



Islamic Republic of Afghanistan

AFGHANISTAN FOOD SECURITY AND NUTRITION CONTEXTUAL ANALYSIS



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Abbreviations

A-SDG	Afghanistan Sustainable Development Goals
AfDHS	Afghanistan Demographic and Health Survey
AFSeN-A	Afghanistan Food Security and Nutrition Agenda
ALCS	Afghanistan Living Conditions Survey
AMICS	Afghanistan Multiple Indicator Cluster Survey
ANPDF	Afghanistan National Peace and Development Framework
BMI	body mass index
BPHS	Basic Package of Health Services
CSO	civil society organizations
GAM	global acute malnutrition
GDP	gross domestic product
GoIRA	Government of Islamic Republic of Afghanistan
IDP	internally displaced person
IMR	infant mortality rate
IYCF	infant and young child feeding
MAIL	Ministry of Agriculture, Irrigation and Livestock
MoEc	Ministry of Economy
MoPH	Ministry of Public Health
MQSUN+	Maximising the Quality of Scaling Up Nutrition Plus
MUAC	mid-upper arm circumference
NAF	Nutrition Action Framework
NAPWA	National Action Plan for the Women of Afghanistan
NGO	nongovernmental organization
NNS	National Nutrition Survey
NPP	National Priority Program
NRVA	National Risk and Vulnerability Assessment
SAM	severe acute malnutrition
SD	standard deviations
SDG	Sustainable Development Goals
SMART	Standardized Monitoring and Assessment of Relief and Transition
SUN	Scaling Up Nutrition
UN	United Nations
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Human Affairs
WASH	water, sanitation, and hygiene
WHO	World Health Organization
WRA	women of reproductive age
Z-score	a statistical unit comparable to standard deviation

Introduction

More than one-third of all deaths among children under five worldwide are attributed to malnutrition. It is estimated that malnutrition in developing countries results in a loss of at least 2-3% of gross domestic product (GDP) (Horton, Shekar, McDonald, Mahal, & Brooks, 2010). Malnutrition levels continue to be high in Afghanistan. Without reducing childhood malnutrition, the country will not be able to achieve the Sustainable Development Goals (SDGs), in particular, SDG 2.

The Islamic Republic of Afghanistan joined the Scaling Up Nutrition (SUN) Movement in September 2017 with a letter of commitment from the Chief Executive of the Government, Dr. Abdullah Abdullah. The Government launched the Afghanistan Food Security and Nutrition Agenda (AFSeN-A) on 16 October 2017 to put an end to hunger, achieve food security, improve nutrition, and promote sustainable agriculture.

The AFSeN-A was developed in 2011-2012 and provides a policy statement by the Government of the Islamic Republic of Afghanistan (GoIRA) reaffirming its determination to address the multiple determinants of hunger and malnutrition. It presents a comprehensive framework for achieving the vision in a coordinated manner, the overall governance structure, and the roles and responsibilities of government and nongovernment stakeholders. However, since the development of the AFSeN-A, the political, economic, and social situation has changed a lot. In addition, the Afghanistan National Peace and Development Framework (ANPDF), presented at the Brussels Conference on Afghanistan from October 4-5 in 2016, has become the new overall policy and strategic framework for national development. Afghanistan has also become signatory of the SDGs, nationalized targets, and established a coordination structure for its implementation and follow up.

The purpose of this contextual analysis is to review and consolidate existing information for further analysis; and provides updated information on the nutritional situation, its multi-faceted determinants, the causal and contributing factors, and recent trends. Furthermore, it includes an analysis of the socioeconomic and political context, an update of the developments of recent years, and a review of the existing policies and strategies related to the objectives of the AFSeN-A.

The AFSeN-A, together with the contextual analysis and the planned stakeholder mapping, will provide the basis for the development of AFSeN-A's Strategic Plan. Following the development of the Strategic Plan, a costing exercise will be conducted to assess the budgetary requirements for achieving the AFSeN-A and Strategic Plan targets. This will help to mobilize financial resources through both GoIRA's regular and development budget allocations, as well as stakeholders' on- and off-budget support.

As requested by the AFSeN-A Chair and the AFSeN-A Secretariat, the global SUN Movement Secretariat, through United Kingdom Department for International Development-funded Maximising the Quality of Scaling Up Nutrition Plus (MQSUN⁺) project, is providing technical assistance to the process. The overall objective of this technical assistance is to support the GoIRA to develop the AFSeN-A Strategic Plan 2018-2022, provide strategic direction, and ensure shared responsibility and contribution towards achieving the joint objective.

The specific objectives of the MQSUN⁺ technical assistance are to:

- Conduct a contextual analysis to consolidate available information and data into one report, and consider and analyze the data in relation to the SDGs and AFSeN-A.

- Assist stakeholders in defining the overall goal, objectives, indicators, and a set of interventions by sector for the AFSeN-A Strategic Plan and ensure the full involvement and ownership of all key stakeholders and partners.
- Assist stakeholders in elaborating the multisectoral AFSeN-A Strategic Plan.
- Support costing of the Strategic Plan to facilitate resource needs estimates.

As outlined above, MQSUN+'s principle approach is to assist and facilitate the process, to build knowledge and capacities, and to enable national institutions and focal points to achieve the objectives. In this regard, the team will review past MQSUN reports, national policies and strategies of multiple sectors, and other relevant documents and will work with the SUN Country Focal Point and other key partners to complete these activities.

It should also be emphasized that a meaningful, proportional gender consideration is mandatory for MQSUN+. Hence, a gender equity lens will be applied throughout the process and ensure that gender and equity are at the forefront of the multisectoral planning process.

