



Islamic Republic of Afghanistan

Ministry of Public Health

**National Public Nutrition Strategy**

1394 – 1399 (2015– 2020)

Revised in March 2015

# FOREWORD

Good nutritional status is fundamentally important for ensuring and maintaining health and enhancing physical and cognitive capacity of populations. Thus, the economic growth and social development of a nation is highly dependent on a well-nourished population. In contrast, nutritional deficiencies lead to increased morbidity and mortality among the population and retard economic growth. More than one-third of deaths among children below five worldwide are attributed to malnutrition, and the World Bank estimates that many countries lose at least 2 to 3 percent of their Gross Domestic Product (GDP) due to malnutrition. Thus, in 2008, the Copenhagen Consensus, backed by world renowned economists, selected five nutrition interventions among the top 10 most cost-effective national investments in developing countries. Yet again, the 2012 Copenhagen Consensus rated interventions to reduce malnutrition in children below 5 as the top investment priority for developing countries.

Although there have been improvements in some indicators of nutritional status of the Afghan population during the past decade, the 2013 National Nutrition Survey indicates that the public health burden of malnutrition is still among the highest in the world. Furthermore, there is substantial variation in the prevalence of various nutritional deficiencies, especially among women and young children, across the nation’s provinces. For example, although the 2013 data indicates that the prevalence of stunting (or chronic malnutrition) has decreased by about 20 percentage point since 2004, the prevalence of this indicator ranges from about 24% to >70% across the country. Another important progress is indicated by a significant improvement in the iodine status of the population; the median urinary iodine concentration among school age children was >170µg/L in 2013, compared to 49 µg/L in 2004. This is likely due to the substantial production and marketing of iodized salt in the country since 2003.

To effectively improve the nutritional status of the population over time, evidence-based intervention must be sustainably implemented with adequate quality and high coverage into the foreseeable future, and tracked through a systematic program monitoring and surveillance system. Therefore, the MoPH is advocating for and supporting food based interventions through public-private sector partnerships, the delivery of preventive and therapeutic nutrition services through the health care system is one of the seven components of the Basic Package of Health Services (BPHS) and part of the Essential Package of Hospital Services (EPHS). The MoPH continues to strengthen the capacity of its Public Nutrition Department (PND) through the recruitment and development of competent staff at the central and provincial levels. The role of the MoPH is integral and is based on its commitment to the successful implementation of almost all inter-sectoral strategies and efforts toward improved nutrition for every Afghan.

The Public Nutrition Strategy for 2009 – 2013 guided the programs and activities of the MoPH and PND. In order to further improve and support population-based nutrition interventions based on the latest international guidance and recommendations as well as lessons learned from national programs, the Public Nutrition Department led a comprehensive revision of the public nutrition strategy in 2014. Thus, the Public Nutrition Strategy for 2015-2020 strategy was finalized after several rounds of consultation with development partners.

The MoPH calls upon all partners; donor community, UN agencies, technical nutrition NGOs, BPHS implementers, private sector, academia and especially the Cabinet of Ministers and other relevant governmental institutions to recognize and acknowledge the critical role of nutrition as a national development and security priority and play their important roles in the implementation of the Public Nutrition Strategy for 2015-2020.

Best regards,

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# ACKNOWLEDGEMENTS

The General Directorate of Preventive Medicine appreciates the instrumental support of the leadership of the Ministry of Public Health in developing this revised version of nutrition strategy. We are grateful for the precious support of the leadership and team members of the Policy and Planning General directorate, Reproductive Health directorate, Afghanistan National Public Health Institute, Child and Adolescent Health Directorate, Environmental Health Directorate, Community Health Directorate, and other departments and units of the Ministry of Public Health for their support in the process of developing this document. The Public Nutrition Strategy is revised by the Public Nutrition Department of the Ministry of Public Health (MoPH) with technical and financial assistance from the Micronutrient Initiative (MI) and in close collaboration with the nutrition partners, comprising representatives from UNICEF, WFP, FAO, WHO, European Union delegation in Afghanistan, USAID, the World Bank, Canadian Embassy in Kabul (DFATD), Nutrition technical NGOs: Save the Children, GAIN, ACF and BPHS implementing partners.

The MoPH appreciates the great leadership of Dr. Bashir Ahmad Hamid, head of nutrition department and his team members for leading the process of developing this document in collaboration and coordination with all nutrition partners and stakeholders. The MoPH is also extremely grateful to the nutrition partners for participating in several rounds of consultation and for the valuable comments, suggestions and inputs for improving upon the strategy. We are thankful to each individual who participated in the process of developing this document actively and made this critical work possible by their efforts and valuable support. Dr. Ibrahim Shinwari and Dr. Wali Aminee (MI), Dr. Sayed, Dr. Tawab Hashemi and Nkosinathi Mbuya (WB), Carmen Lloveres et all (EU), Marie-Eve Hammink et all (USAID), Renata Pistone, Nasir Ebrahimkhail and Genevieve Bussiere (DFATD), Dr. Sherin Varkey, Dr. Zakia Maroof (Unicef), Leo Mutonga (Nutrition Cluster), Dr. Mohammad Qasem Shams (WHO), Carrie Morrison (WFP), Dr. Muhebullah Latifi (FAO), Dr. Muhebullah Wahdati (GAIN), Dr. Homayoun Ludin, Dr. Abdul Khalil Samadi, Dr. Ahmad Nawid Qarizada and other colleagues (PND) are among the individuals provided valuable comments and information in developing this document. We also thank Dr. Ibrahim Parvanta (international expert in nutrition) who started the process by developing the first draft of this document.

We hope that this strategy document will lead the MoPH and partners in designing and implementing evidence-based nutrition interventions to improve nutrition status of the people of Afghanistan and provide evidences and lessons for the global community in combating different types of malnutrition.

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# LIST OF ABBREVIATIONS/ACRONYMS

|  |  |
| --- | --- |
| ACF | Action Contre la Faim |
| AFSANA | Afghanistan Food Security and Nutrition Agenda |
| AISPA | Afghanistan Iodized Salt Production Association |
| ANDS | Afghanistan National Development Strategy |
| ANPHI | Afghanistan National Public Health Institute |
| ANSA | Afghan National Standards Authority |
| BASICS | Basic Support for Institutionalizing Child Survival |
| 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 |
| CAH | Child and Adolescent Health |
| CBHC | Community-Based Health Care |
| CDC | U.S. Centre for Disease Control and Prevention |
| CHW | Community Health Worker |
| CIDA | Canadian International development Agency |
| CSO | Central Statistics Office |
| DEWS | Disease Early Warning Surveillance |
| DFATD | Department of Foreign Affairs, Trade and Development |
| EPHS | Essential Package of Hospital Services |
| EPI | Expanded Program on Immunization |
| EU | European Union |
| FAO | Food and Agriculture Organization of the United Nations |
| GAIN | Global Alliance for Improved Nutrition |
| GCMU | Grant Contracts Management Unit |
| GI | Gastro Intestinal |
| HMIS | Health Management Information System |
| HNPS | Health and Nutrition Policy and Strategy |
| IEC | Information, Education, Communication |
| IMCI | Integrated Management of Childhood Illnesses |
| IRB | Institutional Review Board |
| IYCF | Infant and Young Child Feeding |
| JPRM | Joint Program Review Mission |
| MAIL | Ministry of Agriculture, Irrigation and Livestock |
| MAM | Moderate Acute Malnutrition |
| MDG | Millennium Development Goals |
| MI | Micronutrient Initiative |
| MoCI | Ministry of Commerce and Industry |
| MoE | Ministry of Education |
| MoEc | Ministry of Economic |
| MoF | Ministry of Finance |
| MoHE | Ministry of Higher Education |
| MoI | Ministry of Interior |
| MoICY | Ministry of Information, Culture and Youth Affairs |
| 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 |
| MoU | Memorandum of Understanding |
| MoWA | Ministry of Women’s Affairs |
| MRRD | Ministry of Rural Rehabilitation and Development |
| NAF | Nutrition Action Framework |
| NGO | Non-Governmental Organization |
| NIDs | National Immunization Days |
| NMSS | Nutrition Monitoring and Surveillance System |
| NRVA | National Risk & Vulnerability Assessment |
| NTD | Neural Tube Defect |
| ORS | Oral Rehydration Solution |
| PN | Public Nutrition |
| PND | Public Nutrition Department |
| PNTF | Public Nutrition Task Force |
| QA | Quality Assurance |
| QC | Quality Control |
| RH | Reproductive Health |
| SAM | Severe Acute Malnutrition |
| SC | Save the Children |
| SUN | Scaling Up Nutrition |
| ToR | Terms of Reference |
| UI | Urinary Iodine |
| UNICEF | United Nations Children’s Fund |
| USI | Universal Salt Iodization |
| WFP | World Food Programme |
| WHO | World Health Organization |

# Part I

# BACKGROUND

## Global Perspective

Nutritional deficiencies lead to increased morbidity and mortality, as well as substantial economic losses in countries with high prevalence of malnutrition. More than one-third of all deaths among children under five worldwide are attributed to malnutrition, and the World Bank estimates that many countries lose at least 2 to 3 percent of their Gross Domestic Product (GDP) due to malnutrition[[1]](#footnote-1). Furthermore, it is recognized that without reducing childhood malnutrition, developing countries such as Afghanistan will not be able to achieve the first of the Millennium Development Goals (MDGs), i.e. to eradicate extreme poverty and hunger.[[2]](#footnote-2)

In January 2008, the Lancet—an international medical journal - published a five-part series on nutrition which provided systematic evidence of the negative impact of the high burden of maternal and child under nutrition on children’s cognitive and physical development, which in turn contribute to a less developed workforce and reduced economic growth[[3]](#footnote-3). The publication series also provided evidence of proven interventions to prevent and treat such malnutrition, especially when focused on the “1,000 days window of opportunity” from “minus 9 to 24 months”[[4]](#footnote-4); i.e. from conception until two years of age. This was the impetus for the establishment of the Scaling Up Nutrition (SUN) movement[[5]](#footnote-5), a global multi-sectoral initiative to support large-scale implementation of nutrition interventions to reduce malnutrition in children <5 years old. A package of 13 evidence-based nutrition interventions under four broad categories have been identified as the major areas of focus to help improve the nutritional status of children <24 months of age (see **Table 1**).

Also in 2008, the Copenhagen Consensus[[6]](#footnote-6) (a panel of internationally recognized economists - four of them Nobel Laureates) recognized the essential role of improved nutritional status on economic development, and recommended five public nutrition interventions among its top ten most cost-effective national investments. Again, the 2012 Copenhagen Consensus rated interventions to reduce malnutrition in children <5 years old as the first priority investment for developing countries. The bundle of high benefit-to-cost interventions include provision of vitamin and mineral supplements and fortified complementary foods to young children, de-worming and diarrheal disease treatment, and related behavior change communication.[[7]](#footnote-7) According to the summary report of the 2012 Copenhagen Consensus, “…even in very poor countries and using very conservative assumptions, each dollar spent reducing chronic malnutrition has at least a $30 payoff.”

