to determine the level of nutritional risk –including access and availability of food, health and hygiene conditions, and caring capacity- as well identify local resources and opportunities for response.
126. Interventions addressing the population's immediate food needs and underlying causes of malnutrition are identified (where possible through consultation with the affected population) and implemented effectively, in a timely manner, and using local resources where available.
127. The physiologically vulnerable, including women of reproductive age (15 – 49 years), infants less than six months and children under five years old are given priority in assessments and action.
128. Sub-population groups including marginalized groups, those who have lost their livelihoods and those who have lost access to social support structures, are given priority in assessments and action

Improving the quality of emergency assessments and response capacity as described above requires that the following activities be undertaken:

129. Identify partners with skills and capacity in nutrition and food security in each Province in preparation for emergency response.
130. Provide training for nutrition partners (e.g. Provincial Nutrition Officers and BPHS NGOs) on rapid assessment methods and on the design of appropriate emergency interventions (including food and non-food based interventions)
131. Determine criteria for when a rapid assessment should be initiated (e.g. marked increase in GAM indicated by HMIS data; signs of food insecurity risks –e.g. drought, etc.)
132. Establish a monitoring, evaluation and reporting system for nutrition emergency responses

Strategy 7.2: Appropriate use of food assistance

While the management of food assistance does not fall under the responsibility of MoPH, MoPH has a role to play in ensuring that food assistance meets the nutritional needs of specific target groups and that food rations are safe, culturally acceptable, and effectively targeted to the most vulnerable groups.

The following activities can be implemented to ensure these principles are respected:

133. Participate in the definition of targeting criteria for food assistance for the most vulnerable groups of the population. Findings from research on vulnerability in Afghanistan (e.g. by Afghan Research and Evaluation Unit and NRVA) and previous evaluations must be used when determining targeting criteria.
134. Monitor the adequacy of the food assistance basket to ensure that it is appropriate in quantity and quality, is fit for human consumption, meets the needs of young children and is appropriately fortified.

135. Ensure that ready-prepared foods and BP-5 biscuits (compact dry meal) are only used in situations of emergencies e.g. where populations are on the move or under carefully supervised situations.

Strategy 7.3: Management and prevention of Global Acute Malnutrition and Chronic Malnutrition.

If the prevalence of GAM is greater than 10% or >5% in presence of aggravating factors, SAM treatment services should be expanded if required, and targeted Supplementary Feeding Programmes (SFP) for children under five and pregnant and lactating women should be established for the management of moderate acute malnutrition. If GAM is greater than 15% or 10% with aggravating factors, SAM treatment services should be expanded if required, and blanket SFP should be established for children under five and pregnant and lactating women. In the case of GAM greater than 10%, there is evidence of seasonal increase in malnutrition, or high levels of chronic malnutrition, blanket supplementary feeding may also be considered for children aged 6-24 months as a preventative measure in coordination with relevant stakeholders.

In order to comply with the policy described above, the following activities should be implemented:

136. Training of nutrition partners on adequate appropriate survey methods (N.B. the prevalence of GAM should be estimated through random sampling in a given geographical area, not purposive sampling). (see also section 3.6.2)

For management of Severe Acute Malnutrition:

137. Determine criteria above which routine SAM treatment facilities should be upgraded or expanded to cope with increases in admissions.
138. Develop guidelines adapted to Afghanistan for the management of SAM. These can be a section of SAM treatment guidelines developed for routine services including emergency situations.
139. Train health facility staff on SAM treatment strategies in routine services and emergency situations.

For management of Moderate Acute Malnutrition (MAM):

140. Review the SFP guidelines and update SFP training materials adapted to the Afghan context.
141. Conduct training of nutrition partners on the implementation, including monitoring and reporting, of SFPs.
142. Ensure SFP food rations are adjusted to the Afghan context. When food is provided, food distributions should be combined with cooking demonstrations on improved local recipes, using the commodities provided and locally available foods.
143. In collaboration with WFP, update systems for SFP food management, including stock control, distribution and monitoring within MoPH facilities.
144. The SFP should be implemented in coordination with relevant health and nutrition partners to ensure provision of whole programme packet (eg. Trainings on complementary feeding, healthy family food, breastfeeding etc)

8. Strategies for Human resource capacity development on Public Nutrition

Objective 8: To strengthen in-country capacity to assess the nutrition situation, and design, implement, monitor and evaluate public nutrition interventions.

Strengthening capacity in Afghanistan on public nutrition is absolutely central for the effectiveness and sustainability of all nutrition interventions.

Current capacity-development interventions: achievements and limitations

The main achievement regarding capacity-development for public nutrition has been the establishment of the MoPH Public Nutrition Department, and the recruitment and training of Provincial Nutrition Officers. Furthermore, many nutrition training and workshops have been conducted on various nutrition topics for health and other staff at central, provincial, district and community-levels. However, too few professionals working in health and other nutrition-related sectors (agriculture, education, etc.) have expertise and experience in public nutrition. Furthermore, the sustainability and effectiveness of training efforts is currently weak, as training are not institutionalized as part of pre-service training (university / institute curricula) and in-service training.

Strategy 8.1: Integrate public nutrition in pre-service and in-service training

Training on public nutrition should be integrated in the relevant pre-service and in-service training in the fields of health, agriculture, education, economics and social affairs, to ensure that current and future professionals working in areas related to public nutrition have the knowledge and skills required to address malnutrition problems.

The following activities will be necessary:

145. Detailed identification of key civil servants' training needs related to nutrition, on the basis of their Terms of Reference and existing skills.
146. Updating the mapping of existing pre-service and in-service training programmes and selecting training programmes to collaborate with. The selection should be done according to priority training needs, interest by the institutions to collaborate, as well as opportunities for large coverage and sustainability.
147. Establishment of partnerships with the relevant training institutions and programs to develop curricula jointly and mobilize the necessary human resources. Partners could include:
    - In health: Medical faculties (in particular Kabul Medical University), intermediate medical schools, midwifery and auxiliary midwifery schools, Health Sciences Institute, IbnSina Public Health Program, CDC Field Epidemiology Training Program Medical Universities
    - In agriculture: MAIL, faculties of agriculture
    - In education MoE, Ministry of Higher Education
148. For in-service training, close collaboration should be strengthened with the IMCI department to ensure nutrition modules are continuously part of IMCI training for all relevant health staff.
149. Review of curricula and development of adapted training modules, in collaboration with teaching staff from the partner institutions (in Dari and Pashto).
150. Training of trainers and teachers from the partner institutions, to enable them to integrate the modules in their own curricula.