Socioeconomic Context

Afghanistan is a country deeply affected by conflict, which has undoubtedly marred its development path. Limited investments in human resources and infrastructure over recent decades have resulted in low to no progress in many aspects of economic and social development. However, over recent years, the GoIRA has recognized the importance of creating strong foundations for human and socioeconomic development. According to International Alert's *Peace through Prosperity: Integrating peace building into economic development*, accessibility to education and health services are important investments that would contribute not only to economic progress but also to peace and prosperity (International Alert, 2015). Afghanistan's progress on this track is evidenced by some basic development sector indicators, for example, the increase in school enrollment from one million in 2001 to 9.5 million in 2013 and the reduction in infant and maternal mortality rates by 45.5% and 70.4% between 1990 and 2015 (The Islamic Republic of Afghanistan, 2017).

Geography

Afghanistan is a landlocked country with 34 provinces. The terrain is dominated by mountain ranges of the Hind Kush, running from northeast to southwest. The Afghanistan Multiple Indicator Cluster Survey (AMICS) divides Afghanistan into eight main geographical regions: Central, Central Highlands, East, West, North, Northeast, South, and Southeast (UNICEF, 2013). This terrain creates a natural tendency to fragment the Afghan population and is one of the causes for the great variance between the statuses of different provinces. The mountainous regions are difficult to reach, particularly during winters. This constrains transport, including trade of food and access to basic social services. As a result, the people in the far-flung areas in East, Northeast, West Central and Southwest provinces are more vulnerable to poverty than in other parts of the country (World Bank; Islamic Republic of Afghanistan, 2013).

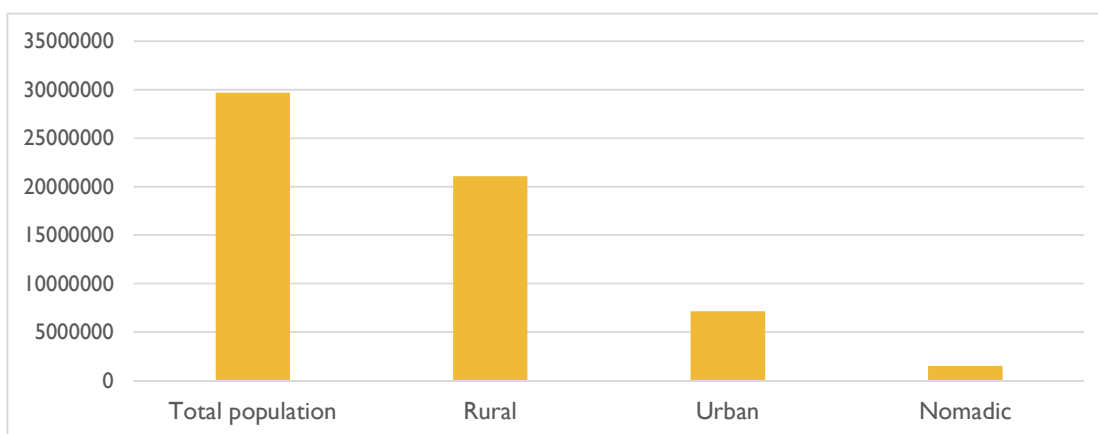
For the most part, Afghanistan has a dry continental climate, though the variation in geography across the country means that weather patterns in different regions also vary greatly. Afghanistan has also been affected by droughts, floods, and avalanches. By accounting for about one-third of the GDP, agricultural production is one of the main pillars of the Afghan economy (Ministry of

Agriculture Irrigation and Livestock, 2016). Therefore, climatic conditions and natural disasters affect the economic performance of the country as a whole.

Demographic context

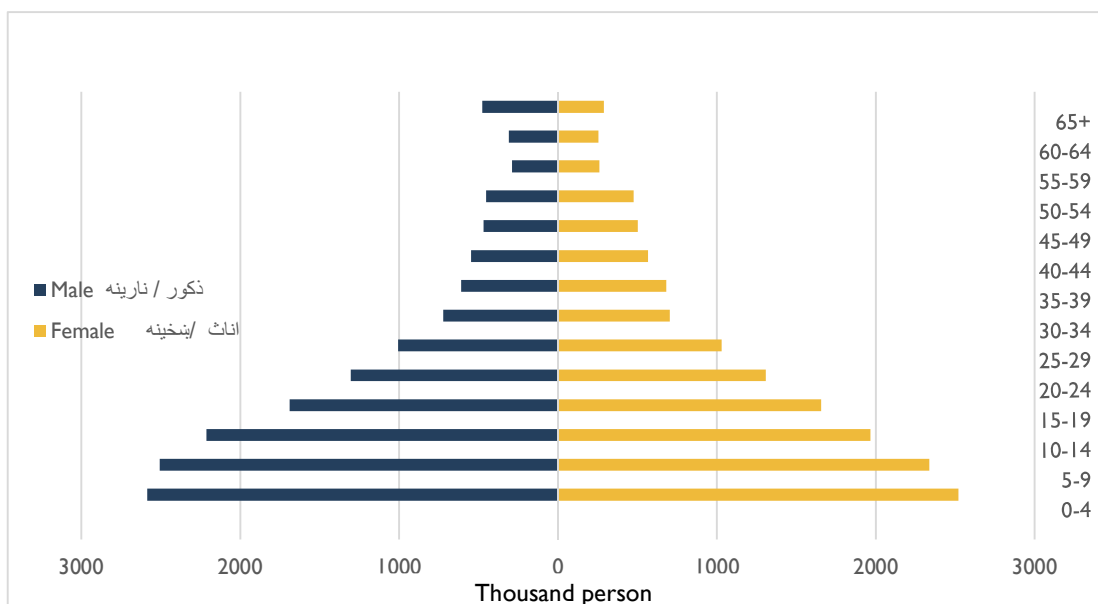
The Humanitarian Needs Overview by the United Nations Office for the Coordination of Human Affairs (UNOCHA) estimates the population at 34.5 million (UNOCHA, 2017c) and over 75% of the population resides in rural areas (Islamic Republic of Afghanistan, 2017). The country is ethnically very diverse. The majority of residents are Pashtun and Tajik, followed by Hazara, Uzbek, Aimak, and Baloch, and 99% of the population are Muslims (World Population Review, 2019). Pashto and Dari are the official languages, and several other languages are spoken as well.

