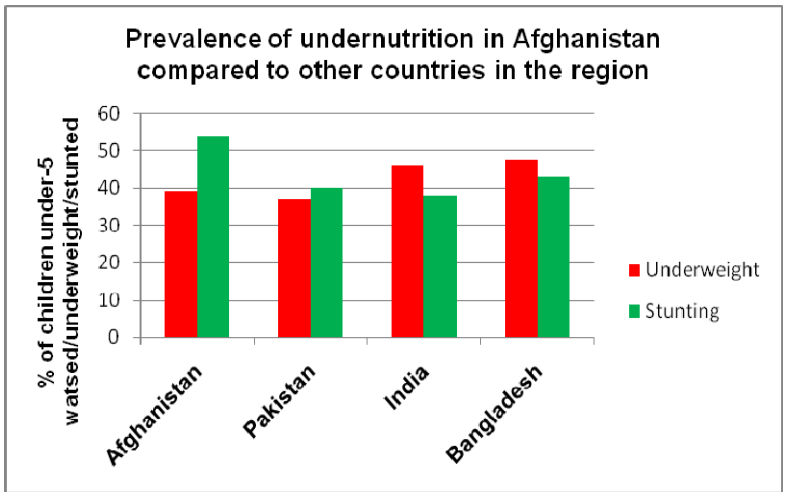
AFGHANISTAN

Overview of Undernutrition

Notwithstanding Afghanistan's considerable improvements in some child health indicators over the past 5+ years, the indicators for child as well as maternal nutrition remain grim and among the highest in the world. In 2004-2005, a National Nutrition Survey found over half (54%) of children below five years (U5) to be chronically undernourished (growth stunted) and 39% to be of low weight for their age (underweight) (**Figure 1***[1]). About 7% suffered from acute malnutrition (wasting), but this level is now expected to be higher as a result of the rising food prices, prolonged drought, and a very harsh winter of 2007-2008. Similar to other South Asian countries, undernutrition is not only confined to infants and young children, but is also highly prevalent amongst women of reproductive age. Over 21% of Afghan women 15-49 years of age have been reported to be undernourished (Body Mass Index < 18.5)



Micronutrient deficiencies: Deficiencies in key micronutrients are also of public health significance in Afghanistan. Among children under 5 years old, about 72% are iron deficient and 38% anaemic. Iodine deficiency disorders occur in 72% of children (most from the mountainous regions of the country) and the prevalence of clinical cases of goiter is between 20-63%. Scurvy, a clinical symptom of vitamin C deficiency, has also been reported (2002) in up to 10% of households from highly food insecure areas where dietary diversity is very poor. Amongst non-pregnant women 15-49 years, iron deficiency and anemia afflicts 48% and 25% respectively and night blindness has been reported in some regional surveys to affect 10-20% of the women.

Causes of Undernutrition

The causes of under nutrition in Afghanistan are multi-faceted and some are largely associated with the prolonged civil war in the country. The immediate causes include chronic *food insecurity*, inadequate access to quality *health services* and improper *feeding and caring practices.*

Food insecurity: The preliminary results of the 2007-08 National Risk and Vulnerability Assessment show 35% of households not meeting their caloric needs, and 46% having very poor diet diversity. Lack of knowledge about nutrition principles is common and

[1] Afghanistan (2004), Pakistan (2001), India (2005), Bangladesh (2004)

adversely affects food choices and child feeding practices. The drastic increase in food prices since 2007 (over 100% on some markets), the very harsh winter of 2007-2008, and drought have also contributed to severely worsen an already alarming food security and economic situation. The growing political insecurity in a number of regions poses ongoing challenges to local food production and market access, and limits humanitarian agencies' abilities to deliver assistance in most insecure areas.