*Table 1. categories of evidence-based direct interventions and their sub-components adopted by the SUN Movement to prevent and treat malnutrition in children <24 months old.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Intervention Category** | | | |
| **I** | **II** | **III** | **IV** |
| **Promoting Good Nutritional Practices** | **Provision of Vitamins and Mineral for Pregnant Women and Young Children** | **Provision of Fortified Foods** | **Therapeutic Feeding for Malnourished Children** |
| 1. Timely initiation and exclusive breastfeeding until 6 months of age | 1. Vitamin A supplements for children | 1. Iodized salt | 1. Prevention or treatment of moderate acute malnutrition |
| 1. Provision of vitamin and mineral-rich complementary foods to infants after 6 months of age | 1. Zinc supplements for treatment of diarrhea | 1. Iron fortification of staple foods | 1. Treatment of severe acute malnutrition (with ready-to-use therapeutic foods) |
| 1. Appropriate hygiene practices, including handwashing, by caregivers of infants and toddlers | 1. Use of multi-micronutrient powders (as “in-home” food fortificants) |  |  |
|  | 1. De-worming drugs for children (to improve nutrient absorption) |  |  |
|  | 1. Iron-folic acid supplements for pregnant women to prevent & treat anemia |  |  |
|  | 1. Iodized oil capsules where iodized salt is unavailable |  |  |

A few essential points that must be considered in the planning and implementation of public nutrition interventions are:

1. In order to be effective, the evidence-based intervention must be implemented with adequate quality and high coverage over time, and tracked through a systematic program monitoring and surveillance system (**Figure 2**). Thus for example, it is essential that the producers, importers and government inspectors of fortified foods follow appropriate procedures that the relevant food products contain the levels of added micronutrients as per the national standards.

*Figure 1. .“Formula” to describe the implementation of an effective nutrition intervention.\**



\* Adapted from “FORTIMAS: An approach for tracking the population coverage and impact of a flour fortification program”. Smarter Futures, January 17, 2014.

1. Some level of “initial impact” may be detected after one or three years of an intervention depending on the indicators that are tracked. To achieve “maximum sustained impact” of the intervention, it will require multiple years of sustained effort. For example, as illustrated in **Figures 3**, in the United States it took well over a decade of implementation of a large-scale, well-financed public nutrition program[[8]](#footnote-8) to help reduce stunted growth among low income SE Asian immigrant children to the target levels of about 5%.
2. When data is reliable, and the prevalent anthropometric indicator of pediatric malnutrition (e.g. height-for-age Z-score (HAZ)<-2.0) is substantially higher than that of the World Health Organization (WHO) standard prevalence of about 2.3%, the entire Z-score distribution will be “shifted to the left” of the standard[[9]](#footnote-9) (**Figure 4**). This indicates that even among children who do not fall below the Z-score cutoff, a large majority have likely not achieved their optimal growth. Thus, targeting interventions only at children with low height-for-age Z-scores will not alter the nutritional profile of entire population of children. The same principle applies to the distribution of weight-for-age and weight-for-height Z-scores, and for that of hemoglobin (Hb) measurements used to screen children or women for anemia (in comparison with the associated reference population’s Hb distribution). Thus, it is essential that evidence-based preventive nutrition interventions, such as those listed in **Table 1**, are accessible by all children and women of childbearing age.

*Figure 2. Trends in prevalence of height-for-age Z-score <-1.65 among low-income children less than 5 years old by ethnic group in the United States.*



Source: Centers for Disease Control and Prevention. Pediatric Nutrition Surveillance System.

*Figure 3, Example of the height-for-age Z-score distribution in children <5 years old in a population with high prevalence of stunting compared to the WHO standard height-or-age Z-score distribution for <5 year old children*



## Nutrition Situation in Afghanistan

Although there have been improvements in some indicators of nutritional status of the Afghan population during the past decade, the 2013 National Nutrition Survey indicates that the public health burden of malnutrition is still among the highest in the world. Furthermore, there is substantial variation in the prevalence of various indicators of nutritional deficiency, especially among women and young children, across the nation’s provinces. Findings of the 2013 national nutrition survey[[10]](#footnote-10) indicate that although there have been some improvements in the nutritional status of the Afghan population over the past decade, substantial proportions of the population continue to suffer from malnutrition. For example:

1. The prevalence of stunting (low height-for-age Z-score <-2) in children <5 years old has apparently decreased by about 20%, from 60.5% in 2004 to 40.9% in 2013. However, large differences were found in such chronic malnutrition among children across the country, from a prevalence of 24% in the province of Ghazni to 71% in Farah (Figure 4).The contributing factors for such a wide variation in the prevalence of stunted growth need to be better understood.

*Figure 4. Prevalence of children <5 years old with height-for-age Z-score<-2.0 by province - Afghanistan, 2013.*

It should be noted that the prevalence of stunting among Afghan children increases from birth until 5 years of age (see Table 3) and indicates urgency of interventions at the early life stages.

*Table 2. Prevalence of children <5 years old with height-for-age Z-score<-2.0 by age*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Age (months)** | **N** | **HAZ <-2 (%)** | **95% CI** | |
| 0-5 | 2301 | 24.5 | | 22.09 - 27.12 |
| 6-11 | 2295 | 31.4 | | 28.62 - 34.37 |
| 12-23 | 3811 | 42.6 | | 40.12 - 45.12 |
| 24-35 | 4377 | 45.6 | | 42.88 - 48.28 |
| 36-47 | 4145 | 47.4 | | 44.84 - 49.94 |
| 48-59 | 3951 | 43.3 | | 40.41 - 46.21 |

This is likely because the fetus is relatively “protected” while in the womb, but is exposed to harsh environmental and dietary risks over time following birth so that the rate of growth slows as the child grows older.

Also, it is important to note that the overall mean height-for-age Z-score of -1.55 among <5 year olds in Afghanistan is shifted to the left of the mean height-for-age Z-score of 0.0 of the international growth standard[[11]](#footnote-11). This indicates that even among those Afghan children with heights above the cut-off for stunted growth, a very large proportion may not have achieved their full physical growth (see Figure 4 for an example).

1. Although the prevalence of acute malnutrition (or wasting) (weight-for-height <-2 Z-score) did not substantially change in 2013 (9.5%) compared to 2004[[12]](#footnote-12) (8.7%) nationwide, very large differences in the prevalence of this indicator were found across the country’s provinces in 2013 – from <4% in Faryab to ~22% in Urozgan.
2. Vitamin and mineral deficiencies are highly prevalent among women of childbearing age and young children in Afghanistan (Table 4). However, the iodine status of the population appears to be substantially improved, and the prevalence of iodine deficiency among women of childbearing age and children 7 – 11 years old (urinary iodine (UI) <100 µg/L) has declined from about 75% and 72% respectively in 2004[[13]](#footnote-13), to about 41% and 30%, respectively in 2013[[14]](#footnote-14). This is most likely due to the impact of the national salt iodization program which started in 2003, and now includes 30 iodized salt production facilities in 12 provinces of the country. The 2013 survey data indicate that 66% of household nationwide consume salt containing >15 ppm iodine.
3. The 2013 data indicate that nearly one-fourth of women and young children in Afghanistan are iron deficient. Based on low serum ferritin levels, 24 % women of reproductive age and 26.1% of children between 6-59 months of age have iron deficiency. Because zinc protophyrin (ZPP) was used to assess iron deficiency in 2004 national nutrition survey, and it was only possible to collect data on 15 survey clusters nationwide then, it is not possible to adequately compare those findings with the 2013 prevalence estimates.

*Table 3. Prevalence of anemia and vitamin and mineral deficiencies by population group. Afghanistan, 2013*

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition/Deficiency** | **Women of Reproductive Age**  **(15-49 Yrs)** | **Children**  **(6-59 mos)** | **Adolescent girls**  **(10-19 yrs)** |
| Prevalence | | |
| **Anemia** | 40.4% | 44.9% | 30.9% |
| **Iron deficiency** | 24.0% | 26.1% | - |
| **Iodine deficiency** | 40% | 29.5% | - |
| **Zinc deficiency** | 23.4% | 15.1% | - |
| **Vitamin A deficiency** | 11.3% | 50.4% | - |
| **Vitamin D deficiency** | 94,8% | 81.0% | - |
| **Folate deficiency** | - | - | 7.4% |

1. Half of children less than 5 years old in Afghanistan are still vitamin A deficient. Thus, a review of the implementation of the national high-dose vitamin A capsule distribution program is warranted.
2. As shown in Table 4, nearly all women of childbearing age are vitamin D deficient, while over 80% of young children are affected by such deficiency. A combination of diets low in vitamin D, combined with very low exposure of people’s skins to sunlight due to wearing of conservative clothing is the cause of such deficiency.
3. Unofficial data from the Rabia Balkhi Hospital (RBH) in Kabul indicate a NTD birth prevalence of ~ 43 per 10,000 births (personal communication, Dr. David Gahn, Afghanistan Safe Birth Project, 2009), which is about 7 times higher than that in the United States[[15]](#footnote-15).

## Causes of malnutrition and framework for interventions

The UNICEF conceptual framework for malnutrition [Figure 5 below] provides a way to understand how these causes are related to each other. The causes are divided into *immediate causes*, u*nderlying causes* and *basic causes*.

**Immediate Causes:** Inadequate food intake and disease are inextricably linked. Food intake refers to both the quantity and quality of food required to provide adequate amounts of nutrients for health and growth. In Afghanistan 58.4% of children less than 6 months receive exclusive breastfeeding, which indicates that almost half of children do not receive adequate breastfeeding and by receiving additional food and water they are at high risk of childhood illnesses. Only 14.2% of children 6-23 months receive Minimum Acceptable Diet, which is a summary measure of the diet of a child which considers dietary diversity and meal frequency. It simply indicates that more than 75% of children do not receive adequate complementary food, which is a great risk for growth stunting[[16]](#footnote-16). The National Nutrition Survey 2013 also found that nearly 65% of children under five years had symptoms of illness among them diarrhea (25.4%), flu (22.9%), fever (21.3%), and abdominal pain (8.3%) were prominent. These conditions also interfere with the normal food intake and push children to malnutrition if proper care is not provided to them.

**Underlying Causes:** The immediate causes of malnutrition may be affected by other factors. Adequate food intake for the individual will not be possible if the food available in the household does not provide the diet needed to avoid malnutrition. In Afghanistan, a limited food supply and access to safe water, combined with poor sanitation conditions and hygiene practices that result in a high prevalence of diarrheal disease and gastrointestinal parasitic worm infestation, are direct causes of the heavy public health burden of malnutrition. Important indirect societal factors that also contribute to malnutrition among women and children in the country include low awareness about the nutritional needs of women and children among the general population, low status of women, large family size, early marriages, multiple gestations, and an intergenerational cycle of females of small stature giving birth to small babies.