Figure 1. Afghanistan's population in rural and urban locations.



Source: (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Figure 2. Afghanistan's population by sex and age group.



Source: (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Afghanistan is facing demographic challenges caused by high population growth. The annual population growth rate is estimated at 2.8% (The Islamic Republic of Afghanistan, 2017). Between 2004 and 2017, the population increased by 21.7 million (Central Statistics Organization; Ministry of Public Health; ICF, 2017). The main reasons are the high fertility rate (5.1 in 2012) (UNICEF, n.d.) and a high influx of returnees settling back in their home country. In 2016, 800,000 Afghan refugees returned from Pakistan and Iran (The World Bank, 2017). According to the World Population Review, in Afghanistan, there is one birth every 27 seconds, one death every two minutes, and one net migrant every nine minutes. Consequently, there is a net gain of one person every 37 seconds (World Population Review, 2019).

Afghanistan's population's age structure is another factor that perpetuates population growth. In 2017, it was estimated that 48% of the population was under the age of 14, and only 3% of the population was above 65 years of age (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Healthcare services have expanded in recent years. Although life expectancy remain low and mortality rates remain high in absolute terms, overall health indicators show significant improvements. Thus, lower mortality rates combined with Afghanistan's high fertility rate of 5.1 further contribute to population growth. Without significant improvements in the provision of social services, including health and education, and the development of labor markets, the rising population number pose additional challenges to Afghanistan's development.

Socio-political context, insecurity, and migration

Towards the end of the twentieth century, the country bore the brunt of civil war and Soviet occupation. At the turn of the twenty-first century, the Taliban regime collapsed and thus began a period of an increasingly violent armed internal conflict. Today, 120 of Afghanistan's 400 districts are considered as highly conflict-affected—a 50% increase from 2015. These districts are home to 14 million Afghans (UNOCHA, 2017c). The United Nations Assistance Mission to Afghanistan reported over 10,000 civilian casualties in 2017 alone (UNAMA, 2018a). Updates from the first quarter of 2018 report that complex attacks and ground engagements have become the leading causes of civilian casualties with 2,258 documented casualties (of which 217 are women and 583 are children) (UNAMA, 2018b).

This context has continued to drive an exponential increase in humanitarian needs, including health and nutrition services. One of the foremost consequences of persisting violence is the displacement of people as they attempt to move away from conflict zones. In 2017, internal displacement averaged 1,100 people daily—two-thirds of them women and children (UNOCHA, 2017c, 2017a). The United Nations High Commissioner for Human Rights reported that 390,940 individuals were newly displaced because of conflict in 2017 (by 10 December), and the projected number of internally displaced persons (IDPs) for the complete year of 2017 was 450,000 (UNHCR, 2017). These IDPs often resettle in informal settlements where the standard of living is already extremely low and the drastic rise in population density further strains resources. This contributed to even greater food insecurity and vulnerability and overwhelmed service delivery capacities. However, it also led to threats against well-being of healthcare workers and closure of facilities. In 2017 alone, several healthcare facilities have been forced to shut down, particularly in Faryab, Laghman, and Uruzgan, which has affected more than two million people (UNOCHA, 2017c).

In 2016, the influx of returnees caused displacements and internal conflicts. Displacements have continued, and the situation has created an urgent need for the Government to protect and provide

basic services to these vulnerable individuals (The World Bank, 2017). The conflict also results in a rise of poverty levels, while the regional variations in poverty have not changed much over recent years. The Southwest region has witnessed an increased level of conflict as well as military spending; given this, it is not surprising that poverty levels have increased most in this region—from 28% to 56% between 2011/12 and 2013/14 (The World Bank, 2017).

The National Unity Government of 2014 made a conscious effort towards peace building through the ANPDF and the efficacy of its execution—however, consequent translation into increased prosperity is yet to be determined. Even apart from conflict, Afghanistan must also deal with problems of corruption, criminality, and unemployment to improve the foundations of the country's governance structure. The ANPDF has been adopted as a plan to enhance citizen security and create a more conducive environment for growth and development.

Economic context

Growth rates for the country's GDP are the lowest in the region, with an annual GDP growth rate of 2.2% in 2016, and a 0% growth in per capita GDP (Asian Development Bank, 2019). This muted growth has led to an increase in poverty. By 2013/14, the rate of poverty for Afghanistan had risen to 39.1% from 35.8% in 2011/12—which means an additional 1.3 million became poor in that time period (The World Bank, 2019). Poverty increased more so in recent years, with 54.5% of the population living below the national poverty line in 2016/17 (Central Statistics Organization, 2016). While poverty is particularly concentrated in rural areas where the majority of the Afghan population lives, the recent sharp increase in poverty has affected the urban population alike due to high migration rates into cities (Central Statistics Organization, 2016). As well, the intensity or severity of poverty, measured by the poverty gap ratio, increased sharply from 7.2% to 15% between 2007/08 and 2016/17 (Central Statistics Organization, 2016). Increases in poverty combined with the inflation and rising food prices have serious implications for the household food insecurity situation.

Unemployment poses a great problem for the country's economy and people, particularly in the context of the high population growth rates. The Afghanistan Living Conditions Survey (ALCS) 2016-2017 shows an approximate one-percentage point increase in the unemployment rate compared with the preceding years (The World Bank, 2019). Women and unskilled workers are most drastically affected by unemployment and thus remain at the highest risk of falling into poverty.

Afghanistan's economy also has a large informal sector. In fact, a study on Afghanistan's private sector has found that the informal sector contributes 10-12% to the country's official GDP (Ghiassy, Zhou, & Hallgren, 2015). Future growth and development of the Afghan economy would need to also take this into account and leverage its contributions.