151. Regular training on public nutrition topics conducted as part of in-service and pre-service training, with regular technical supervision by the Public Nutrition Department.
152. Continue to expand the Public Nutrition Resource Centre and make public nutrition materials available to a wider public.

Strategy 8.2: Support to the Public Nutrition Department

The success of the Public Nutrition Policy and Strategy largely depends on having strong leadership and technical support. This will be primarily provided by the Public Nutrition Department. The Department therefore requires adequate technical, human and logistics resources to support the Public Nutrition Policy and Strategy implementation. The following activities should be implemented to mobilize these resources:

153. Identify key resource constraints (logistics, staff, money) preventing the Public Nutrition Department from fully carrying out its mandate. Mobilize resources to address these constraints.
154. Strengthen coordination mechanisms to use available technical and financial resources more effectively and improve support to the Public Nutrition Department. (See also institutional mechanisms, below).
155. Develop a network of national staff, among Ministry, UN and NGO partners, with knowledge and skills in public nutrition, which can provide technical support for key issues in the Public Nutrition Policy and Strategy.
156. Advocate for greater political commitment and resource allocation for nutrition amongst donors, central and provincial Government, and implementing partners, notably by participating in relevant meetings, coordination mechanisms and sensitizing senior government officials on nutrition.
157. Establish and strengthen relationships with well-recognized academic institutions abroad to offer fellowships and scholarships for Afghan health professionals interested in specializing in graduate level training in human and public nutrition and related fields (e.g. nutrition epidemiology, food science, nutrition and health communication, nutrition policy, etc.).

Section V: Institutional Mechanisms

Institutional framework and main partners

The implementation of the Public Nutrition Policy and Strategy will be supervised and monitored by the MoPH Public Nutrition Department, at central level, and at provincial level, through Provincial Nutrition Officers. Certain interventions are jointly supervised with other MoPH Departments, such as the IMCI, Health Promotion, EPI, HMIS and other departments. The Public Nutrition Department will regularly report to the Consultative Group on Health and Nutrition and seek members' technical advice. The Inter-Ministerial Committee can provide a forum for discussing, advising and taking decisions related to activities jointly implemented with other ministries. Furthermore, the possibility of establishing a High-Level Committee for Nutrition at the Cabinet, President's Office and/or Parliament level will be explored and implemented if feasible, as described under strategy 1.1, activity 4.

The Public Nutrition Department currently receives technical and financial support from various technical agencies, in particular WHO, UNICEF, FAO, WFP, Micronutrient Initiative (MI), USAID/BASICS, IBFAN, BPNI, and WABA.

Implementation of the Public Nutrition interventions is mainly done through partnerships with NGOs (in particular BPHS NGOs, but also NGOs working in agriculture, rural development and education) and the private sector (notably for food fortification).

Collaboration with other ministries is central to each of the specific objectives and associated strategic components described in the Public Nutrition Policy and Strategy. The main ministries involved in public nutrition interventions include: MAIL, MRRD, MoE, MoWA, MoRA, MoC, MoJ, MoM. Table 3, below, maps the roles and responsibilities of these partners for each of the specific objective and associated strategic components.

Coordination mechanisms

Effective coordination mechanisms are essential to the success of the Public Nutrition Policy and Strategy. A number of coordination mechanism are already in place. These should be strengthened and built upon. In the case where working groups are in place, a co-chairing organisation should be identified. This co-chair shall be responsible for assisting the Public Nutrition Department in organizing meetings, preparing minutes and contributing to logistics costs. Members of these working groups should be assigned clear responsibilities and collectively take the responsibility for ensuring that the specific objectives of the Public Nutrition Policy and Strategy are achieved, monitored, evaluated and reported on regularly.

In cases where working groups are not established, alternative coordination mechanisms are proposed. Specific coordination systems for each specific objective are presented below.

Nutrition promotion: Nutrition promotion is both a specific objective *per se*, and an integrated part of each nutrition strategy. All of the working groups listed below will therefore address nutrition promotion issues. For example, community-based nutrition promotion activities are being discussed as part of the IYCF working group. However, some tasks require a comprehensive vision of nutrition promotion activities. These include: the review of all nutrition education materials to identify gaps and ensure coherence across materials; coordination with other MoPH Health promotion activities; the coordination with other

ministries involved in nutrition promotion. Coordination for such issues can be ensured through:

- Timely meetings according to need
- Participation in the IEC working group of MoPH
- Regular work of the Public Nutrition Department staff (e.g. ensuring coherence between nutrition promotion activities planned in the different working groups)
- Participation in other existing coordination groups such as the Healthy Schools Initiative and Functional Literacy Initiative.

Infant and Young Child Feeding: An IYCF Working Group has been operational since 2002. Its core members include UNICEF, WHO, FAO, WFP, MI, USAID/BASICS, Save the Children US and Save the Children UK. Other NGOs and ministries are also invited to participate depending on the objectives of the working group meetings. Public Nutrition Department and UNICEF and/or USAID/BASICS are currently co-chairing this working group. The working group has recently finalized a complete IYCF Policy and Strategy, has elaborated a work plan and costing. Regular meetings are held to ensure planned activities are taking place.

Micronutrient working group: A Micronutrient Working Group has been operational since 2002. Its core members include MI, UNICEF, WHO, WFP, and FAO. Public Nutrition Department and MI are co-chairing to the working group. MI is also providing technical assistance to the Public Nutrition Department and working group to elaborate a Micronutrient Investment Plan, which is nearing completion.

Severe Acute Malnutrition: A SAM Working Group has been operational since 2002. Its core members include UNICEF, WHO, WFP, and NGOs implementing the Community-based Management of Acute Malnutrition pilot project (Oxfam Novib, SC-UK, SC-US, CHA, STEP, IbnSina, Cordaid, AHDS and AMI). MoPH, WHO and/or UNICEF are co-chairing the working group. This Working Group should now focus on capitalizing the lessons learned from the CMAM pilot and establish a clear plan to action to apply the strategy for SAM treatment presented in the present Public Nutrition Policy and Strategy.