Based on the National Risk and Vulnerability Assessment 2011-12 (NRVA 2011-12) survey[[17]](#footnote-17), 30% of the population are food-insecure (consume< 2,100 kilo calories/person/day), and among them, 27% are severely food insecure (consume< 1,500 kilo calories/person/ day). It was also found that a large percentage of the population consumes a cereal-based diet (>500 g/person/day) which is generally low in micronutrient content, and about 19% of the people have low intakes of protein (< 50 g/person/day). It is also important to note that based on the NRVA 2011-12, the diets of a somewhat larger proportion (20%) of the urban population is low in calorie and protein compared to 18% and 15% of the rural and Kuchi populations, respectively. Thus, although the bulk of the international donor agency funds for nutrition programs in Afghanistan have targeted rural populations, it should be understood that urban dwellers are at substantial risk of malnutrition as well.

More than 70% of households nationally, and close to 90% of urban ones, purchase wheat flour[[18]](#footnote-18). The vast proportion of commercial flour is imported into Afghanistan, but not fortified. Similarly, nearly all Afghan households purchase industrially produced vegetable oil and ghee. More than 90% of such oil and ghee products are imported while one or two domestic factories produce the remaining amount. None of the oil/ghee is yet fortified, though efforts are underway to ensure fortification of these staple food ingredients with vitamins A and D.

Less than half (46%) of the population uses improved sources of water (e.g. from hand pumps, bored wells, protected springs or piped). Although this is a substantial improvement compared to 27% in 2007-08[[19]](#footnote-19), the distribution of access to improved sources of water remains substantially different across population groups - 71% among urban dwellers, and only 39% and 21% among rural and Kuchi populations, respectively. However, it should be noted that access to an improved water source does not always equate to consumption or use of “safe” or uncontaminated water. This is because a very large proportion of Afghan households store potable water in containers without sealed lids and dispenser nozzles, and dip other utensils to obtain the water from the containers. Such conditions result in contamination of water within the households.

With regard to sanitation and hygiene, the 2011-12 NRVA found that only 8% of the Afghan population uses improved sanitation facilities. As >90% of the population uses uncovered latrines, open pits or open field/bush for defecation, the transmission of excreta-related disease through animal and insect routes is very high. Human-to-human transmission of disease is also frequent because a large proportion of the people do not use soap and clean water after defecation.

Due to the consumption of unsafe water and exposure to poor sanitary conditions and behaviors, young children are highly prone to frequent bouts of diarrheal disease and other infectious illnesses. Based on the 2006 Afghanistan Health Survey[[20]](#footnote-20), 46% of children less than five years old suffer from diarrhea. Severe and repeated bouts of diarrhea are the primary causes of pediatric acute malnutrition in the country.

Also due to the consumption of contaminated water and food, and skin contact with soil contaminated by feces containing worms or worm eggs, it is estimated that 60% of Afghan children are infected by intestinal worms[[21]](#footnote-21).Such parasites reduce the absorption of nutrients which leads to malnutrition. Furthermore, although specific data are not available for Afghanistan, it is estimated that two-thirds of the world’s population is infected by the Helicobacter pylori (H. pylori) bacterium – a gastrointestinal (GI) parasite[[22]](#footnote-22). Although the transmission of H. pylori is not well understood, it is thought to be due to fecal-oral transmission as a result of poor sanitation and hygiene practices which is a common problem in Afghanistan. H. pylori infection is a major cause of GI ulcers and associated bleeding that increases the risk of iron deficiency and anemia due to the increased blood loss.

**Basic Causes:** All the above mentioned causes are developed in a context where the social, political and economic institutions and structures are not appropriate. Availability and distribution/redistribution of wealth, accountability and transparency, peace and tolerance, employment opportunities, cultural issues are the basic causes of malnutrition. In summary high rate of child malnutrition in a society is a sign of social, political and economic failure. Afghanistan where the GDP per capita is 678 USD the country is heavily dependent on external aid from donor agencies. The Human Development Index has seen gradual improvement over the last decade, though Afghanistan is still ranked 175th out of the 187 countries. Interestingly, the HDI for health has shown a consistent increase. The huge reliance on external aid also poses a problem and challenges the sustainability of health and nutrition interventions. To address the basic and underlying causes of malnutrition in Afghanistan some efforts have been started since 2012 by the MoPH and development partners. The Nutrition Action Framework (NAF) document has been developed by five ministries (MoPH, MoE, MRRD, MAIL and MoCI), which document the key roles and responsibility of each sector in reduction of malnutrition and improving nutrition status. This development was a great step towards recognition of the role of nutrition as a national development agenda. However, the framework is only a document so far and needs to be translated into action with support from the political leadership of the country to ensure accountability, transparency and effectiveness of each sector in improving nutrition status of the Afghans.

The Lancet journal in its series on maternal and child nutrition published in 2013, proposes three levels of interventions to combat the problem of malnutrition among children (see figure 6, shows the framework). These interventions, in fact, address the immediate, underlying and basic causes of malnutrition, according to Unicef Conceptual framework on malnutrition and are categorized as:

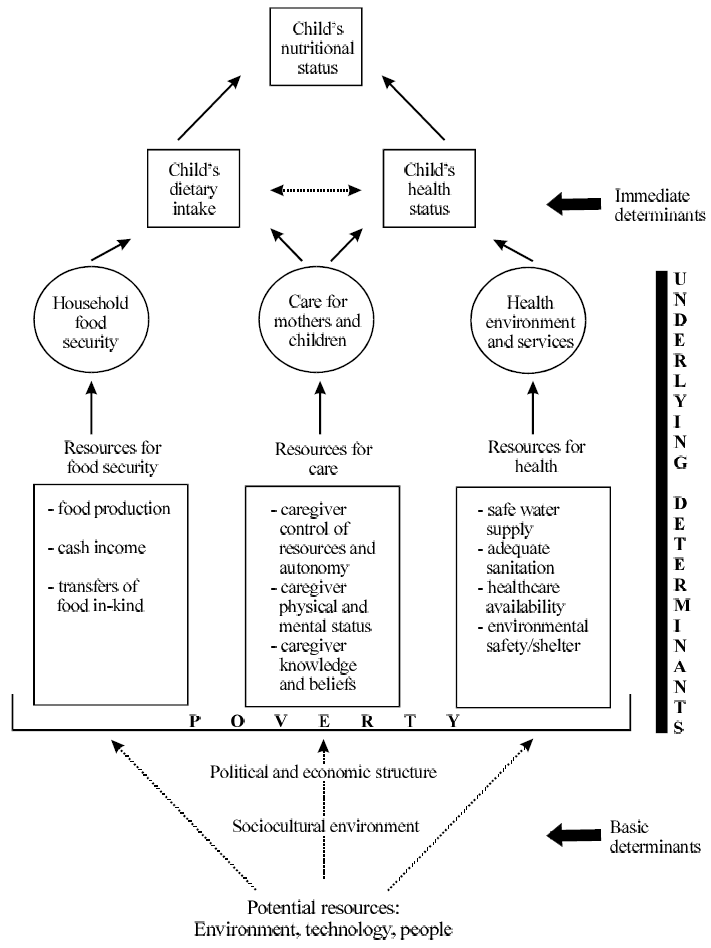
1) Nutrition specific interventions: Includes interventions such as adolescent and pre-conception nutrition, maternal nutrition, micronutrients supplementation and food fortification, breastfeeding and complementary feeding, dietary supplementation for children, dietary diversification, feeding behaviors and stimulation, treatment of acute malnutrition, disease prevention and management and nutrition interventions during emergencies.

2) Nutrition sensitive interventions: Includes agriculture and food security, social safety net, early child development, maternal mental health, women’s empowerment, child protection, classroom education, water and sanitation, health and family planning services.

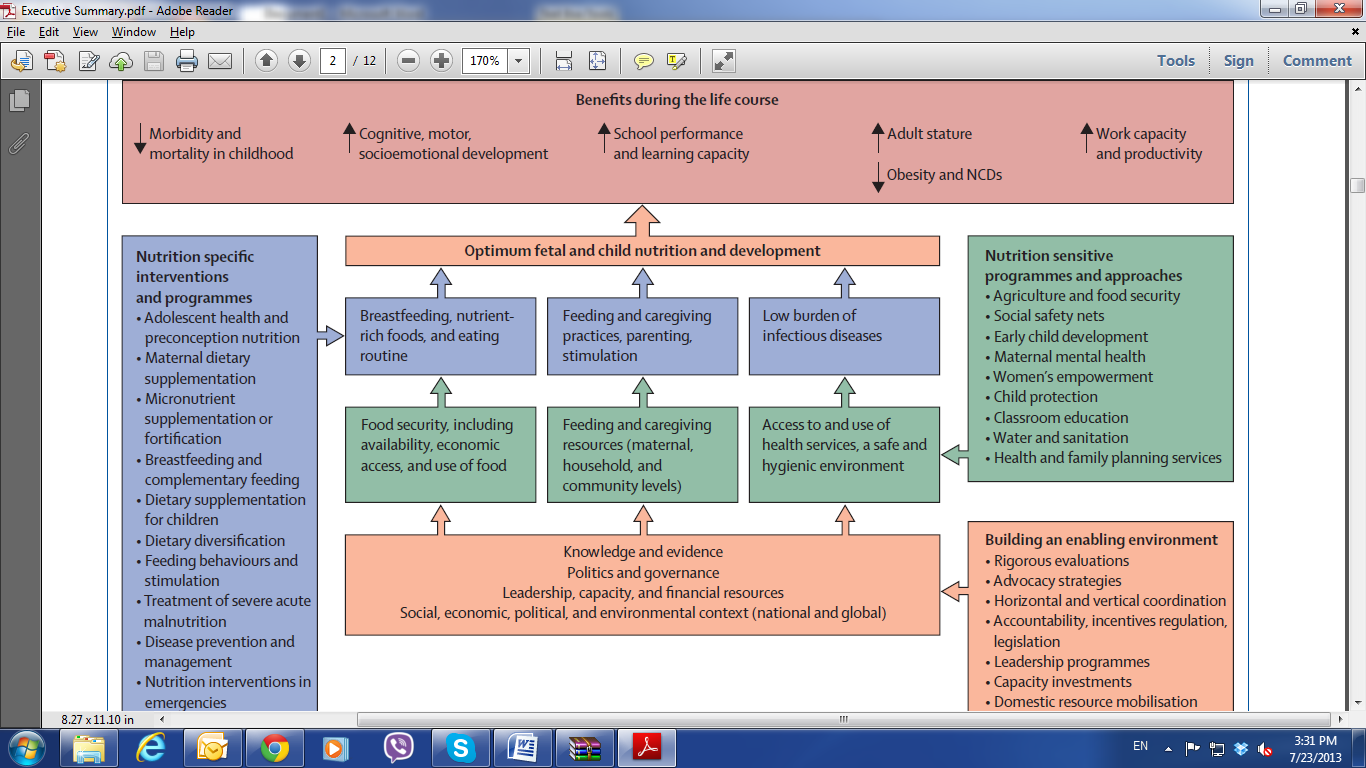
3) Building enabling environment: Rigorous evaluation, advocacy strategies, horizontal and vertical coordination, accountability, incentives, legislations, and regulations; leadership programs; investment in capacity development and mobilization of domestic resources.

These evidence-based interventions have been used in this document to formulate strategies based on realities of the Afghanistan context.