Poverty in Afghanistan is multidimensional and varies by location, region, access to social services and markets, and socioeconomic groups, among others (The Islamic Republic of Afghanistan, 2017). As noted above, more than half of the population (54.5%) falls below the poverty line, which exposes those people to the risk of having insufficient access to nutritious foods, becoming food insecure, and consequently suffering from nutritional deficiencies in various forms. The incidence of poverty is particularly severe in rural areas, which are characterized by low productivity, weak markets, and recurrent shocks that maintain poverty across generations, lack of access to social services, etc.

Long-term economic development for the country will necessitate structural changes and a deliberate effort toward increasing human capital—enhancing the agricultural sector to create new opportunities for growth is essential. Since agriculture is the predominant activity in the country and

source of income for 45% of the households (Central Statistics Organization, 2016), it must be leveraged as a driver of economic growth through modernization.

Social development context

According to the 2018 Humanitarian Needs Overview, a total of 8.7 million Afghans suffer from chronic humanitarian needs (UNOCHA, 2017c). While substantial progress has been made in recent years, absolute levels of development and achievement of social indicators in education, water, sanitation and hygiene (WASH), health and other related areas still remain worryingly low.

Though school enrollment has increased over nine-fold since 2001, as many as 3.5 million children remain out of school (Education, 2016). Conflict keeps children out of school. Children of poor households, in particular girls in rural areas, are more likely to be out of school and show a lower attendance (non-poor attendance 62%, poor attendance 48%). Nonetheless, it is encouraging to note that female attendance of schools has substantially increased over the years, and girls comprise more than one-third of the total numbers of students today (The Islamic Republic of Afghanistan, 2017).

There has been a significant improvement in infant and maternal mortality rates, which have declined by 45.5% and 70.4% respectively between 1990 and 2015 (The Islamic Republic of Afghanistan, 2017). However, in absolute terms, health indicators remain alarming. The infant mortality rate remains high at 70 per 1,000 live births (UNOCHA, 2017c). Though access to safe drinking water has increased—AMICS 2010 reported 56.7% of the population had access to improved sources of drinking water and the National Nutrition Survey (NNS) 2013 found this figure to have risen to 62.9%—clean water remains inaccessible for roughly 35% of the population (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013). This is a major cause of intestinal diseases, diarrhea, and other infectious diseases contributing to child mortality (The Islamic Republic of Afghanistan, 2017).

Challenges/barriers

One of the greatest challenges Afghanistan faces is insecurity. Insecurity and instability hinder, and even jeopardize, development efforts. Apart from the direct outcome of civilian deaths, conflict also contributes to several other issues, including internal displacement, food insecurity, reduced access to social services, etc. According to the SDG 2 Zero Hunger Strategic Review (World Food Program, 2017a), the large challenges in agriculture, food security, and nutrition that Afghanistan faces are unlikely to be resolved while the country is still suffering from conflict.

Specifically, with regard to food security and nutrition, the following main challenges have been highlighted by the AFSeN-A document (Islamic Republic of Afghanistan, 2017). They are:

- Insufficient food production and availability at national and household level, due to low agricultural productivity, insufficient agricultural services, conflict and insecurity, destroyed and neglected irrigation systems, weather hazards, land disputes, migration, etc.
- Insufficient access to food, due to high levels of poverty, unemployment, gender disparity, and poor infrastructure.
- Poor food utilization and nutrition as a result of poverty and other related causes—such as limited access to a diverse diet resulting in a poor dietary diversity, infectious diseases, limited access to health services, insufficient capacities in the health sector, no access to safe drinking water, poor care practices, gender inequity, poor education, particularly of women, weak food quality control, etc.

- Instabilities of food production and supplies, due to recurrent and temporary shortages arising from seasonal factors, from natural disasters, conflicts, market failures and price shocks, and climate change.

While solutions in the food system are considered important, most people interviewed by the Zero Hunger Strategic Review asked for larger development-based actions including economic development and job creation, social support services, education, and health and nutrition services.

Nutrition Situational Analysis

Nutritional status

Nutritional status of children

Anthropometric measurements to assess growth and development, particularly in young children, are the most widely used indicators of nutritional status. These indicators include stunting (or chronic malnutrition measured by low height-for-age), wasting (or acute malnutrition measured by low weight-for-height) and underweight (measured by low weight-for-age).

In Afghanistan, child malnutrition is a widespread concern. The NNS 2013 reports that 40.9% of children aged 0-5 years are stunted, 9.5% suffer from wasting, and 25% are underweight (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013). From a public health perspective, these figures are high. According to World Health Organization (WHO) standards, Afghanistan falls into the categories of very high prevalence for stunting and high prevalence for wasting. However, the rates for wasting are below the globally declared emergency threshold of 15%.

Stunting: height-for-age

As a national average, 40.9% of children in Afghanistan are stunted, and 20.9% are categorized as severely stunted. The incidence of stunting increases with age, peaking at 47.4% among children between 36 to 47 months of age. Stunting was also found to be slightly higher among male children than among female children (42.3% and 39.4%, respectively). Stunting is significantly associated with wealth indices—49.4% of children of poorer households suffer from stunting while only 31.1% of children from richer quintiles are stunted (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Children of the poorest population quintiles, living in rural areas, or whose mothers are less educated are at a much higher risk for stunting than their peers from richer wealth quintiles and of educated parents. However, stunting is still at high levels among those well off, who should not be neglected while designing measures for improvements.