Food Safety: Food safety in MoPH falls under the responsibility of the Food and Drug Quality Department in the Afghan Public Health Institute. A food safety steering committee was operational in 2006 and 2007, and several inter-ministerial meetings were held on this issue at cabinet level. However, these efforts were not pursued partly due to lack of political and donor commitment to support coordination on this issue. There is currently no clear structure or mechanism to support continuous inter-ministerial and inter-institutional dialogue on food safety and to ensure that a coherent food safety system is put in place. The question of coordination mechanisms for food safety should be raised at cabinet level and discussed amongst senior government officials, and donor support should be sought to develop a coherent food safety and quality control system.

Nutrition surveillance and M&E: A specific working group for nutrition surveillance does not exist, but nutrition surveillance issues are essentially discussed in the Nutrition Cluster (see below). The Nutrition cluster should continue to be the forum for discussions regarding nutrition surveillance amongst nutrition partners. But Public Nutrition Department and nutrition partners should regularly liaise with the HMIS departments and other MoPH Departments involved in the Health Information System, notably by participating in tasks forces and

meetings regarding HMIS, health surveys, disease surveillance and M&E. The Public Nutrition Department and its food security partners (FAO and WFP) should establish linkages with food security surveillance systems and corresponding coordination mechanisms (N.B. A Food security surveillance coordination mechanism has recently been established under the leadership of MAIL).

Nutrition in emergencies: The Nutrition Cluster is the main forum for discussing nutrition in emergency issues, as well as nutrition surveillance. It is co-chaired by UNICEF and FAO, and is in relation to other thematic clusters through OCHA and inter-cluster meetings. The Nutrition cluster is also the widest nutrition stakeholder meeting and can play a role in supporting general nutrition coordination issues.

Public Nutrition Capacity-Development: Capacity-development activities do not require a specific working group be established. The Public Nutrition Department can liaise with key partners through timely meetings (e.g. with IMCI for nutrition in IMCI training) and task forces, such as the task forces that should be organised between the MoPH, the Ministry of Higher Education, and relevant faculties and institutes.

Table 3: Public Nutrition Partners according to the type of roles and responsibilities

Specific objective	Strategic Components	MoPH Departments	Other Ministries	Technical & Financial Assistance providers	Implementing partners
1. Nutrition Promotion	Harmonized NP	PND, Health Promotion	MAIL, MoE, MOWA, MRRD, MoRA	UNICEF, WHO, FAO, MI, USAID/BASICS	Media, BPHS NGOs, other NGOs, religious leaders, DoPH, DoE, DAIL, DRRD, CHWs, shuras
	Community-based	PND, Community-based Health Care (CBHC)	MAIL, MoE, MoWA, MRRD, MoRA	UNICEF, WHO, FAO, MI, USAID/BASICS	BPHS NGOs, NSP NGOs, CHWs, shuras, Family Health Action Groups (FHAG), literacy circles, producer groups…
	Link to Food Security	PND	MAIL, MRRD	FAO,	DAIL, DRRD, NGOs
2. IYCF	Advocacy, regulations, guidelines	PND, Policy and Planning,	MoJ, MoWA, MoC	UNICEF, WHO, IBFAN, WABA	NGOs, private sector, emergency service providers
	Community support	PND, CBHC	MAIL, MRRD, MoE	USAID/BASICS, FAO, UNICEF, WHO	NGOs (BPHS and others), CHWs, FHAG, shuras, literacy circles, producer groups…
	IYCF in BPHS/EPHS	PND, GCMU, CBHC, HP, RH, CAH, IMCI		UNICEF, WHO, IBFAN, WABA	BPHS NGOs, CHWs
3. Micronutrients	USI	PND, Food & Drug Quality Control	MoM, Municipality, MoC (customs houses), ANSA, MoJ	UNICEF, MI	Private sector: Iodised Salt producers, wholesalers, mine leasers, retailers; Media, NGOs, shuras, CHWS…
	Flour Fortification	PND, Food and Drug Quality Control	MoC, MAIL, ANSA, MoJ	WFP, MI	Private sector: flour millers, retailers Media, NGOs, shuras, CHWs…
	Ghee and oil fortification	PND, Food and Drug Quality Control	MoC, ANSA, MoJ	MI, UNICEF	Oil and ghee importers, retailers
	Complementary food fortification	PND, Food and Drug Quality Control	MoC, ANSA	MI, UNICEF, WHO, FAO	Private sector
	Supplementation	PND, EPI, GCMU			
	Nutrition education	PND, HP	MAIL, MRRD	MI, UNICEF, WHO, FAO	NGOs, media, private sector
4. Severe Acute Malnutrition	Screening	PND, CBHC, BPHC, GCMU		UNICEF, WHO	BPHS NGOs, DoPH
	In-patient care	PND, EPHS, BPHS, GCMU		UNICEF, WHO	DoPH, BPHS NGOs
	Out-patient care	PND, BPHS		UNICEF, WHO	BPHS NGOs
5. Food safety	Consumer and food retailer education	PND, IEC, Food and Drug Control	MAIL, MoC, ANSA	WHO, FAO, EU & USAID (MAIL)	Private sector, NGOs
	Food quality control	Food and Drug	MAIL, MoC, ANSA	WHO, FAO, EU & USAID	Private sector

	system	control, PND		(MAIL), WB & UNIDO (ANSA),	
6. Nutrition Surveillance	Surveillance	PND, HMIS, 3rd party evaluation (JHU)	CSO, MRRD, MAIL	UNICEF, WHO, FAO,	BPHS NGOs, DoPH, CHWs, NRVA, JHU
	M&E	PND, M&E, HMIS, 3rd party evaluation (JHU)	CSO, MRRD	UNICEF, WHO, FAO,	BPHS, DoPH, NRVA, JHU
7. Moderate acute and chronic malnutrition	Improved assessment and design	PND, MoPH Emergency?	MAIL, MRRD, Disaster Management Committee	UNICEF, WHO, FAO, WFP, OCHA	NGOs (BPHS and others), DoPH, DRRD, DAIL
	Food assistance	PND	MAIL, MRRD, DMC	WFP	NGOs, DoPH, DRRD, DAIL
	Management of GAM	PND		UNICEF, WHO, WFP, FAO, MI	NGOs (BPHS and emergency service providers
8. Public Nutrition Capacity Development	In-service training	PND, IMCI, Human Resources	MAIL, MoE, MoWA, MRRD	UNICEF, WHO, FAO, WFP, MI, USAID/BASICS	BPHS NGOs, other NGOs
	Pre-service training	PND, Health Sciences Institute	MoHE, Medical Faculties, Agriculture faculties, MoE	UNICEF, WHO, FAO, , MI	Medical Universities, agriculture faculties, other technical assistance programmes supporting universities
	Strengthening of PND	PND, Human Resources, General Directorate PHC		UNICEF, WHO, FAO, WFP, MI, USAID/BASICS	