*Figure 5, Unicef conceptual framework*

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*Figure 6, Nutrition Action Framework, Lancet series on maternal and child nutrition, 2013*



## Consequences of malnutrition:

The estimated consequences of the high burden of malnutrition in Afghanistan are summarized in **Table 4.** It is evident that without appropriate public and private sector investments to help improve the nutritional status of women of childbearing age and young children, the cognitive and physical development and work performance potential of the population will be diminished and economic development of the country will continue to be retarded, even when peace is restored.

*Table 4. Summary of the burden of malnutrition among Afghan children and women and its potential consequences\**

|  |  |  |
| --- | --- | --- |
| **Form of Malnutrition** | **Prevalence in Afghanistan** | **Consequence**† |
| Stunting | **40.1%**  (in children under age 5) | Reduction of 5-11 IQ points per child. |
| Wasting | **9.5%**  (in children under age 5) | Odds ratio of mortality: moderate wasting = 3.0; severe wasting 9.4‡‡. |
| Iodine deficiency disorder | **29.5%**  (in children under age 5) | Reduction of 10-15 IQ points per child |
| Anemia | **44.9%**  (in children under age 5) | Reduced adult productivity by 5-17%.  Loss of up to 25 IQ points in children less than 2 years of age. |
| Vitamin A deficiency | **50.4%**  (in reproductive age women) | Reduced immunity to disease by 23%. |

\*Source: Islamic Republic of Afghanistan. Nutrition Action Framework: 2012 – 2016. April, 2012 (DRAFT).

†The source for the estimated levels of consequence are from the 2008 Lancet series (The Lancet, “Maternal and Child Undernutrition,” Special Series, January, 2008).

‡‡i.e. a severely wasted child has a 9.4 times greater risk of dying before the age of 5 than a child who is not wasted.(Source: Black Ret al. Maternal and child undernutrition: global and regional exposures and health consequences. The Lancet: 371:9608: 243-260: January 19, 2008).

In summary the consequences of malnutrition, especially stunting among children can be divided in shorter and long terms consequences in three categories of 1) health; 2) Development and 3) Economy. Table 5, bellow shows these consequences:

*Table 5. Consequences of stunting growth and development*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Health consequences of stunting** | **Development Consequences** | **Economic Consequences** |
| **Short term** | Premature death  Infectious diseases such as diarrhea, pneumonia and measles | Motor skills: delay in sitting, standing and walking  Cognitive development: delayed learning | Health costs |
| **Long term** | Increased risk of overweight later in life with associated higher risk of coronary heart diseases, stroke, hypertension and type II diabetes  Higher risk of complicated labor and retarded fetal growth | Cognitive and language ability at age 5 years  Learning in school  Lower score in development tests (IQ) and school performance | Lower aerobic capacity affect physical work  Reduced likelihood of formal employment; earn 20% less than non-stunted individuals  1% loss in adult height due to childhood stunting is associated with 1.4% loss in economic productivity |

## Review of Nutrition Policy/ strategy 2009-2013 Achievements/ constrains

In the National Nutrition Policy & Strategy 2009-2013, eight strategic priorities were proposed, which were also integrated in the MoPH Strategic Plan 2011-2015 under the first strategic direction. The following is an analysis of achievements and constrains for each of the strategic priorities:

***Strategic Objective 1 (SO-1): To advocate for and increase awareness about healthy eating among the general population***

The MoPH has great achievements in terms of communication and advocacy at different levels, including within the multi-sectoral approach, as well as spreading nutrition education messages to the public through different channels. Developing Nutrition Action Framework with different sectors, involving mass media in nutrition communication, including nutrition agenda in different curricula with several programs with development partners are among the outstanding achievements.

However, there are several developments at the global level which require Afghanistan to scale up nutrition activities further. The Lancet Series on Child and maternal nutrition published in June 2013, establishment of a global movement called Scale Up Nutrition (SUN movement), importance of nutrition in the first 1000 days of life, linkage of stunting with hygiene and sanitation, role of women empowerment in reducing child malnutrition are among the key examples. Based on all these new developments in the field of nutrition, the MoPH also needs to clarify its leadership role in the sector and step up to involve other sectors with more clear roles and responsibilities in providing nutrition sensitive interventions as well as improving the effectiveness and quality of nutrition specific activities. On the other hand, still a lot of mothers and caretakers do not have appropriate knowledge on malnutrition causes and consequences of malnutrition and do not practice appropriate feeding and caring practices to prevent malnutrition.

Therefore, the current achievements are not enough and MoPH needs to focus more on advocacy at different levels as well as public awareness on appropriate nutrition behaviors. Furthermore, a shift in the strategic approaches from dissemination of nutrition messages to more behavior change, skill building and enabling environment is required.

***Strategic Objective 2 (SO-2): 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 illnesses such as scurvy***

Micronutrient programs are also one of the successful interventions on combating micronutrients malnutrition and stunting in the country, national strategy on prevention and control of micronutrients deficiencies has been developed. National Nutrition Survey 2013 shows that micronutrients deficiencies, especially Iron, Iodine and zinc have been reduced considerably. Iron folic acid supplementation, salt iodization and supplementation of zinc during treatment of diarrhea have been the key programs, with wide coverage in Afghanistan.

However, high level of vitamin D and vitamin A deficiency among children and women was discovered in the NNS 2013. Still the level of iron deficiency, iodine deficiency, folate deficiency are very high, as compared to the WHO cut-off point. Therefore, there is a need for more clear strategies on food fortification, food diversification as well as improving the quality of current supplementation programs for addressing micronutrient deficiency.

***Strategic Objective-3 (SO-3):******To strengthen case management and increase access to quality therapeutic feeding and care at health facility and community levels***

To strengthen the treatment and follow up of acute malnutrition cases, the Community-based Management of Acute Malnutrition (CMAM) was integrated to Basic Package of Health Services (BPHS) in 2009 and subsequently the CMAM guideline has been revised and integrated (outpatient and inpatient) as Integrated Management of Acute Malnutrition (IMAM) in 2014. Currently there are more than 500 Out-patient Department for SAM (OPD-SAM), more than 500 Out-patient Department for MAM (OPD-MAM CH/AM-PLW) and around 100 Inpatient Department for SAM (IPD-SAM) sites under the IMAM program is functioning in 34 provinces.

These all efforts are done as part of nutrition in the emergency program and for further long term development we need to strengthen the nutrition components in BPHS which covers treatment of MAM and SAM.

***Strategic Objective-4 (SO-4):******To ensure that all commercial and home-produced foods are safe for consumption***

In the MoPH the Food and Drug Quality Control Department has been established a long time ago which is responsible for qualitative analyses of water, iodized salt, fortified flour, edible oil and other food items. Also inspections of foods in the costume, production and market levels performing by relevant departments of MoPH and MAIL.

There is need to develop clear protocols with clear roles and responsibilities of each entity and ensure its proper implementation in each level of food supply chain.

***Strategic Objective-5 (SO-5):******To monitor the nutritional situation in Afghanistan and strengthen the monitoring and evaluation of nutrition strategies and programs, in order to inform development planning and emergency responses***

National Nutrition Survey was conducted in 2013, a nutrition surveillance system is established, and for routine activities of nutrition through health system a reporting database is developed. Monitoring checklists are developed to ensure the quality of programs.

However, there is a need to focus on use of data for decision making, conducting more evaluation of current programs, and regular assessment of nutrition programs as well as nutrition status of the population to be addressed in the revised policy and strategy.

***Strategic Objective-6 (SO-6):******To ensure that responses to treat and prevent moderate acute, severe acute and chronic malnutrition are timely and appropriate, and that increases in Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM) are effectively managed***

Nutrition cluster coordinated efforts in resource mobilization and management of acute malnutrition in the country with support from humanitarian funds. All achievements in treatment of SAM and MAM in the country are mainly due to joint efforts of the Public Nutrition Department of MoPH, nutrition cluster, relevant UN partners and all other nutrition stakeholders.

For sustainability of the programs, it is needed to strengthen the nutrition component of BPHS/EPHS through regular development funds and the resources mobilized by nutrition cluster in emergencies to be used in innovative approaches to increase coverage and improve quality of services.

***Strategic Objective-7 (SO-7): To increase the percentage of child caregivers adopting appropriate infant and young child feeding practices***

A national Infant and Young Child Feeding Policy and Strategy has been developed in 2009 to strengthen the IYCF program. Breastfeeding counseling tools development and training of more than 100 breastfeeding master trainers and 5000 counselors at health facilities and community level, the Code of Marketing of Breast Milk Substitutes by the government endorsed in 2009 and national board on implementation and enactment of the Code has been established which is responsible for the monitoring of any violation of the Code. The Baby-Friendly Hospital Initiative (BFHI) established in 65 tertiary, regional, provincial and district hospitals of the country, IYCF communication campaigns through mass media and print materials, celebration of the world breastfeeding week each year to promote and support exclusive breastfeeding and timely introducing of complementary feeding practices to families and mothers, according to National nutrition survey 2013 report the exclusive breastfeeding rate is around 58.4% and initiation of breastfeeding within one hour of birth is 69.4%. Based on World Breastfeeding Trend Initiative (WBTi) assessment , Afghanistan ranked 12th out of 81 assessed countries, due to the existence of its IYCF policy, regulation, training package, counseling, exclusive breastfeeding and initiation of breastfeeding within one hour of birth high rate.

However, low complementary feeding rate was re-emphasized in the NNS 2013. Community food demonstration, IYCF counseling and monitoring of Code of BMS requires clear strategies and guidelines which need to be strengthen to improve the nutrition status of infants and young children.

***Strategic Objective-8 (SO-8): To strengthen in-country capacity to assess the nutrition situation, and design, implement, monitor and evaluate public nutrition interventions***

One of the key achievements of the MoPH was establishing the Public Nutrition Department and hiring nutrition officers at the provincial offices. Developing technical guidelines on key nutrition interventions, training of trainers for NGOs and periodic training sessions on different topics of public nutrition for the staff of implementing NGOs were some other achievements.

However, the great need of the country considering the nutrition situation of the population requires further attention and allocation of more resources to this important public domain.

In the training part, there is also a need to shift from knowledge transfer methods to more competency based training of health personnel to enable them provide quality services. These trainings cannot be done at once, and there should be a system of continuous education to make sure personnel keep their knowledge and skills updated and are able to answer to the growing needs of their clients. To achieve this there is a great need for academically qualified staff in nutrition with bachelor or master degrees. There is need for creating positions within the health system for these nutrition cadres to create demand for education in the field of nutrition.