Wasting: weight-for-height

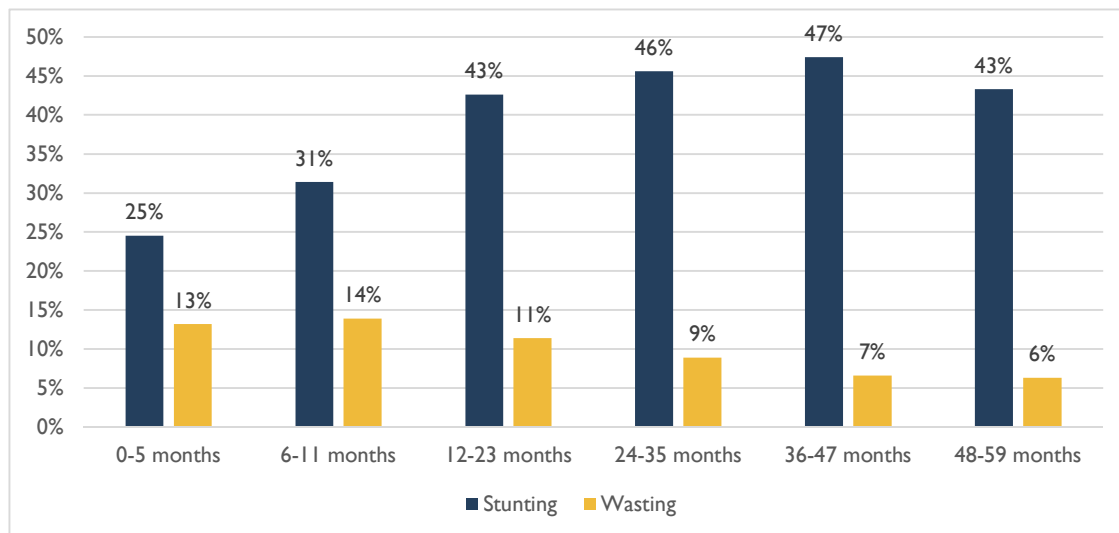
Nationally, 9.5% of children are wasted. Wasting appears highest among the youngest age group and decreases with age. The highest incidence being in the 0-5 month age group (13%) and the lowest in the 48-59 month age group (6.3%). Wasting is slightly higher for boys than for girls (10.3% and 8.7%, respectively). Although wasting was lowest among the richest households, there was no significant difference between other wealth groups (6.8% among the richest, and between 9.8% and 11.4% among other wealth quantiles) (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

It is a concern to observe such high rates of wasting among children below six months of age. Although there are methodological limitations in measuring and analyzing weight-for-height among children below six months of age, it is indicative of an alarming state among newborn children. The possible causes could be due to serious maternal problems, such as high levels of maternal anemia, together with suboptimal breastfeeding (that is, a lack of early initiation of breastfeeding, introduction of pre-lacteal foods, or too-early introduction of complementary foods), and care practices for newborns.

Underweight: weight-for-age

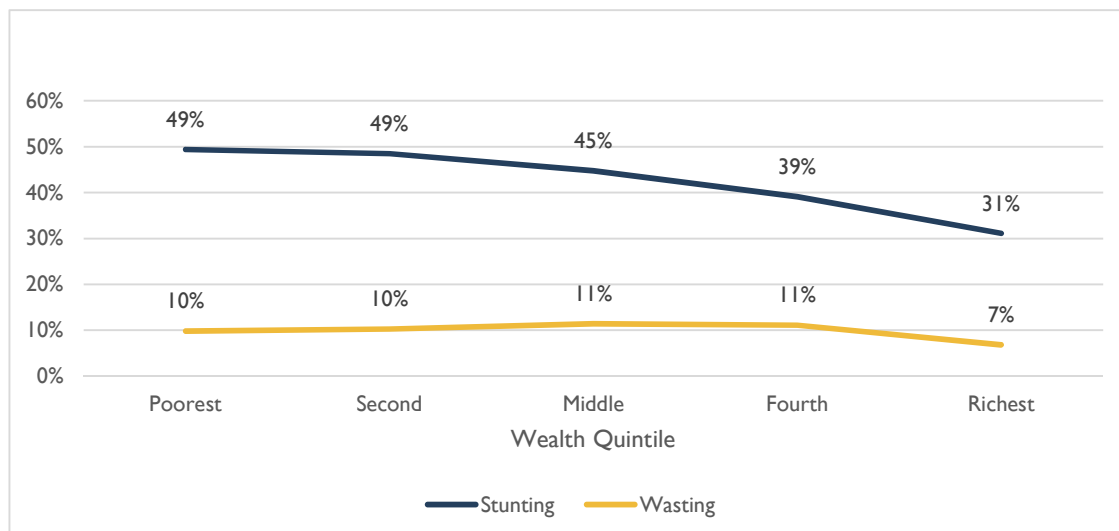
Overall, 25% of Afghan children are underweight while 9.7% are severely underweight. While there were similar patterns of incidence among different age groups, male children were more likely to be underweight. Being underweight was also closely related to wealth index quintiles, with the poorest being 30.7% underweight, and the richest quintile being 17.7% underweight.

Figure 3. Nutrition indicators by age group.



Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Figure 4. Nutrition indicators by wealth quintile.



Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Province prevalence of undernutrition among preschool children

There is considerable variation in the nutritional status of children across provinces.¹ In the context of stunting, the values range from 24.3% for Ghazni to 70.8% for Farah. The high occurrence of stunting in some provinces can probably be attributed to low food security, as reported in the National Risk and Vulnerability Assessment (NRVA) 2012 (Central Statistics Organization, 2014b). The provinces of Bamyan, Badghis, Nangarhar, Ghor, Paktia, Kunar, Nuristan, and Farah are most adversely affected with a stunting prevalence rate more than 50% (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Provincial variations in the prevalence of wasting ranged from 3.7% in Faryab to 21.6% in Uruzgan. In the provinces of Laghman, Kunar, Wardak, Paktia, Khost, Nuristan, Nangarhar, and Uruzgan, more than 15% of preschool children were wasted. As per WHO classifications, a prevalence of more than 15% is considered as a critical situation (World Health Organization, 2000).

Kunar, Paktia, Nuristan, and Nangarhar are the provinces with the worst nutritional indicators, as they show very high prevalence rates for both stunting (over 50%) and wasting (over 15%).