Next steps

The next steps towards the implementation of the Public Nutrition Policy and Strategy include the following activities:

- The working groups that are established (**IYCF, Micronutrients, SAM, and nutrition cluster**) should carry out the following steps:
    - Review the strategic components and activities presented in the revised PNPS and prepare / update a work plan in line with these proposed activities.
    - Prepare a costing estimate for the proposed activities until 2013.
    - Initiate and/or complete guidelines required to support implementation.
    - Review monitoring indicators and identify specific means of verification and assign responsibilities for gathering, analysing and reporting monitoring information.
    - Initiate activities as per the prepared work plans.

For strategies for which a specific working group does not exist, the following next steps are proposed:

- **Nutrition promotion**:
    - Call a / several meetings to review existing materials, identify gaps, and materials that need to be reprinted, revised, or developed. Identify resources that are available or can be mobilized to prepare the necessary materials.
    - Meet with representatives of key partner ministries and prepare an agreement whereby all nutrition promotion activities
    - Participate in the MoPH IEC Working Group

- **Food safety:**
    - Food and Drug Control Department to hold discussion with other key partner ministries and institutions (namely ANSA) to clarify the current status of initiatives related to food safety. Discuss potential coordination mechanisms and prepare a proposition to be submitted to Ministers and Deputy Ministers, for potential discussion at cabinet level.
    - The Food and Drug Control Department, IEC department and Public Nutrition Department should identify opportunities and requirements (including cost) for launching a public education campaign on food safety.

- **Nutrition surveillance**:
    - Review the proposed indicators and mapping of existing indicators, and meet with HMIS, Johns Hopkins University, and other key stakeholders involved in Health Information Systems to assess which indicators could be integrated in the existing systems (and where).
    - Liaise with the stakeholders working on food security surveillance (e.g. coordination group initiated in MAIL), to discuss with food security partners if and how nutrition indicators can be better included in food security surveillance systems.

- **Public Nutrition Capacity-Development**
    - Meet with the University of Massachussetts Amherst project supporting the revision of the Kabul Medical University curricula (a Task Force will probably be established by the project).

- Identify other similar projects that are providing technical assistance to pre-service training providers.
- Once the Millennium Development Goals (MDG) -Fund Joint Programme on Nutrition and Food Security is started (January 2010), recruit an international expert responsible for providing technical support for nutrition training in in-service and pre-service training curricula.

Section VI: Monitoring and Evaluation

Regular Monitoring and Evaluation & proposed indicators

The responsibility for monitoring and evaluating the Public Nutrition Policy and Strategy will lie principally with the MoPH Public Nutrition Department and its main technical assistance and implementing partners (c.f. Table 3). Monitoring and evaluation should be integrated in existing M&E systems. Specific monitoring and evaluation methodologies need to be developed for each specific objective, in close consultation with the MoPH Departments and partners working on the Health Information System and other related M&E tools. The working groups listed in section 4 will have a responsibility of detailing exact M&E strategies for their area of work.

Table 4 proposes sets of indicators that can be used to assess progress towards achieving the Public Nutrition Policy and Strategy goal, overall objective, and specific objectives. Each working group will have a responsibility for finalizing and validating these indicators. Some of these indicators are currently being collected, but for most of them, reliable information is not available. Therefore, Public Nutrition Department and its technical partners should liaise regularly with the HMIS and M&E Departments of MoPH, as well as Johns Hopkins and other relevant partners, to discuss the integration of these indicators in the relevant survey forms and methodologies.

Provincial Nutrition Officers have a responsibility of conducting regular monitoring visits, in coordination with NGO implementing partners and other Provincial Health Officers. They should report nutrition-related monitoring information to the central level Public Nutrition Department on a regular basis.

Progress Reviews

The information generated by the M&E system should be used to regularly assess progress on the implementation of the Public Nutrition Policy and Strategy and make necessary adjustments in the implementation plan. This work should be regularly undertaken by the thematic working groups and Public Nutrition Department at central level.

Furthermore, progress should be reported to the relevant authorities and stakeholders, for issues of accountability, but also to maintain / generate motivation to pursue implementation. A national review workshop should be conducted annually to assess progress and prepare the following annual work plan. During this annual review, each working group should report on the progress achieved on the specific objective they are responsible for.

Progress on the implementation of specific components of the Public Nutrition Policy and Strategy should also be reviewed at the regional level through regional workshops (e.g. on IYCF, as described in the IYCF Policy and Strategy). Progress can be reviewed at least once a year at the provincial level using the Provincial Health Coordination Committee (PHCC) or other forums. Finally, information on this progress should be shared through the Consultative Group on Health and Nutrition (CGHN), as well as other through media, such as “Sehat” and “Salamaty” journals.

Table 4: Proposed indicators, targets, and means of verification for monitoring the Public Nutrition Policy and Strategy

Note: This table provides a foundation for discussion on the selection of indicators and appropriate methods for collecting the information. It shall be further discussed with the MoPH M&E and HMIS Departments, as well as technical partners through the thematic working groups. The frequency of data collection is to be determined during these discussions.