Health services & Health environment: The 2006 government health survey found 47% of U5s had diarrhea during the previous month. Data from therapeutic and supplementary feeding centers show that acute undernutrition rates vary in relation to trends of diarrheal disease (summer) and acute respiratory infections (winter). An estimated 65% of households in 2006 had nearby access to primary health care services, compared to 9% in 2000, but many households still do not make optimal use of these facilities. The volunteer corps of Community Health Workers plays a limited role in nutrition-focused programs.

According to UNICEF (2006), only 22% of the population has access to improved drinking water sources (17% in rural areas). Only 30% of the population uses improved sanitation services, and hygienic conditions in homes are often deplorable. De-worming campaigns have focused on school-aged children.

Feeding and caring practices: Therapeutic Feeding Unit monitoring data shows that 40% of admitted children are under 6 months, and nutritional survey results show that acute undernutrition rates are highest in the 6-29 months age group. These results point to poor infant feeding and caring practices as a major cause of undernutrition. The rate of exclusive breastfeeding was estimated at 70% in a 2006 study, but qualitative field studies have found that true exclusive breastfeeding from 0-6 months is extremely rare. Introduction of solid/semi-solid foods also occurs late and with foods of inadequate nutrient density. Many mothers express concern about breast milk insufficiency, which is often due to early cessation of breastfeeding (during a consequent pregnancy or illness), but it is also associated with experiencing stress or other mental health issues.

Policy and Programmatic Responses to Malnutrition

The Islamic Republic of Afghanistan has long recognized the problem of undernutrition and has devised policies and strategies to address the problem. In 2003, the country's first Public Nutrition Policy and Strategy (2003-06) was developed with 7 strategic areas (working groups) to be addressed – surveys and surveillance; micronutrients; maternal and child feeding; community-based food security; emergency supplementary feeding; management and treatment of severe malnutrition; and nutrition communication and education. This policy is currently under review in preparation for a new 3-year plan.
In addition to the national nutrition strategy, "sub-strategies" (micronutrients, infant and young child feeding) and concept notes (nutrition training, school gardens and food processes) have also been developed to guide the nutrition program in Afghanistan.

Programmatic responses to malnutrition have generally emphasized centralized strategies through the health sector. For example, vitamin A supplementation is dovetailed to National Immunization Days; severe acute malnutrition is largely managed through therapeutic feeding units in government-run hospitals, breastfeeding counseling by health staff and the nutrition interventions of the Basic Package of Health Services. However, as infrastructure and services improved, multi-sectoral efforts became a greater feature of the policy and programmatic landscape reaching into communities, with notable involvement and commitment from the agriculture sector. Behavior-change communications (BCC) activities have included breastfeeding counselor trainings, child feeding trainings, school gardens, and food processing for year-round household food security. Basic nutrition education has also received significant support from gender-focused programs including those promoting women's literacy. Salt Iodization and fortification of flour with iron and folate are also being done with some level of success.

Institutional arrangements for Nutrition

The MOPH Public Nutrition Department is the main focal point in the GoA for nutrition. As originally conceived, the PND's main functions include developing nutrition policies and guidelines, developing information gathering systems as well as coordinating a series of task forces with representation from multiple sectors. The MOPH PND supports a cadre of Provincial Nutrition Officers (PNOs), one per each of the 34 provinces. The PNOs provide monitoring and evaluation functions of nutrition programs, coordinate provincial level stakeholders, and assist with campaigns. The Ministry of Agriculture, Irrigation and Livestock (MAIL)'s Home Economics Department works closely with the PND on nutrition promotion. A Home Economics Officer staff line has been approved for each province and these focus on nutrition education and food security activities. About half have been hired and trained. There is no formal district-level staff specifically working for nutrition. Through mainstreaming activities, some district-level programs are including nutrition components (e.g. women's literacy, school gardens, government health clinics). Also in place at the central-level is a Nutrition Cluster, composed of national and international institutions supporting nutrition. This group meets monthly to coordinate emergency interventions and is co-chaired by UNICEF and the UN Food and Agriculture Organization (FAO).