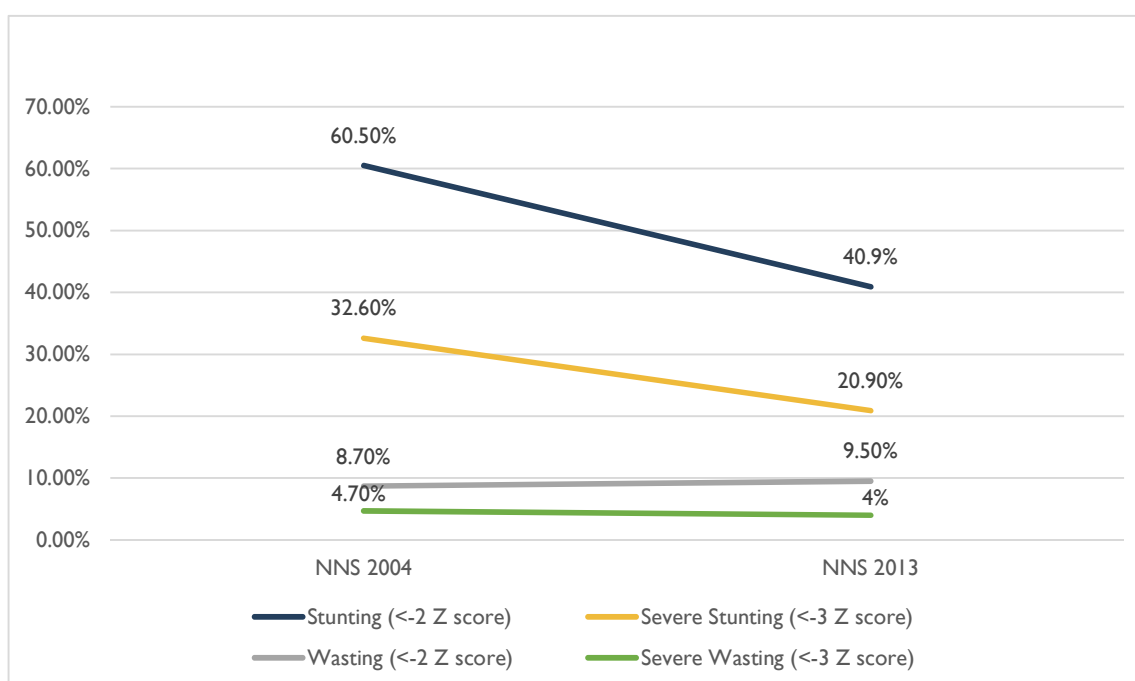
Afghanistan also has ongoing nutrition emergency assessments (SMART and Rapid SMART). Some of those surveys were carried out in selected districts and others covered entire provinces. Overall, provincial prevalence rates match the national averages presented in the NNS 2013 or fall slightly below the NNS estimates. Exceptions are Kabul, where only IDP settlements were assessed (51% stunting) and Helmand where only two districts, Lashkargah and Nawa, were assessed. For Farah, the prevalence measured by the SMART survey remained far below the prevalence measured by the NNS 2013 (45.4% compared to 70.8%) (Afghanistan Nutrition Cluster, 2018; Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013). A detailed overview is presented in Annex 4.

Nutrition indicators over time

A comparison between NNS 2004 and 2013 shows the prevalence of stunting has improved significantly—dropping by 20% from 60.5% to 40.5%. This is an enormous improvement given the increased poverty and food insecurity, as well as the state of insecurity, in some areas of the country. Global acute malnutrition (GAM or global wasting, below -2 standard deviation/SD) increased slightly from 8.7% to 9.5%. However, the percentage of children suffering from severe acute malnutrition (SAM or severe wasting, below -3 SD), dropped slightly (from 4.7% to 4%), hence, the rise was observed only within the group of children suffering from moderate acute malnutrition (4% to 5.5%) (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013; Ministry of Public Health; UNICEF, 2004).

¹ See also Annex 4.

Figure 5. Nutrition indicators over time.



Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

The National Nutrition Surveillance Bulletin issued by the Ministry of Public Health (MoPH) provides more current estimates of the prevalence of GAM and SAM for children under two years of age in emergency-prone and affected areas. According to Issue No. 10, GAM stood at 25.3% in September 2017 while the estimates for SAM were 11.2% (Ministry of Public Health, 2017). Those percentages are far above the national averages measured by the NNS 2004 or NNS 2013. Therefore, despite an overall improvement observed in the national averages, the situation in emergency-affected areas remains alarming. Information on time trends from those locations is not available.

Infant and young child feeding practices

Adequate nutrition during infancy and early childhood is essential to ensure growth, health, and development of children to their full potential. The period from conception to a child's second birthday—the 1,000-day period—is very crucial in which good nutrition and healthy growth have lasting benefits throughout life.

Initiation of breastfeeding

Early initiation of breastfeeding, feeding children colostrum, and discouraging pre-lacteal feed are globally accepted best practices for nutrition. According to the Afghanistan Demographic and Health Survey (AfDHS) 2015, only 41% of infants were breastfed, as recommended, within an hour of birth, while 91% were breastfed within one day of birth (Central Statistics Organization; Ministry of Public Health; ICF, 2017). Better breastfeeding patterns were assessed by the NNS 2013—69.4% of newborn were breastfed within an hour, and 89.9% were breastfed within the first day. In any case, those numbers indicate good practices. However, about half of children being breastfed within the first day were also given pre-lacteal feeds on the first day (52.4%). This is a non-favorable practice causing problems and requires corrections (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

While the NNS 2013 reports no significant differences for initiation of breastfeeding practices with or without delivery assistance, by place of delivery or by mother's education, the AfDHS finds some differences when disaggregating for those background characteristics:

- The proportion of children breastfed within one hour of birth was higher among those delivered in a health facility (43%) than among those born at home (40%).
- The proportion of children breastfed within one hour of birth was higher in rural areas (42%) than in urban areas (38%).
- Children in Farah were most likely to start breastfeeding within one hour of birth (87%), while children in Baghlan (13%) and Paktika (14%) were least likely to be breastfed within one hour.
- Mothers in the lowest wealth quintile were more likely to initiate breastfeeding within one hour of birth than those in the highest wealth quintile (45% versus 35%) (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Exclusive breastfeeding

Breast milk is globally accepted as the best source of nutrition for a child in the first six months of life. The milk contains all the nutrients that a child needs for healthy development. Complementary feeding within the first six months is discouraged, as it can lead to contamination and introduces a greater risk of diarrheal disease.