Colour coding for this table:

- Green: indicators that are readily available through existing monitoring and evaluation systems (*see annex 1*). Data quality and reliablility for these indicators must nevertheless be checked / improved
- Orange: indicators for which some information is available, but not complete or insufficiently reliable or representative.
- Red: indicators for which there is no information and for which a data collection and analysis system must be established (as part of existing surveillance and M&E systems)

Nutrition objectives	Indicators *(final selection & definition to be discussed)*	Baseline	Target	Means of verification
Goal: ***To protect and promote child and maternal nutrition, reduce chronic malnutrition and associated MDDs, and reduce mortality from SAM***	• Prevalence of chronic malnutrition • Prevalence of MDDs (see micronutrient targets, below) • Prevalence death associated to SAM among children <5 yrs of age • Coverage of treatment of SAM among children < 5yrs of age. (Note: Proportion of SAM among children < 5 yrs of age cured and discharge. This indicator will be used as proxy indicator to measure the coverage of SAM among children <5yrs of age.	• 54% • see below • see below	• 47% • see below • see below	MICS, HMIS, AHS?
Objective: ***To increase access to and utilization of quality nutrition services provided at community level and through health facilities.***	• % of BPHS facilities provide nutrition services planned in the BPHS • % of EPHS facilities provide nutrition services planned in the BPHS • % of villages (defined by presence of a Community Development Council) where community nutrition promotion activities are delivered	• CHECK • Not available	• 100% • 40%	HMIS, Balance Score Card
1. Nutrition promotion: *To increase the awareness about nutrition amongst the general population, and provide caregivers with the knowledge, skills and*	• % of Afghan adult and adolescent population is aware of key healthy nutrition message on IYCF. (e.g. 9 messages in MoPH nutrition booklet) • % of Afghan adult and adolescent population is aware of key healthy nutrition message on SAM (e.g. 9 messages in	Not available	• 70% • 90%	

support required to adopt healthy nutrition practices	MoPH nutrition booklet) • % of community leaders and shura members (men & women) aware of key healthy nutrition messages. • # of functional community support groups promoting breastfeeding practices. • % of the households applies improved family nutrition practices (including their dietary diversity).		• To be determined	
1.1 Advocacy and sensitization	• Number of senior government officials actively partipating in nutrition advocacy and sensitization meetings. • % of funding commitment to public nutrition interventions as compare to year 2008.	• Not clear • TBD	• At least 5: MoPH, MAIL, MRRD, MoE, MOWA • At least 4 (namely WB, EU, USAID)	• Press releases, speeches, workshop minutes • Donor reports
1.2 Harmonized Nutrition Promotion	• # of Radio & TV spots on nutrition disseminated through the local media and average airing time • % of health facilities providing nutrition education messages • # of schools where nutrition education is provided • # of producer groups receiving nutrition education through agricultural extension projects	• CHECK • CHECK • CHECK • CHECK • CHECK	• To be determined • 100% • 100% • TBD • TBD	• Media reports / campaign reports • HMIS • Healthy Schools Ini. Reports • MAIL / FAO
1.3 Community-based nutrition promotion	• Number of IYCF community support groups established and operational	CHECK	• TBD	
1.4 Nutrition promotion through schools and literacy courses	• Number of schools with school gardens available. • Number of children participating in school gardening recreational activities • Number of literacy learners receiving nutrition education	• CHECK • CHECK • CHECK	• TBD • TBD • TBD	• MAIL/ FAO • MoEd/FAO • MoEd / FLI
1.5 Linkages to food security interventions	• # of communities where nutrition activities are effectively linked to food security interventions (diversification and increase of home based production), or where nutrition promotion activities are integrated in agricultural and rural development programmes	Need to compile information	To be determined	FAO, MAIL and NGO reports
2. IYCF: *To increase the percentage of child caregivers adopting appropriate infant and young child feeding practices*	• Increase in percentage of mothers who have initiated breast feeding within first hour after birth • Increase in percentage of mothers that are exclusively breastfeeding until the child is 6 months. • Increase in percentage of mothers who continue breastfeeding until the child is two years or older. • Increase in percent of children that are receiving	37%* (AHS) 19-70%* 54% (MICS 2003) 28% (MICS 2003) TBD MICS 2009	20% increase 20% increase 20% increase 20% increase	MICS & AHS

	complementary foods at the age of 6 months • Increase in percentage of children's under 2 with adequate frequency of complementary feeding		20% increase	
2.1 Advocacy, regulations, guidelines	• Number of Relevant government officials, civil servants, NGO and health sector personnel, and private sector aware the IYCF Policy & Strategy • Financial resources for IYCF mobilised and allocated • National Committee for the Code of Marketing of BMS active • Number of Violations of the Code and Maternity Protection Act denounced and condemned	• 0 $2m for 2009 No committee 0 No guidelines	• 100% At least 2m/year 1 committee According to events 1 guidelines set	IYCF WG minutes IYCF WG minutes Code Commit. Reports IYCF WG minutes
2.2 Behaviour change	• 45 % of Afghan adult and adolescent population is aware of key IYCF practices • 60% of community leaders and shura members (men & women) are aware of good IYCF • Number of IYCF community support groups established and operational • Number of women receiving satisfactory breastfeeding counselling *at community level* • Number of mothers having participated in at least 5 participatory cooking sessions	• N/A • TBD • Need to compile • 0 • TBD	• 70% • 90% • 1500 • 20000 • 20000	• KAP surveys? AHS? LQAS? • KAP? AHS? LQAS? • HMIS? LQAS? AHS? • HMIS?, AHS?, LQAS? • HMIS?, AHS?
2.3 IYCF integration in BPHS/EPHS	• Number of facilities certified as Baby-friendly facilities. • 50% of the EPHS facilities and health centres (CHC&BHC) provide IYCF counselling as part of the MCH services. (=700) • 50% of health care providers demonstrate correct counselling skills on IYCF • Number of women receiving breastfeeding counselling per month per counsellor in health services • Number of health facilities conducting participatory cooking demonstrations sessions	5 in process • TBD • 4,000 (% TBD) • Check • Check with FAO	• >30 • >50% • 50% • >3/month/ counsellor • >100	• PND monitoring visit reports: HMIS (MIAR); BSC? • Training reports HMIS? LQAS? AHS? • HMIS? LQAS? AHS? • HMIS? BSC?
3. Micronutrients: *To reduce the prevalence of major micronutrient deficiency disorders, in particular iron, folic acid, iodine, vitamin A, and zinc, throughout the country*	• Prevalence of iodine deficiency among school age children and women of reproductive age • Prevalence of iron deficiency among under-five children and women of reproductive age. • Prevalence of vitamin A deficiency among under-five	• 72% & 75% • 72% & 48% • 20% nightblind • CHECK	• <50% • <50% & <35% • 10%	MICS, National Nutrition Survey?