## Summary of the situation (Problems Statements)

1. Continued high prevalence of malnutrition among young children and women of childbearing age, exhibited by essentially the entire population of children not achieving their growth potential, and very high prevalence of vitamin and mineral deficiencies among the children and women.
2. Inadequate understanding among the general population about malnutrition, its causes and consequences, as well as about age-appropriate feeding, stimulation and caring for young children.
3. Insufficient understanding by the high level national policy makers about the role of malnutrition in impeding national economic development, and the high benefit-to-cost ratio of sustained evidence-based nutrition interventions. Thus, there is an inadequate investment of national funds in public nutrition programs and substantial dependence of the MoPH on support from international donor agencies, which have earmarked most of the funds for humanitarian and emergency-related nutrition interventions rather than development nutrition programs. Furthermore, there has been insufficient coordination among different sectors engaged in nutrition-specific and nutrition-sensitive programs.
4. Continued high rates of infectious diseases and parasitic infestation due to the use of unsafe water, exposure to an unsanitary environment and inappropriate hygiene practices that are direct causes of malnutrition among women and children, as well as cultural practices of early marriages, multiple gestations, and low status of women within society are underlying determinants of maternal and child malnutrition.
5. Inadequate human resource capacity in planning, implementation and evaluation of public nutrition programs, as well as (shortfalls in the) delivery of preventive and therapeutic nutrition services by BPHS and EPHS providers. Furthermore, the PND has limited human resources, infrastructure, and budgetary and administrative capacity to carry out its responsibilities as the nation’s lead public nutrition agency.
6. Limited national capacity for regulatory quality control to assure the fortification and sanitary quality and safety of food products (fortified and otherwise) at the production and retail levels.
7. Lack of data to track the quality, coverage and impact of population-based nutrition interventions(e.g. food fortification and nutrition promotion efforts),and the delivery of nutrition services through the BPHS and EPHS, as well as an inadequate capacity to carry out applied research in public nutrition within the Afghanistan context or to fully evaluate the overall effectiveness of nutrition programs so as to guide related policy decisions.

# PART II

# National Nutrition Strategy 2015-2020

## Guiding Principles of the Public Nutrition Strategy

This Public Nutrition (PN) Strategy is developed with consideration of the MoPH core values of Equity, Honesty, Right to Health, Accountability and working principles of Right to health especially for women, children and other vulnerable groups, Gender balance. Quality; Transparency; Sustainability; Responsibility; Results orientated culture; Teamwork; cross functional and sectoral working; Evidence based decision-making; and Life long learning (Health Policy 2015-2020).

In addition this strategy has been developed in the light of following guiding principles:

* **Enhancement of nutritional status is an investment in economic development:** The highest levels of leadership within national and local governments, industry and business, and public and private health care and academic sectors must understand about the essential role of good nutrition in the economic development of the nation and take action accordingly.
* **Increased focus on prevention**: Orient nutrition interventions to promote optimal growth in young children, especially those <24 months old (i.e. infants and toddlers), and micronutrient deficiencies in women before and during pregnancy and infants and toddlers.
* **Transparent public-private sector partnership:** The public sector must acknowledge the critical role of private sector food producers, importers and retailers as protectors of the nutritional health and cognitive development of the population, and engage and enable them, through relevant inter-sectoral incentives and promulgation and transparent enforcement of appropriate laws and regulations to market nutrient-rich foods.
* **Quality and high coverage interventions:** To be effective, evidence-based maternal and child nutrition interventions should be implemented with high standards of quality, be accessible to essentially all women and children, and sustained over time. Interventions would range from enabling the population to have access to sufficient nutrient-rich foods, to promotion of appropriate dietary and feeding practices, to delivery of preventive and therapeutic maternal and child nutrition services.
* **Integrated approach:** Public nutrition interventions are integrated with reproductive health and family planning, child and adolescent health, immunization, water and sanitation, agriculture, rural development, education, and commerce, industry and labor programs, as well as through a collaborative and transparent partnership with the private food production, importation and retail sectors.

## Vision, Mission and Goal of the Public Nutrition Strategy

**Vision**

**Optimal nutritional status for all Afghans**

**Goal**

To reduce mortality and morbidity and contribute to economic development of the nation

**Strategic Objective:** Timely use of high quality, evidence based nutrition specific and sensitive services throughout Afghanistan

**Mission**

To sustainably improve the nutritional status of the people of Afghanistan, especially women and children, by advocating for and supporting strategies and actions to enable the population to adopt healthy dietary practices, access nutritious foods and benefit from quality preventive and therapeutic nutrition services.

## Results Framework

**Assumption:**

Government and development partners remain committed;

Political, security situation remain stable;

Other sectors responsible for nutrition sensitive interventions remain cooperative

No major emergency or crisis occurred

**GOAL: To reduce nutrition related mortality and morbidity and contribute to economic development of the nation**

Sub IR1.1. Increased availability of essential nutrition services at public and private facilities

Sub IR 1.2 Improved availability of nutrition products

Sub IR 1.3 Strengthened community based nutrition services

**INTERMEDIATE RESULT 1**

**Increased access to nutrition services and products**

**STRATEGIC OBJECTIVE: Timely use of high quality, evidence based nutrition specific and sensitive services throughout Afghanistan**

Sub IR 2.1: Improved knowledge of caretakers and community leaders/influencers on optimal nutrition behaviours

Sub IR 2.2 Increased awareness and engagement of media in promotion of optimal nutrition behaviours and products

Sub IR 2.3 Increased basic nutrition education for front line workers in health, education, agriculture, rural development and other institutions

Sub IR 3.1 Strengthened capacity of service providers and facilities to deliver nutrition interventions

Sub IR 3.2 Improved performance monitoring of nutrition services

Sub IR 3.3 Improved quality assurance system for nutrition products

Sub IR 3.4 Strengthened nutritional status monitoring and surveillance system

Sub IR 4.1 Strengthened the stewardship and governance role of MoPH in leading and coordinating multi-sectoral nutrition programs

Sub IR 4.2 Improved capacity to generate and use knowledge and evidence for nutrition programming and policy

Sub IR 4.3 Increased resources for nutrition

Sub IR 4.4 Strengthened nutrition policies, standards and regulations

**INTERMEDIATE RESULT 2**

**Improved nutrition behaviors and practices of public**

**INTERMEDIAT RESULT 3**

**Improved quality of nutrition services and products**

**INTERMEDIATE RESULT 4**

**Strengthened social, regulatory and political environment for nutrition**

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**GOAL: To reduce nutrition related mortality and morbidity and contribute to economic development of the nation**

**STRATEGIC OBJECTIVE: Use of high quality, evidence based nutrition specific and sensitive services throughout Afghanistan**