Despite this being an internationally accepted best practice, only 43% of Afghan infants are exclusively breastfed for the first six months. In fact, the AfDHS reports that 10% of infants consume plain water, 2% consume non-milk liquids, 28% consume other milk, and 14% consume complementary foods. Nineteen percent of infants are also fed using a bottle with a nipple, which increases the risk of illness to the child. Exclusivity of breastfeeding declines with age with only 33% of infants between 4-5 months being exclusively breastfed (Central Statistics Organization; Ministry of Public Health; ICF, 2017). This estimate was reported to be higher in NNS 2013—58.4% of infants aged 0-5 months were exclusively breastfed—which may represent a decline in adoption of this practice in subsequent months or a difference in the methodology adopted for the two reports (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Continuation of breastfeeding up the two years of age is recommended. In Afghanistan, 78% of children were breastfed up to 12-15 months, while 59% of children received breastmilk up 20-23 months. Overall, the AfDHS reported that 60% of children were receiving age-appropriate breastfeeding (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

An overview of infant and young child feeding (IYCF) breastfeeding indicators, as reported in the AfDHS, is given in Annex 1, and of breastfeeding practices, as reported in NNS 2013, is given in Annex 2.

Complementary feeding

The transition from exclusive breastfeeding to family foods is referred to as complementary feeding. This period is one of the most critical phases of child nutrition as children are extremely susceptible to becoming undernourished at this stage. Key factors to consider in appropriate complementary feeding is ensuring timeliness (introduce at six months of age) and diversity of foods to ensure all nutrient requirements for the child are met. The AfDHS reported that food made from grains was the most consumed item among children 6-23 months of age, but it is important to ensure that along with plant-based food sources, children also receive protein-rich foods, such as meat, poultry, and eggs (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

The NNS explored practices for the introduction of complementary foods (solid, semi-solid, or soft foods) to infants aged 6-8 months. The data showed that 41.3% of infants 6-8 months of age were introduced to solid, semi-solid, and soft foods. No differences were observed for those practices between boys or girls (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Illiterate mothers were less likely to introduce complementary foods to infants at the recommended age as compared to mothers with some level of schooling or high level of schooling (29.3%, 34.5%, and 55.2%, respectively) (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013). Children from the richest households were more likely to receive complementary foods at an appropriate age than their counterparts belonging to lower wealth quintiles (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Dietary diversity and minimum acceptable diet

Adequate complementary foods, appropriate diversity, and meal frequency are essential to ensure proper growth. Dietary diversity means ensuring that children are fed from at least four food groups, as this increases the likelihood of children consuming at least one animal source and at least one fruit or vegetable in addition to a staple food (grains, roots, or tubers) (Central Statistics Organization; Ministry of Public Health; ICF, 2017). The four groups should come from a list of seven food groups: grains, roots, and tubers; legumes and nuts; dairy products (milk, yogurt, or cheese); flesh foods (meat, fish, poultry, or liver/organ meat); eggs; vitamin A-rich fruits and vegetables; and other fruits and vegetables.

The AfDHS reports 24% of children had an adequately diverse diet—that is, they had been given foods from the appropriate number of food groups (Central Statistics Organization; Ministry of Public Health; ICF, 2017). The estimates reported by NNS are slightly higher—about 29.2% of female children received foods from four or more food groups as compared with 26.1% of male children. Children of illiterate mothers (26.4%) were less likely to receive foods from four or more food groups as compared to children of mothers with higher education (34.3%). A similar pattern was observed among the poorest (16.9%) and richest households (37.4%) (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Minimum meal frequency is based on how much energy a child needs and, if the child is breastfed, the amount of energy needs not met by breast milk. Breastfed children have a minimum meal frequency of at least 2-3 complementary meals a day depending on age. Non-breastfed children require at least four meals a day to meet the minimum meal frequency requirement.

Only 16.3% of children aged 6-23 months received a minimum acceptable diet. Children of illiterate mothers (14.9%) and children from the poorest households (10.0%) were less likely to receive a minimum acceptable diet as compared to mothers with higher education (29.6%) and children from the richest households (25.0%) (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

The minimum standards with respect to all three IYCF practices of ensuring dietary diversity, minimum meal frequency, and minimum acceptable diet (Ministry of Public Health, 2008; World Health Organization, 2008) were met for only 16% of Afghan children aged 6-23 months. Minimum standards of dietary diversity and meal frequency were ensured for 16% of breastfed children of the same age group. Similarly, minimum IYCF standards listed above are met among 14% of non-breastfeeding children. Some patterns by background characteristics are:

- The percentage of children aged 6-23 months fed according to IYCF guidelines is higher in urban areas (22%) than in rural areas (13%).
- There are wide variations in feeding practices by province. Two percent or less of children in Wardak, Paktika, Nuristan, Daykundi, Kandahar, Jawzjan, Helmand, and Nimroz are fed as recommended. On the contrary, more than 35% of children in Nangarhar, Baghlan, Paktika, and Sar-E-Pul are fed according to the global recommendations.
- Mother's education has a positive impact on children's feeding practices: 29% of children whose mothers have more than secondary education are fed according to the global recommendations, as compared to only 14% of children whose mothers have no education (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

In summary, in Afghanistan, IYCF practices are suboptimal, in particular, the provision of pre-lacteals feeds to newborns, the late introduction of breastmilk, the too-early introduction of complementary food, and the poor quality of complementary foods are all factors jeopardizing a child's proper development. This requires urgent attention—improving the quality of services around nutrition counselling and promotion through healthcare providers are the most direct interventions proposed. These have to be complemented by measures to improve early childhood care practices. Multiple options might exist, including the improvement of services through the Basic Package of Health Services (BPHS) providers, private healthcare providers (private sector), other nongovernmental service providers, the engagement of traditional community leaders, etc.