and prevent possible outbreaks of vitamin C	children and women of reproductive age (night-blindness and vitamin A level in blood) • Number of outbreaks of vitamin C deficiency		• 0	
3.1 Universal Salt Iodisation	• % of households using Iodised salt • Quantity of Iodized salt produced responding to MoPH quality standards	• 53% (NRVA 2007) • 95,000MT	• 90% • 95,000-100,000MT	• NRVA • IS producers
3.2 Flour fortification	• % of households using fortified flour • Annual production of fortified flour compliant with MoPH standards	• N/A • 30,000 MT/year •	• 400,000 people by 2010 •	• NRVA? • Flour millers
3.3 Ghee & oil fortification	• Standards developed for fortified ghee and oil • Quality controls for imported ghee & oil in place at customs	No standards No quality control	Standards developed Random sapling checking in place	ANSA & MoPH docs Customs offices reports? Spot checks?
3.4 Supplementation	• % of women pregnant and lactating women receiving iron/folic acid supplements. • % women receiving post-partum vitamin A supplements • Coverage of vitamin A supplementation through NIDs • % of patients treated for diarrhoea receiving zinc • Number of health facilities applying MoPH guidelines for supplementation	• Not available • Not avail. • 95% children U5 • Not avail.	• 100% • • 100% • 100%	• HHS • HMIS/Monitoring Missions
4. SAM treatment: *To reduce mortality from severe acute malnutrition through strengthened case management and increased access to quality therapeutic feeding and care at health facility and community levels.*	• # of children under 5 years admitted for SAM treatment in in-patient and/or out-patient care • % Admitted SAM children cured • Percentage of defaulted SAM children <5yrs of age in TFUs and CMAM.	4202 Jan-Aug 09 1988 (81,3%) (N.B. 1756 patients still in programme)		HMIS (MAAR, MIAR)
4.1 Screening & community mobilization	• # of children screened and referred at community level • # of children screened and referred in health facilities • Number of CHWs applying MoPH screening guidelines	Obtain 2009 data from PND		HMIS (MAAR, MIAR)
4.2 In-patient care	• # of SAM children admitted for in-patient care • # of SAM patients referred for out-patient care after stabilization • # of inpatient cases cured • # of inpatient cases died • # of inpatient cases defaulted	• 1523 Jan-Aug 09 • 43 (3.2%) • 1113 (83%) • 53 (4%) • 129 (9,6%) • Still in	• Compliance with Sphere standards	HMIS (MAAR, MIAR)

	• inpatient Average weight gain • inpatient Average length of stay • Number of health facilities correctly applying MoPH guidelines for in-patient care	programme: 182		
4.3 Out-patient care	• # of children admitted for out-patient care • # of patients referred for in-patient care if complications • # of outpatients cured • #of out patients died • # of out patient defaulted • out patients average weight gain • out patients average length of stay • Number of health facilities correctly applying MoPH guidelines for out-patient care	• 2679 Jan-July 09 • N/A • 875 (79%) • 19 (1.7%) • 221 (20%) • Still in programme: 1574	• Compliance with Sphere standards	HMIS (MAAR, MIAR)
5. Food safety	• Nationwide campaign on food safety and food hygiene targeted at the public and food retailers is implemented	• No campaign	• Nationwide campaign	Media reports, campaign reports
5.1 Consumer and food retailer education	• Effective inter-ministerial coordination mechanism for food safety established • Relevant standards defined and legislation passed • Number of inspectors trained and carrying out regular inspections • Number of foodstuffs which can be checked in laboratory facilities or number of analyses which can be made (N.B. Not necessarily in MoPH labs)	• No mechanism • Legislation & standards for USI, flour and water • CHECK • CHECK	• 1 mechanism • TBD • TBD • TBD	Meeting minutes Legislation Food and Drug control register Lab reports
5.2 Food quality control system	•	•	•	
6. Nutrition surveillance & M&E *To monitor changes in the nutritional situation in Afghanistan and evaluate the impact of nutrition strategies and programs,*	• Information available to measure progress on the PNPS according to the indicators described in the present table. • Number of Information sharing sessions on nutrition situation is regularly shared with key stakeholders (Government, donors, technical assistance providers and implementing partners)	• 31/93 indicators in 'green'	• 93 indicators in 'green' (or more or less, depending on feasibility and consultation)	HIS review; PNPS progress reviews
6.1 Surveillance	• Estimates of prevalence of acute malnutrition among children <5yrs of age.	National estimates available but no provincial / district data + limited trend data	Reliable national & provincial trend estimates available	HMIS, MICS, AHS?
6.2 M&E	• IYCF M&E indicators effectively collected and results regularly disseminated to main partners • Inpatients care M&E indicators effectively collected and	31/93 indicators in 'green'	+/- 93 indicators in 'green'	PNPS Progress reviews & WG mins

	results regularly disseminated to main partners • Outpatient care M&E indicators effectively collected and results regularly disseminated to main partners • Micronutrient M&E indicators effectively collected and results regularly disseminated to main partners			
7. Severe and Moderate acute malnutrition: *To ensure that responses to nutritional emergencies are timely and appropriate, and that increases in global acute malnutrition prevalence are effectively managed*	• Number of Effective & relevant responses to nutritional crises implemented in timely manner	6m to 1 year delay in response	Interventions implemented in <6m	Project evaluations; nutrition cluster minutes
7.1 Assessment and response capacity	• Number of quality nutrition emergency assessments carried out when a crisis justifies such assessment	CHECK	Assessments carried out whenever crisis justifies it	Nutrition cluster minutes. Assessment reports
7.2 Food assistance	• Number of food assistance rations that meet the MoPH requirements (nutritional adequacy, safety, cultural acceptability)	CHECK	100%	WFP,, BPHS/ MoPH report
7.3 GAM cases management	• # of children admitted for MAM in SFP • # of children admitted for SAM in-patient care • # of children admitted for or SAM out-patient care • # of patients referred for in-patient care if complications • #of MAM patients cured from SFP • # of MAM patient defaulted from SFP • Average weight gain of MAM cases in SFP • Average length of stayof MAM cases in SFP • Number of partners applying correctly SFP guidelines	System not yet in place	• 90% coverage • Treatment outcomes in line with Sphere standards	HMIS + NGO reports if GAM management outside of health system
8. Public Nutrition Capacity-development: *To strengthen in-country capacity to assess the nutrition situation, and design, implement, monitor and evaluate public nutrition interventions*	• # of professional staff trained in nutrition topics related to their terms of reference • Number of professionals trained in nutrition who apply in practice the skills they have acquired	• To be compiled	• To be determined	PND & IMCI training reports; Balanced Score Card Faculty reports
8.1 In-service and pre-service training	• # of academic institutions providing pre-service public nutrition training • Nutrition of session training on IYCF conducted, • Number of session training on Micronutrients conducted,	• Very limited/ absent • Timely training organised by PND	• >2 medical faculties and >2 institutes • PN in regular in-	Faculty and training institutes curricula