Child mortality rate

Stunting among children < 5

Anemia among women of reproductive age

**INTERMEDIATE RESULT 1**

**Increased access to and availability of nutrition services and products**

Treatment coverage for children <5 with acute malnutrition

**INTERMEDIATE RESULT 2**

**Improved nutrition behaviors and practices of public**

Use of minimum acceptable diet in children 6-23 months

**INTERMEDIATE RESULT 3**

**Improved quality of nutrition services and products**

Service delivery points improved quality as per score card

**INTERMEDIATE RESULT 4**

**Strengthened social, regulatory and political environment for nutrition**

Overall budget allocated for nutrition $US per year

97 /1000 Live Birth

40.9 %

40%

34 %

16.3 %

21.7 M

65/ 1000 Live Birth

35.9%

30%

80 %

40%

**Results**

**Indicators**

**Baseline (2015)**

**Targets (2020)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Strategic approach** | **Interventions areas** | **Illustrative Activities/evidence-based actions** | **Indicators** |
| **Ultimate outcome - Goal To reduce nutrition related mortality and morbidity and contribute to economic development of the nation** | | | |
| **Intermediate Results – 1 Increased access to nutrition services and products** | | | |
| **Sub Intermediate Results** | | | |
| **1.1 Increased availability of essential nutrition services at public and private facilities** | | | |
| Essential Nutrition Actions (ENA) focused on the 1000 day window of opportunity | Infant and Young Child Feeding and Caring Practices | Providing skilled counselling and support on infant and young child feeding at health facility level   * Delayed cord-clamping * Early Initiation of breastfeeding (within one hour of birth) * Exclusive breastfeeding up to six months of age * Timely, adequate, safe and appropriate complementary feeding with breastfeeding up to 2 years   Scale up of Baby Friendly Hospital Initiative  Support monitoring of national regulation on marketing of breast milk substitutes  Growth monitoring and skilled counselling and support for appropriate IYCF  Provision of IEC materials to the Health facilities | *Proportion of children born in the last 24 months who were put to the breast within one hour of birth.*  % of infants who were exclusively breastfed up to 6 months of age    *Proportion of infants 6–8 months of age who receive solid, semi-solid or semi-solid foods.*  *% of children 6–23 months of age who receive foods from 4 or more food groups.*  *% of children 6–23 months of age who receive solid, or semi-solid, the mini­mum number of times or more.*  *% of caregiver of infants aged 0-23 months who received IYCF counselling from health workers*  *% of caregiver of infants aged 6-23 months who received complementary feeding counselling from health workers*  *% of maternity facilities that apply at least 6 of the 10 Steps to Successful Breastfeeding*  *Number of health facilities supporting monitoring of national legislation on marketing of breast milk substitutes*  *% of children less than two years received growth monitoring and promotion last two quarters*  *Proportion of health facilities with adequate nutrition IEC materials (a list of materials to be included as a check list)*  *Proportion of health facilities with nutrition SOP guideline* |
|  | Promote adequate intake of vitamin A in children under five | Provide semi-annual Vitamin A supplementation for children (6-59 months)  Provide semi-annual deworming for children (24-59 months)  Provide Vitamin A supplementation for children with measles  Multiple-micronutrients supplementation for children under five  Screening, diagnosis and treatment of anemia/other micronutrient deficiency among children under five | *% of children 6-59 months who have received vitamin A supplementation during the previous 6 months*  *% of children 24-59 months who received deworming in the previous 6 months*  *% of children 6-24 months who received multiple micronutrient in the previous 6 months*  *% of children 0-59 months diagnosed with anemia/other micronutrient deficiency who received treatment* |
| Diarrhea treatment and management for children under five | Provide zinc supplementation with ORS for diarrhoea treatment for children under five | *Proportion of health facilities without stock outs of ORS and Zinc lasting more than 1 week in the last 3 months*  *% of children under five with diarrhea received Zinc and ORS* |
| Integrated management of acute malnutrition for under five children | Provide In-patient and Out-patient services for management of acute malnutrition | *Proportion of health facilities with no stock outs of nutrition treatment products in the last 3 months*  *% of health facilities that provide IMAM (IPD-SAM, OPD-SAM and OPD-MAM)*   * *% of children 0 -59 months with acute malnutrition who were admitted for treatment (IPD-SAM, OPD-SAM and OPD-MAM) in the last 3 months* * *Proportion of children 0 -59 months with acute malnutrition who did NOT default from IMAM programme ( IPD-SAM, OPD-SAM in the last 3months* * *Proportion of children 0- 59 months with acute malnutrition who were cured IPD-SAM, OPD-SAM and OPD-MAM) in the last 6 months* |
| Adolescent nutrition | Provide weekly Iron folate supplementation and deworming for school going and out of school adolescent girls  Conduct nutrition education on healthy dietary practices for school going and out of school adolescent girls | *Proportion of adolescent girls 10-19 years who received weekly Iron Folic Acid supplementation (WIFS)*  *Proportion of schools promote food based dietary guidelines* |
| Maternal nutrition-pregnant and lactating mothers  Integrated Management of acute malnutrition for pregnant and lactating women | Provide Iron folate supplementation for pregnant women during ANC  Conduct nutrition education at health facility on healthy dietary practices to Women of reproductive age.  Conduct routine weight Monitoring and appropriate counseling and support for improved dietary intake for the pregnant women  Conduct skilled counselling and support for improved dietary intake for lactating women (Promotion of nutrient rich foods: eggs, milk, liver, pulses (beans, lentils, chickpeas) and fortified food (iodized salt, fortified wheat flour and oil)  Promotion use of food based dietary guideline  developing and implementing nutrition protocols  Provide Post-partum Vitamin A and deworming  Provide Multi-micronutrient supplementation for pregnant & lactating women  Screening, diagnosis and treatment of anemia/other micronutrient deficiency among PLW  Calcium supplementation for targeted pregnant women  Provide supplementary foods to pregnant and lactating women according to the admission criteria on integrated management of acute malnutrition guidelines. | *.*  *% of pregnant women received 90+ IFA during pregnancy*  *Proportion of pregnant mothers who received any IFA*  *Proportion of health facilities with no IFA stock-outs lasting more than 1 week in the past 3 months*  *Proportion of pregnant women reporting having received information and counselling on dietary diversity by a health worker*  *Proportion of health facilities with no multiple-micronutrient supplements stock-outs lasting more than 1 week in the past 3 months*  *Number of PLW diagnosed with anemia who received treatment*  *Proportion of health facilities provide calcium supplements for targeted pregnant women*  *Proportion of pregnant and lactating women with acute malnutrition who are receiving food supplements* |
| Nutrition of sick children under five | Promotion use of food based dietary guideline  developing and implementing nutrition protocols for sick children e.g. low birth weight, preterm etc., | *Proportion of caregiver of sick infants aged 0-23 months who received IYCF counselling – feeding during illness from health workers* |
| **Nutrition in the context of Emergency** | Nutrition cluster coordination  Nutrition assessment during emergency  Management of acute malnutrition during emergency  Access to Micronutrients from fortified foods , supplements or micronutrient preparations  Infant and young child feeding (e-IYCF) accessed by affected women and children during emergency | Coordination with other active stakeholders in emergencies  Conduct rapid nutritional assessment in emergency affected areas  Monitor food safety of nutrition commodities for use in emergencies  Screening and referral for acute malnutrition during emergencies  Children and women with acute malnutrition access appropriate management services  Blanket, targeted food distribution & micronutrient supplementation, as appropriate in emergencies  Provide vitamin A deworming to children under 5 in the emergency affected areas  Provision of micronutrient powder for children under 5 in the emergency affected areas.  Providing education and skilled counselling and support on infant and young child feeding at health facility level  Support monitoring of national regulation of marketing of breast milk substitute | *Number of cluster coordination meeting at national level*  *Number of Provinces conducting regular cluster coordination meeting at provincial level*  *Number of provinces with emergency response plan in place*  *Number of RNA conducted in emergency affected areas*  *Number of children screened and referred for acute malnutrition during emergencies*   * *Proportion of children 0 -59 months with acute malnutrition who were admitted for treatment (IPD-SAM, OPD-SAM and OPD-MAM) during emergencies* * *Proportion of children & women with acute malnutrition who were admitted for treatment (OPD-MAM) during emergencies*   *Number of beneficiaries received Blanket, targeted food distribution & micronutrient supplementation, as appropriate in emergencies*  *Number of 6-59 months received vitamin A and deworming in the emergency affected areas*  *Number of children 6-59 months received micronutrient powder for children in the emergency affected areas.*  *Proportion of caregiver of infants aged 0-23 months who received IYCF counselling in the emergency affected areas*  *Number of violation against National Regulation on Promotion and Support of child feeding with breast milk reported during emergencies* |
| **1.2 Improved availability of nutrition products** | | | |
| Developing public-private partnership | **Industrial food fortification**  Scale up fortification of staple food | Fortification of Wheat Flour and edible oil with micronutrients  Universal Salt Iodization  Promotion of the use of fortified foods including iodized salt at household level  Advocate and create public awareness on food fortification  Monitor quality of fortified foods regularly at all level | *% of household using fortified wheat flour*  *% of households using fortified edible oil*  *% of household using iodized salt > 15 ppm*  *Number of advocacy meetings about food fortification*  *Number of TV and radio spots produced and aired on promotion of fortified staple foods*  *Number of quality control monitoring visits conducted at production and market levels* |
| **Home-based food fortification**  Home-made complementary foods  Home fortification with multiple micronutrient | Fortification of complementary foods with multi-micronutrient powders | *% of children 6 -23 months received 2 dose ( 120 sachet) of MNP in the last year* |
| Supply chain management for all nutrition products | Provision of therapeutic food for treatment of acute malnutrition  Support secure delivery chain of critical supplies | Developing standard operation producers for supply chain management  Procure and distribute essential nutritional commodities (micronutrient supplements, MNP for home fortification, therapeutic milks and foods) and equipment (anthropometric and others) as per the SOP  Establishing systems to support the procurement, storing and delivery of critical supply such as therapeutic food etc | *% of health facilities with no stock-out of nutrition products for treatment of acute malnutrition among children under five* |
| * 1. ***Strengthened community based nutrition*** | | | |
| Community outreach for essential nutrition actions focussed on 1000 days window | Community based Infant and Young Child Feeding and Caring Practices  Control and prevention of diarrhea and parasitic infections | Community Growth monitoring and promotion  Providing community support on infant and young child feeding through CHW, family action groups, shuras etc.  Community mobilisation and awareness on national regulation on promotion and support of child feeding with breast milk  Provide community support for appropriate complementary feeding through CHW, family action groups, shuras etc.  Provision of IEC materials to the health post/ CHW)  Promote proper hygiene practices, and timely seeking of health care.  Provision of adequate amount of Zinc and ORS to all health post based on case load for management and control of diarrhoea in under 5 children | *Proportion of health post/CHW reporting having had no stock-outs of MUAC tapes*  *Proportion of health post/CHW with adequate materials/job aids/counselling cards etc. to promote optimal IYCF practices and handwashing with soap at community level*  *Proportion of caregivers of children 6-11 months who can correctly state the five critical points for handwashing with soap (after defecation, before and after eating, before food preparation, before breastfeeding, after nappy change)*  *Proportion of caregivers of children 6-11 months with evidence of practicing handwashing with soap at the household (observe for presence of handwashing place, water and soap for practicing handwashing)*  *% of health post with adequate amount of zinc and ORS supply during last 3 months ( based on case load)* |
| Management of acute malnutrition | Community mobilization for integrated management of acute malnutrition  Conduct active screening, referrals and follow up of malnourished children by CHW  Recipes for locally available food for treatment of MAM and prevention of SAM | *Number of health posts providing management of acute malnutrition for children under five* |
| Prevention of iron deficiency anaemia among children, adolescent girls and PLW | Promotion of nutrient rich foods: eggs, milk, liver, pulses (beans, lentils, chickpeas)  Promotion use of food based dietary guideline  Promotion of nutrient rich and fortified foods |  |
| Promote Innovations in provision of nutrition services | Request for applications on innovative approaches | Use new technology e.g. Rapid SMS to communicate information on referrals between community-level workers and facility to minimize the need for additional facility visits by community workers. | *Number of children referred-in with acute malnutrition from communities* |
| **Intermediate Results – 2: Improved nutrition behaviours and practices of public** | | | |
| **Sub Intermediate Results** | | | |
| **2.1: Improved knowledge of caretakers and community leaders/influencers on optimal nutrition behaviours** | | | |
| Community-centred approach that empowers communities with knowledge and tools to address their own nutrition issues | Promotion of Infant and Young Child Feeding and Caring practices  Promotion of nutrition sensitive interventions    Intake of iron and folic acid (IFA) supplementation during pregnancy and post-partum  Consumption of adequately iodized salt by family member, including pregnant women  Consume fortified staple foods  Use of micronutrient powder for home fortification of complementary food  proper feeding during and after illness for children | Develop adapt and disseminate harmonised IEC/BCC material on Nutrition in 1000 Days (Job aids, booklets, brochures, wall charts)   * Early and Exclusive breastfeeding up to six months of age * Timely, adequate, safe and appropriate complementary feeding with breastfeeding up to 2 years * Promoting hands washing during critical times (after defecation, before and after eating, before food preparation, before child feeding, after nappy change). * Promotion of using improved sanitary latrines in the home in order to prevent sanitation related diseases * Control and prevention of diarrhea and parasitic infections   Conduct community growth monitoring and promotion as apart of collective accountability on nutrition at community level | *% of caretakers, community leaders/influencers who can correctly describe dietary diversity practices (based on the food based dietary guidelines - 6 food groups and 2 extra meals for pregnant and lactating)*  *% of caretakers, community leaders/influencers who can correctly state the five critical points for handwashing with soap (after defecation, before and after eating, before food preparation, before breastfeeding, after nappy change)*  *% of caretakers, community leaders/influencers who report that household members do not practice open defection*  *% of caretakers, community leaders/influencers who can properly state proper disposal of child feces*  *Number of community gathering session conducted by CHW*  *% of CHW reporting using food based dietary guideline for counselling and community dialogue*  *% of family health action group conducted in community* |
| Interpersonal and peer to peer counselling | Conduct interpersonal communication activities and outreach at community levels among the primary target groups (Lactating mother, Family elders (male, female) to provide comprehensive messages on nutrition in the first 1000 days of life, including through household visits by CHW and community dialogue sessions  Promote peer to peer accountability and sharing experiences using various benchmark setting such as community growth chart and scoring board |
| Supporting Family Health Action Groups to focus on nutrition | Provide standard kit for health workers of health facilities and CHWs, family health action group: Guideline and flip chart nutrition in the first 1000 days of life (nutrition of Pregnant women, Lactating Mother, Children 0-6months, Children 6-23Monhts)  Promote the national Food Based Dietary Guidelines for counselling and education of dietary diversity |
| **2.2 Increased awareness and engagement of media in promotion of optimal nutrition behaviours and products** | | | |
| Mobilize mass and community media to play leading advocacy and information dissemination role for nutrition and care during the first 1000 days of life, through mass communication and campaigns | Awareness creation on maternal and child nutrition through mass media using | Develop and launch mass media and below-the-line campaigns on 1000 special days (TV spots, Radio spots, documentary, and billboards) including the unifying logo/branding for the campaign.  Orient and train key media executives and the media producers  Using media free times to promote nutrition messages  Conduct mass media campaigns both at National media and local stations (TV spots, Radio spots, documentary, billboards) on key themes of nutrition in the first 1000 days of life (Pregnant women, Lactating Mother, Children 0-6months, Children 6-23Monhts) | Number of Mass media and below the line campaigns conducted on nutrition during first 1000 days  Number of media executives and media producers oriented and trained on nutrition first 1000 special days campaign  Number of TV spots, radio spots, documentary and billboards including unifying logo/branding for nutrition first 1000 special days campaigns disseminated and aired |
| Social Marketing | Advocate and create public awareness on food fortification, supplementation and dietary diversification. | Develop and launch mass media and below-the-line campaigns on flour fortification, supplementation and dietary diversity (TV spots, Radio spots, documentary, and billboards) including the unifying logos for the campaign  Using web-based social media to promote nutrition messages | Number of TV spots, radio spots, documentary and billboards including unifying logo/branding for food fortification, supplementation, use of micronutrient powder for home fortification, and dietary diversity developed and disseminated  number of nutrition messages on posted on web-based social media platforms |
| **2.3 Increased knowledge and skills of front line workers in health, education, agriculture, rural development and other institutions to promote basic nutrition** | | | |
| Increased linkages with health, education, agriculture, rural development, WASH, ECD and other institutions for resilience building at the community level | Basic nutrition package for front line workers in health, education, agriculture, rural development and other institutions  Inclusion of nutrition education in different social programs, such as literacy for life, Life skill education, cash transfer, community development, and other development activities | Provide standard kit and orientation for frontline workers: Guideline and flip chart nutrition in the first 1000 days of life (nutrition of Pregnant women, Lactating Mother, Children 0-6months, Children 6-23Monhts) | % of frontline workers by cadre and sector oriented and trained on basic nutrition |
| **Intermediate Results 3: Improved quality of nutrition services and products** | | | |
| **Sub-Intermediate Results** | | | |
| **3.1 Strengthened capacity of service providers and facilities to deliver nutrition interventions** | | | |
| - Nutrition to be recognized as core competencies of health providers  - Update nutrition knowledge and competencies of health care providers | * In-service training * Pre-service nutrition education * Accredited degree education in public nutrition * Creating positions within the health system that require a nutrition certificate * Strengthen the capacity and role of PND within MoPH | * Conduct initial and refresher trainings BPHS/EPHS personnel * Create a system of mandatory training on nutrition as a continues education program for health professionals * Include Nutrition in Nursing, midwifery and physicians curricula * Increase number of nutrition officers in sub national/facility level * Establish training tracking database within PND * Advocate to strengthen the role of PND within MoPH   - Develop and update nutrition guidelines and SOPs | # of health personnel received in-service training  # of public and private institutes/universities included nutrition curricula in their system  # of staff obtained a post graduate diploma or degree on nutrition  # of nutrition officers positions filled at the sub-national/ facility level  # of guidelines developed and updated |
| **3.2 Improved performance monitoring of nutrition services** | | | |
| * Involvement of MoPH different departments * Innovative approaches * Strengthening M&E system | * Establishing service delivery of ENA quality standards * Performance improvement system in MoPH * Community involvement in monitoring especially in areas with insecurity * Use of technology to monitor activities | * Conduct joint monitoring with M&E and GCMU in monitoring nutrition services * Develop, update and apply monitoring checklists, reporting forms and feedback system * Create communication/feedback mechanisms between facility and community-level through periodic meetings and supportive supervision   - Include and update nutrition indicators in the national monitoring checklist and third party evaluations | *# of monitoring visits conducted*  *% of improvement in performance based on monitoring follow up* |
| **3.3 Improved quality assurance system for nutrition products** | | | |
| Focus on special foods with claims of additional nutrition value (fortified food, ready to use complementary food, therapeutic food) | * Developing Standards, regulations and quality assurance monitoring system * Involving multi-sectoral stakeholders | * Develop food fortification regulation * Develop guidelines on quality assurance of nutrition products * Monitor fortified foods standards   Monitor quality and safety of nutrition products (special foods i.e. fortified food, complementary food) | *FF regulation endorsed*  *# of guidelines developed for quality assurance of nutrition products*  *% of special food samples certified based quality assurance standards* |
| **3.4 Strengthened nutritional status monitoring and surveillance system** | | | |
| * Facility and community based sentinel site surveillance (non-probabilistic) * Population based probabilistic surveys | * Maintain and strengthen nutrition surveillance system * Conduct small scale population based surveys * Disseminate reports of surveys for decision making and programmatic use | Refresher training of staff on nutrition surveillance, updating guidelines, distributing data collection tools and equipment  Conducting population based surveys  Disseminate surveys reports | *# of bulletins generated from Nutrition Surveillance system*  *# of small scale surveys conducted*  *# of events conducted for dissemination and advocacy* |
| **Intermediate Results – 4: Strengthened social, regulatory and political environment for nutrition** | | | |
| **Sub-Intermediate Results** | | | |
| **4.1 Strengthened the stewardship and governance role of MoPH in leading and coordinating multi-sectoral nutrition programs** | | | |
| Involving the leadership of sectors to support the follow up actions taken by technical levels | * AFSANA/ NAF * NPCC * National board of Fortified food * National committee on BMS code * SUN movement | * Advocate for activation of high level steering committee of AFSANA * Lead NAF sub-committee meetings * Strengthen NPCC meetings * Establish/Strengthen national board of FF * Strengthen National committee on BMS code * Enrol Afghanistan in SUN movement * Conduct joined multi-sectoral monitoring and assessment of nutrition programs | *# of AFSAN high level steering committee meetings*  *# of NAF meetings chaired by MoPH*  *# of NPCC meetings chaired by PND*  *% coverage of use of fortified food at household level*  *# BMS code violations monitored and followed up*  *# of joined monitoring with multi-sectoral body* |
| **4.2 Improved capacity to generate and use knowledge and evidence for nutrition programming and policy** | | | |
| Culture and ability to use data for decision making  Generating evidences for scaling up and advocacy | - Applied research  - Evaluation of projects  - Use of Secondary data for knowledge generation in nutrition | - Establish Nutrition institute  - Establish collaboration with a similar institute  - Conduct evaluation of pilot and innovative activities  - Conduct applied researches  - Conduct secondary analysis of existing data on nutrition and interpret findings  - disseminate findings for decision making | *# of studies conducted*  *# of events for dissemination of the results of studies*  *# of reports generated/ published* |
| **4.3 Increased resources for nutrition programs** | | | |
| advocacy and supporting national champions | - National budget line for nutrition in the government budget  - Continuous advocacy with the international development partners | - Advocacy with the policy makers and high level decision makers at the government and donors community  - Design long term nutrition projects for funding through MoF/Donors  - Develop/disseminate an estimate of benefit-to-cost ratio of feasible large-scale public nutrition interventions | *# of advocacy meetings conducted*  *# of nutrition projects designed*  *% of nutrition fund allocated by the government increased*  *% of nutrition fund allocated by donors increased* |
| **4.4 Strengthened nutrition policies, standards and regulations** | | | |
| Evidence-based,  Inclusive,  Follow up | * Institutional and human capacity building, | *- Conduct need assessment* | *# of nutrition policies, standards and regulations developed/amended*  *% of improvement in implementation of standards/ regulations* |

# PART III

# INVOLVEMENT OF OTHERS

## Partnerships within the MoPH

The MoPH, as steward of the public health and nutrition sector, sets policies and standards, develops guidelines, and coordinates the actions of its various departments with those of its partner and donor agencies, and implementing NGOs. The PND is the main technical unit of the MoPH responsible for the implementation and oversight of this strategy. The Public Nutrition Strategy calls for the PND to closely coordinate its work with other relevant programs of MoPH, such as child and adolescent health, reproductive health, environmental health, health promotion, food and drug quality laboratory, immunization, and grants and contracts management. The nutrition related responsibilities of the relevant units of the MoPH and coordination of their roles vis-a-vis the PND are described as below:

*Table 7. Coordination with other departments of MOPH*

| **Departments of MoPH** | **Nutrition Related Responsibilities** | **Key Nutrition Related Roles** | **Related Role of PND** | **Coordination Mechanism** |
| --- | --- | --- | --- | --- |
| Child and Adolescent Health (CAH) | Integrated Management of Childhood Illness (IMCI) | Overall leadership, guidelines development, and implementation monitoring | Technical support, oversight and review of nutrition components of IMCI | General Directorate (GD) of Preventive Medicine, Child Health Taskforce, and ad-hoc meetings |
| Community-Based Health Care (CBHC) | Nutrition services provided by Community Health Workers (CHWs) | Overall leadership, guidelines development, and implementation monitoring | Technical support, oversight and review of nutrition components of CBHC | GD of Preventive Medicine, CBHC Taskforce |
| Immunization | High dose vitamin A supplementation and deworming | Vitamin A supplementation and deworming during National Immunization Days (NID) | Technical support and monitoring of intervention coverage | GD of Preventive Medicine, EPI Taskforce |
| Reproductive Health | Iron/folic acid supplementation for pregnant and lactating women, and IYCF promotion | Monitoring and capacity building | Technical support, development of strategies guidelines, and IEC materials, and monitoring coverage of nutrition interventions | RH Taskforce |
| Health Promotion | Behavior change communication (BCC) | Developing BCC messages, fund raising for BCC, relationship with media and production companies, and monitoring delivery of BCC messages | Technical support related to development of nutrition messages, and monitoring coverage of BCC efforts | Health Promotion Taskforce |
| Food and Drug Quality Control Laboratory | Quality control of hygienic safety and micronutrient composition of foods (e.g. fortified foods, therapeutic foods, infant formulas) | Laboratory-based Quality Control monitoring of food products | Technical support, providing food samples for testing, interpreting results and coordination with fortified food production and importing firms | Food Safety and Quality Working Group |
| GCMU | Coordination with BPHS implementing NGOs | Managing contracts, monitoring and coordination | Technical support to NGOs in implementation of nutrition components of BPHS and monitoring quality and coverage of nutrition services | EPHS/BPHS coordination workshops and ad-hoc meetings |
| Curative Medicine | EPHS and in-patient treatment of SAM, implementation of Baby Friendly Hospital Initiative | Overall leadership in hospital care services | Technical support, ensure availability of therapeutic food items and monitoring service delivery | Ad-hoc meetings and workshops |
| Policy and Planning | Strategic planning, developing procedures and ToRs based on regulations | Processing reports, follow up of MoPH plan, processing approval of procedures and ToRs based on national regulations | Provide annual implementation plans, reports, draft procedures and ToRs related to nutrition | Ad-hoc meetings and workshops |
| Afghanistan National Public Health Institute (ANPHI) | Nutrition surveillance, survey, and research | Leading implementation of Disease Early Warning Surveillance(DEWS), and Institutional Review Board (IRB) | Implementation and sharing findings of Nutrition Monitoring and Surveillance System, and seeking IRB approval for research/surveys and studies IRB | Nutrition Surveillance Taskforce, ad-hoc meetings and workshops |
| Environmental Health | Food safety and quality | Monitoring and inspection of markets for safety and quality of food (other than special foods[[23]](#footnote-23)) | Monitoring and inspection of special foodsat the production and market level;  Certification and authorization of use of fortification logo for special foods | Food Safety and Quality Working Group |
| Health Law &Regulations Enforcement Dept. | Enforcement of regulations (fortified food and code of BMS) | Legal monitoring of private and public institutions and enforcement of relevant national laws and regulations | Technical support, coordinating and providing evidence toward disciplinary measures | Need based meetings |
| Human Resource | Employment services, and capacity building | Employment and management of civil service employees, and regulating capacity building programs | Developing ToRs for relevant PND positions, supporting HR management in recruitment process, and PND staff capacity building | Capacity Building Committee and ad-hoc meetings and workshops |
| Pharmacy | Micronutrient supplements and therapeutic foods | Developing national lists of licensed and essential nutrition products | Technical support and development of pharmacy related guidelines for nutrition items | National Food and Drug Board |