	• Number of session training on SAM conducted • Number of session training on CMAM conducted	+ IMCI	service training	
8.2 Support to PND	• Number of PND staff received Diploma/master degree in Public Nutrition • Number of PND staff received training on IYCF. • Percentage in Staff turnover	• Difficulty participating in all meetings & events • Risk of losing key technical staff	• PND staff able to fulfil all essential tasks • No loss of key technical staff	PND staff feedback

Annexes

Annex 1: Mapping of nutrition indicators currently being collected

This map can assist to improve the integration of nutrition indicators in the Health Information System and other relevant surveillance and M&E systems. It is not exhaustive, and should be further completed during discussions between PND and HIS partners.

System	Form	Nutrition Prevalence	Nutrition Education	IYCF	Micronutrients	SAM treatment
HMIS - Community level	**Monthly Activity Report (MAR)**	# Children Screened with MUAC # children Referred due to Nutrition Problem				
	Monthly Aggregated Activity Report (MAAR)	Total ## children Screened with MUAC Number of Referred				
HMIS - Facility Level	**Patient card**					
	MIAR	Number screened; SAM & MAM; Low Birth Weight			Ante- & post-natal visits (not supplementation); Stock for Vit A & Fe/Fo	
	Facility Status Report	Equipment check: MUAC, salter scale, adult scale (not height board)	Services provided: Nutrition IEC?		Ante-natal care (not specified supplements)	Services provided: Nutritional rehabilitation?
HMIS - Hospital level	**Hospital in-patient card**					Nutrition rehabilitation of under fives: # admitted, # improved, # defaulted, # referred out; # deaths
	Hospital Status report	Child scale; height board	Services provided: Nutrition IEC			Services provided: 2. Nutritional rehabilitation?
3rd party evaluation	**National Monitoring checklist & Balanced Score Card**		Staff training on causes and prevention of malnutrition? On general nutrition for child? On GMP? Clinical guidelines on GMP available?	Staff training on BF counselling?	Staff training on causes, clinical symptoms and treatment of MDDs?	Staff training on SAM rehabilitation

Surveys	**AHS**			BF counselling received as part of ante-natal care? % ever BF, % initiation of BF, % EBF in last 24h, % receiving CF betw 6-9m	Fe/fo received as part of ante-natal care?	
	MICS	Underweight, stunting & wasting prevalence		Timely initiation of BF, EBF, Continued BF rate, timely CF rate, frequency of CF	Iodised salt consumption rate; vit A supplements for U5's and for post-partum. Sub-sample for: • urinary iodine • salt samples for titration • haemoglobin levels • iron deficiency • vitamin A deficiency • Zinc deficiency • Wheat flour samples • Cooking oil samples	
	NRVA	Food consumption: caloric sufficiency and dietary diversity			Household coverage of iodised salt	
	LQAS / Household Health Survey	Attendance in weighing sessions		Ever BF? Initiation of BF? Duration of BF? Age of introduction of CF?	Received vitamin A capsule? (6) Zinc during diarrhoea?	
Early Warning	**DEWS**					

Annex 2: Public Nutrition Services by type of facility in BPHS as per 2008 revision

Interventions and Services Provided	Health Facility Level					
	Health Post	Health Sub-Center	BHC	MPHS	CHC	Dist. Hospital
a. Assessment of Malnutrition (Population Level)						
Nutritional status	*Estimate prevalence of malnutrition (z-score using indices of weight for height [wasting], weight for age [underweight], and height for age [stunting] as well as the underlying causes. Surveys conducted at district or provincial level for purposes of* ***baseline****,* ***monitoring,*** *and* ***evaluation*** *or in case of* ***obvious deterioration*** *in nutritional situation.*					
b. Prevention of Malnutrition						
Vitamin A supplementation: To all children 6 months to 59 months	Yes during NID	No, yes after NIDs stop	No, yes after NIDs stop	yes only after NIDs stop	No, yes after NIDs stop	No, yes after NIDs stop
Promotion of iodized salt	Yes	Yes	Yes	Yes	Yes	Yes
Promotion of balanced micronutrient-rich foods	Yes	Yes	Yes	Yes	Yes	Yes
Support and promote exclusive breastfeeding	Yes	Yes	Yes	Yes	Yes	Yes
Promotion of appropriate complementary feeding for young children with behavior changes	Yes	Yes	Yes	Yes	Yes	Yes
Community food demonstration	Yes	Yes	Yes	Yes	Yes	Yes
Growth monitoring and promotion for children less than 5 years[1] (Where applicable and linked with IMCI)	No	Yes	Yes	Yes	Yes	Yes
Iron/folic acid supplementation for pregnant and lactating women	Yes	Yes	Yes	Yes	Yes	Yes

Interventions and Services Provided	Health Facility Level					
	Health Post	Health Sub-Center	BHC	MPHS	CHC	Dist. Hospital
Vitamin A supplementation post-partum (during 42 days after delivery)	Yes	Yes	Yes	Yes	Yes	Yes
Promotion of maternal nutritional status[2]	Yes	Yes	Yes	Yes	Yes	Yes
Control and prevent diarrheal disease and parasitic infections	Yes	Yes	Yes	Yes	Yes	Yes
Underlying causes: based on analysis of causes of malnutrition, support, and advocate for interventions to address underlying causes.	BPHS NGO will demonstrate understanding of underlying causes and outline appropriate interventions to prevent and address malnutrition including in areas of food security, social and care environment and health (including water and sanitation (see Conceptual Model of Causes of Malnutrition).					
e. Treatment of Malnutrition						
Micronutrient deficiency diseases diagnosis and treatment	Identify and refer	Yes	Yes	Yes	Yes	Yes
Treatment of severe malnutrition based on MoPH protocols for 24-hour care for Phase I; day care/home-treatment for Phase II[3] and follow-up	No—refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Pre-referral treatment and refer	Yes
Community-based Management of Acute Malnutrition (CMAM): Community Mobilization and screening	YES refer	Yes (Pre- referral treatment and refer)	Yes	Yes	Yes	Yes
Out patient management (OTP)	No	No	Yes	No	Yes	Yes
Inpatient care /Stabilization Center (SC)	No	No	No	No	No	Yes
Supplementary Feeding Programme to treat of prevent moderate malnutrition in areas where acute malnutrition levels higher than 10% or 5% with additional risk factors.	No	Yes - Where applicable				
d. Surveillance and Referral						