## Other Ministries and Government Agencies

Collaboration with a number of other ministries (as described in the table below) is necessary for effective implementation of the Public Nutrition Strategy:

*Table 8. Role of other government agencies in implementation of Nutrition Strategy*

| **Ministry/ Government Agency** | **Nutrition Related Responsibilities** | **Key Nutrition Related Roles** | **Related Role of PND** | **Recommendations** |
| --- | --- | --- | --- | --- |
| MoF | Taxation and customs control of imported foods budget allocation | Represented on the National USI Board, and the National Committee on Code of BMS | Engagement with Customs Department regarding enforcement of fortification laws to imported foods, and providing information on PND budgetary requirements | Current level of coordination is not satisfactory and should be improved |
| MoEc | Strategic planning and advocacy for the role of nutrition in national economic development | To be developed; could be engaged in NAF | To be developed | Need to clarify roles and responsibilities |
| MoE | Incorporation of nutrition into subject-specific curriculum; provision of nutritious foods through school meals | NAF | To be developed | Implement NAF |
| MAIL | Food security and food safety (of unprocessed food) | NAF and AFSANA | Coordination and collaboration with strategies and activities of Home Economics Department | Implement NAF and renew existing MoU on food safety |
| MoCI | Regulation and control of domestic and imported fortified foods and fortified food industry related materials and equipment | NAF, National Board on Iodized Salt, National Committee on Code of BMS | To be developed | Implement NAF and specify roles and responsibilities |
| MRRD | Water, sanitation and hygiene in rural communities | NAF | To be developed | Implement NAF and specify roles and responsibilities |
| MoRA | Public awareness building through religious leaders and facilities | National Committee on Code of BMS | To be developed | Strengthen the follow up of existing TOR |
| MoWA | Women’s empowerment and nutrition education | To be developed | To be developed | Clarify roles, responsibilities and need for technical support |
| MoLSAMD | Safety net and nutrition education through targeted programs;  maternity protection | To be developed; could be involved in NAF | To be developed | Clarify roles, responsibilities and need for technical support |
| MoJ | Developing national laws and regulations | Based on need | Provision of information as needed | Strengthen coordination |
| MoI | Enforcement of food laws and regulations | National Board onIodized Salt; National Committee on Code of BMS | Collaborate with Health Department of MoI | Strengthen coordination andfollow up of existing TORs |
| ANSA | Development of fortified food standards | National Board on Iodized Salt; National Committee on Code of BMS; Food and Drug Board | Collaborate with Standards Development Department | Strengthen coordination |
| Municipalities | Monitoring of national regulations (e.g. Code of Marketing of BMS, USI) at the market level | National Board on Iodized Salt; National Committee on Code of BMS | Collaborate with Environmental Health Unit | Strengthen coordination, especially at the provincial level |

## Non-Government Partners

The PND has essential collaborative relationships with various entities outside of the government sector. Public nutrition programs and projects are supported financially and technically by several partners. They include UN agencies (UNICEF, WHO, WFP, FAO); bi-lateral and multi lateral donor agencies (World Bank, USAID, EU and DFATD); NGOs (Micronutrient Initiative, GAIN, BASICS, ACF, Save the Children, Oxfam, and BPHS implementers); and private sector (salt factories, flour millers and importers, vegetable oil/ghee producers and importers, micronutrient powder producers, media).

Examples of collaborations between PND and some of its non-government partner agencies are as follow:

*Table 9. Role of non-government agencies in the implementation of nutrition strategy*

| **Stakeholders** | **Organizations** | **Key Nutrition Related Activities** | **Coordination mechanisms** | **Recommendations** |
| --- | --- | --- | --- | --- |
| United Nation Organizations | UNICEF | IYCF, treatment of SAM, maternal and adolescent nutrition, Community based surveillance, technical support to PND | Annual plan, nutrition cluster, several other mechanisms | Involvement of PND as co-lead of nutrition cluster |
| WHO | Inpatient treatment of SAM, facility based surveillance, food safety and quality, IYCF | Annual plan, nutrition cluster, several other mechanisms | Involvement of PND in the health cluster coordinate the two mechanisms |
| WFP | Treatment of MAM, maternal nutrition, production and promotion of fortified food | Annual plan, nutrition cluster, several other mechanisms | Develop comprehensive annual plan |
| FAO | Food based dietary guideline, food diversification | National committee on FBDG | Develop comprehensive annual plan |
| UNOCHA | Supporting nutrition in emergency | Nutrition Cluster | Involvement of PND in the decision process |
| Development Partners | World Bank | BPHS/EPHS, system strengthening, nutrition communication/ advocacy | Nutrition Program Coordination Committee | Appreciation of stewardship role of PND in the sector |
| USAID | In-service training, multi-sectoral approach to improve nutrition, nutrition in emergency, Food fortification, strengthening nutrition in BPHS | NPCC | Involvement of PND in the management of projects |
| European Union | Pre-service training, strengthening nutrition in BPHS, community based nutrition | NPCC | Involvement of PND in the management of projects |
| Canada – DFATD | Nutrition surveillance, strengthening nutrition in BPHS through Save the Children and World Vision | NPCC, Project Steering Committee meetings | Appreciation of stewardship role of PND in the sector |
| DFID | Nutrition in emergency, agriculture | No mechanism | Need to establish mechanism |
| GAIN | Supporting private sector in producing fortified food | NPCC, annual plan, MOU | Comprehensive annual plan and MoU |
| International NGOs | MI | Provision of Vitamin A supplies, supporting food fortification, zinc supplementation and IYCN | NPCC, MOU | Comprehensive annual plan and MoU |
|  | AKDN | Multisectoral approach to nutrition, diploma course in nutrition | Project Steering Committee, technical sub committee | Comprehensive annual plan and MoU |
|  | NEI | Production and promotion of Soy products | Ad hoc | Comprehensive annual plan and MoU |
|  | IBFAN | Supporting IYCF | Annual breastfeeding forum and IYCF advocacy, capacity building | Comprehensive annual plan and MoU |
| BPHS/EPHS implementers |  | Public nutrition component of BPHS and EPHS, implementation of nutrition in emergency | BPHS/EPHS coordination meeting, GCMU | Strengthen through GCMU |
| Food industry | Iodized Salt Production companies | Producing Iodized salt | National Board on USI, quarterly meetings | Strengthening it by more involvement of other sectors |
| Fortified flour producers/ importers | Producing/ importing fortified flour | Ad hoc | Need to establish national board of food fortification |
| Fortified Oil Producers/ importers | Production/ importing fortified vegetable oil | Ad hoc | Need to establish national board of food fortification |
| Special food producers/ importers | Production of Micronutrients powder, LNS, fortified supplementary food | Not clear | Need to establish a working mechanism |
| Others | Academia | Training, education and research | Not established | Need to establish a working mechanism |
| Mass Media | Broadcasting nutrition communication messages | Ad hoc | Need to establish a working mechanism |

## COORDINATION MECHANISM

Although the PND is the technical unit of the MoPH and is responsible for coordination with all actors in the sector through regular and need based coordination mechanisms and meetings, the following mechanisms are proposed to help improve the coordination and collaboration:

*Table 10. Coordination mechanisms*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Coordination Mechanism** | **Chaired by/ secretariat** | **Key participants\*** | **Meeting Frequency** | **Main Areas of Work** | **Recommendation** |
| High level committee on nutrition | 2nd Vice-President | Ministers of health, economy, agriculture, rural rehabilitation and development, education, commerce and industry | Semi-annually | Multi-sectoral NAF | Support of the Minister of Public Health is need to help activate the NAF |
| National Board on Universal Salt Iodization | Minister or deputy minister of public health/PND | Representatives of MoF, MoMP, ANSA, MoCI, MoI, MoICY, MAIL, technical agencies (UNICEF, GAIN, MI) and Afghanistan Iodized Salt Producers’ Association (AISPA) | Semi-annually | Mandatory salt iodization | Already active, based on national regulation on salt iodization  To be changed to National Board on Food Fortification once the food fortification law is promulgated, and representatives of additional Food Fortification Alliance members can be added |
| National Committee for Promotion and Protection of Child Nutrition With Breast milk | Minister or deputy minister of public health/ PND | MoCI, MoF, MoI, Municipality, MoWA, MoRA, MoICY, tehnical agencies (Unicef) | Semi-annually | Regulating the marketing of BMS | Already active, based on national regulation on promotion and protection of child nutrition with breast milk (Cod of Marketing of BMS) |
| Nutrition Program Coordination Committee | PND Director/PND | Donor agencies, UN agencies, technical agencies (MI, GAIN) | Monthly | Strategic directions on nutrition programs | To be appreciated and supported by the leadership of the MoPH |
| Nutrition Cluster | UNICEF | Bi-lateral donor agencies, UN agencies, NGOs, PND | Monthly | Nutrition in emergency | PND to gradually take the lead |
| NAF technical meetings | PND Director/PND | Technical representatives of ministries involved in NAF | Quarterly | Multi sectoral NAF | Needs support from the highest levels of related Ministries |
| Technical Working Groups | PND Director/PND | NGOs, UN agencies, private sector, donors, other technical departments of MoPH | Quarterly and as needed | Separate groups for: IYCF, IMAM, Micronutrients, Assessment, Surveillance, Trainings | Strengthening involvement of relevant partners |

\*In addition to MoPH and PND.

# PART IV

# IMPLEMENTATION

## Annual Action Plans

This strategy serves as a roadmap towards the gradual improvement of the nutritional status of the population of the country, especially in women of childbearing age and young children. Once approved, the PND will develop annual work plans related to the responsibilities of the MoPH for successful implementation of the six broad Strategic Components. The work plans will be prepared in close consultation with PND’s partners within MoPH and other public and private sector entities (as described in Coordination Mechanism section). Table 11, summarizes the implementation plan of the nutrition strategy for the year 2015 and the annual plan will be reviewed at the end of each year to plan the next year activities and provide evidences to readjust activities to address the strategic directions of this strategy document.

## Nutrition Program Monitoring, Surveillance and Evaluation

In order to track the implementation and anticipated improvements in the nutritional status of the target populations, the PND will:

* Improve its system for administrative monitoring of the implementation of nutrition services through BPHS and EPHS implementing facilities.
* Implement the Nutrition Monitoring and Surveillance System (NMSS) that is being developed with funding support of CIDA and technical support of WHO and UNICEF, and is expected to track the quality, coverage and impact of large-scale nutrition interventions in the country.
* The indicators mentioned above (in the strategic framework) will be used to track the progress of this strategy over time.

1. **Implementation Plan and its cost**

A plan for the implementation and monitoring and evaluation of this Public Nutrition Strategy in 2015 is developed according to the MoPH planning format and will be updated each year.

*The revision of Public Nutrition Strategy was undertaken with technical and financial support of MI (the Micronutrient Initiative) with the support of the Government of Canada through the Department of Foreign Affairs, Trade and Development (DFATD).*

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