Interventions and Services Provided	Health Facility Level					
	Health Post	Health Sub-Center	BHC	MPHS	CHC	Dist. Hospital
Clinic-based surveillance: all children under 5 years measured for weight for height (using HMIS forms), monitor trends and children showing developmental delay referred to physiotherapy services	No	Yes	Yes	No	Yes	No
Screening: Screening and referral of at risk using mid-upper-arm circumference (MUAC), or weight/height, or clinical signs of micronutrient deficiency diseases (MDDs)	Yes	Yes	Yes	Yes	Yes	Yes to (H2)

[1] Growth monitoring and promotion (GM and P): Some studies indicate that facility-based GM and P is an ineffective intervention for improving nutritional status, especially when growth monitoring is conducted without adequate growth promotion. During 2004 or 2005, The MoPH in collaboration with WHO and on assessment to identify what needs (resources, training, skills, and adaptation) to be in place for GM and P to be effective in Afghanistan. BASICS is currently piloting Community-based GMP in selected provinces. Preliminary results for C-GMP are promising; this approach should be explored further and potentially upscaled.

[2] Maternal nutrition: Improving the nutritional status of women remains a priority, a strategy for addressing the poor nutritional status of women developed.

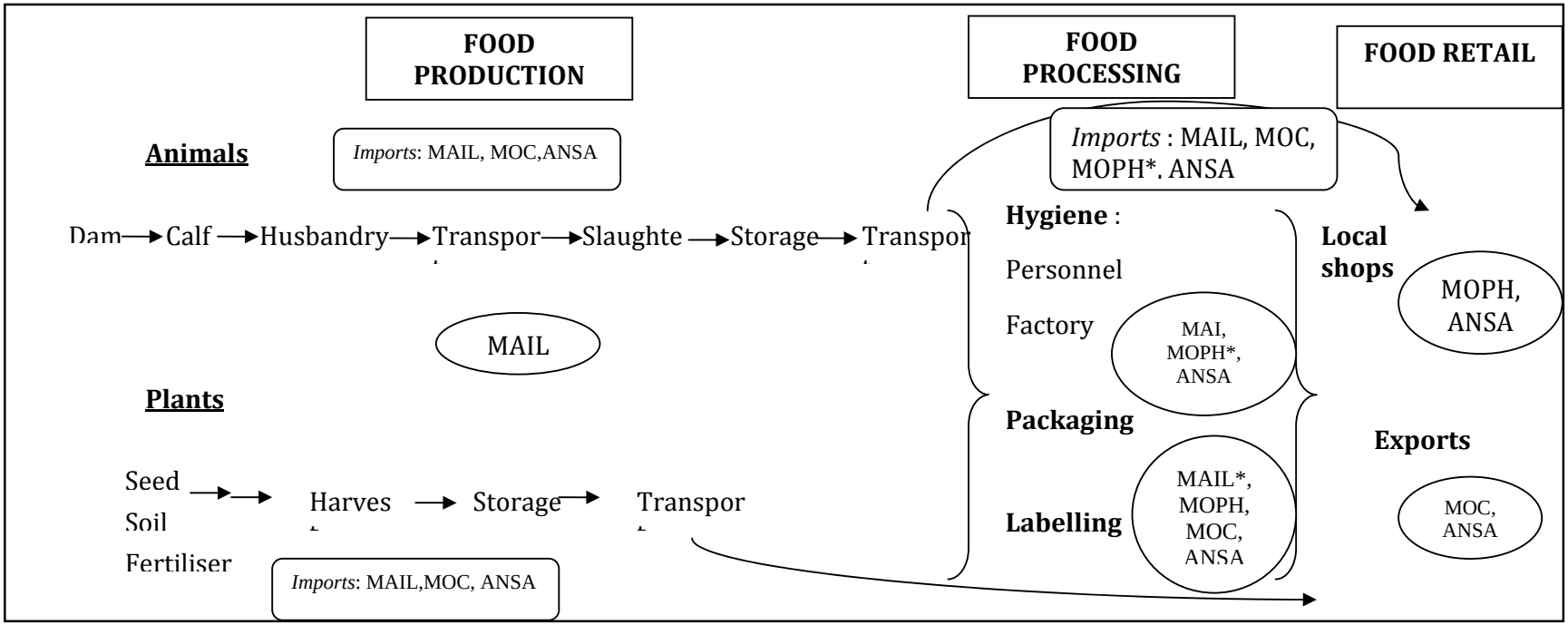
[3] Treatment of severe malnutrition: The MoPH currently has guidelines and a strategy to support hospital-based (24-hour/day care) treatment, which are implemented in hospitals.

[4] Supplementary feeding programme (SFPs): Emergency SFPs will only be implemented in those identified districts which have a prevalence of acute malnutrition > 10% and/or high risks (see MoPH Guidelines for Supplementary Feeding).

Community-based Management of Acute Malnutrition (CMAM) with its components will be implemented where vertical input is provided by UNICEF and WFP in agreement with the Public Nutrition Department of MoPH.

Annex 3: Potential responsibilities of different ministries for food safety, in the food production chain

This graph was prepared through an inter-ministerial workshop held in November 2006, with participants from MAIL, MoPH, MoC, ANSA and several technical support agencies supported by donors. It can be a foundation for further discussions between ministries and with the private sector.



* For imports and processed foods, the distinction of responsibilities between MOPH and MAIL is the following:
  - for processed foods of animal origin (imported and domestic): MAIL
  - for other processed foods: MOPH

for processed foods which have a mixed content, including meat: this is to be determined by specific regulations for specific foods.