Nutritional status of adolescent girls

A good nutritional status among adolescent girls is a precondition for a healthy pregnancy, delivery, and the proper growth of the fetus. NNS 2013 conducted height and weight measurements of 5,805 adolescent girls aged 10-19 years and calculated body mass index (BMI) z-scores (BMI kg/m²). Overall, 8.0% of adolescent girls were thin (BMI below -2 SD), and 1.5% were severely thin (BMI below -3 SD). Thinness decreased with age, 10.2% of adolescent girls aged 10-14 years were thin as compared to 4.1% among those 15-19 years old. It was also higher among those that had some years of schooling as compared to those that had a high school or higher education (5.1% and 1.3%) (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Provincial variation in the prevalence of thinness (below -2 SD) ranged from 0.4% in Kandahar to 20.3% in Badakhshan province. Prevalence of thinness among adolescent girls was equal or less than the national estimate of 8.0% in 19 provinces.

National estimates for overweight and obesity were 11.6% (greater than +1 SD) and 2.7% (greater than +2 SDs), respectively. Education has a positive impact on the health status in this regard, as adolescent girls with no education (15.0%) were more likely to be overweight (greater than +1 SD) as compared to those who have completed high school and above (3.9%). Provincial variation in the prevalence of overweight (greater than +1 SD) ranged from 3.3% in Samangan to 42.9% in Helmand. The prevalence of overweight in 25 provinces was equal or less than national estimates (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Given these results, underweight is a problem among younger girls while overweight is common among both groups. Both forms of malnutrition among adolescent girls, underweight and overweight, particularly among girls of lower educational status, require attention when formulating the Strategic Plan.

A detailed overview of anthropometry measures of adolescent girls from NNS 2013 is given in Annex 3.

Nutritional status of women of reproductive age

Nutritional status of women of reproductive age (WRA) is another important indicator to be analyzed when designing programs addressing malnutrition. Nutritional status of women is expressed by 'underweight' and measured by analyzing BMI (kg/m²). The overall mean BMI value of women aged 15-49 was 23.4 kg/m², with no significant association to the socioeconomic situation of the household. Overall, 9.2% of WRA were too thin or undernourished (BMI <18.5 kg/m²), and this improved by age (17.7% among those 15-19 years old and 6.4% among those 45-49 years old).

In contrast, 29.0% of WRA were overweight (BMI 25-29 kg/m²) and 8.3% were obese (BMI 30 kg/m² or above). Percentages were even higher among those who are illiterate as compared to those having a high school or even higher level education (63.3% compared to 48.4%). Consistent with the trend of overweight and obesity in adolescent girls, both those indicators showed higher prevalence rates among the poorest as compared to the richest wealth quintile (74.4% and 48.2%) (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Underweight among WRA is a problem, in particular among illiterate and poorer population groups, while overweight and obesity are particularly high among the better-off households. Both need to be addressed by adequate measures. Promotion of adequate and nutritious diets, as well as healthy lifestyles, are some urgent priority actions.

A detailed overview of the BMI of WRA from NNS 2013 is given in Annex 4.

Micronutrient intake

Micronutrient deficiency is a major contributor to other forms of malnutrition and increases the risk of morbidity and mortality. Micronutrients are available in various foods groups and can also be provided through direct supplementation.

Table 1. Micronutrient deficiencies.

	Iron deficiency		Anemia		Vitamin A deficiency	Zinc deficiency
	NNS 2004	NNS 2013	NNS 2004	NNS 2013	NNS 2013	NNS 2013
WRA (non-pregnant)	48.4%	24%	24.7%	40%	11.3%	15.1%
Children (6-59 months)	71.5%	26%	38%	43%	50.4%	23.4%

Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013; Ministry of Public Health; UNICEF, 2004). Acronym: NNS, national nutrition survey; WRA, women of reproductive age.

Table 2. Iodine deficiency.

	Iodine deficiency	
	NNS 2004	NNS 2013
WRA (non-pregnant)	74.7%	40.7%
School-age Children (7-11 years)	71.9%	29.5%

Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013; Ministry of Public Health; UNICEF, 2004). Acronym: NNS, national nutrition survey; WRA, women of reproductive age.

Vitamin A

Vitamin A is an essential micronutrient for the immune system and plays an important role in maintaining the epithelial tissue in the body. Severe vitamin A deficiency can cause eye damage and is the leading cause of childhood blindness. It also increases the severity of infections, such as measles

and diarrheal disease, in children and slows recovery from illness. Vitamin A deficiency is common in dry environments where fresh fruits and vegetables are not readily available.

Vitamin A supplementation is an important strategy undertaken to prevent vitamin A deficiency among young children. In Afghanistan, Vitamin A supplementation covers only 44.6% of preschool children. Global targets are to achieve at least 90% coverage to control vitamin A deficiencies effectively. Children receive vitamin A supplements as part of National Immunization Day campaigns (Central Statistics Organization; Ministry of Public Health; ICF, 2017). The AfDHS reports that nearly half of children (48%) under age two in Afghanistan consumed vitamin A-rich foods in the 24 hours before the interview (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Results of the NNS 2013 show that half (50.4%) of children 6-59 months of age and 11.3% of WRA suffered from vitamin A deficiency. Of these, 45.8% of children (0-59 months) had a mild deficiency while 4.6% were severely deficient. For WRA, 10.8% suffered from a mild deficiency while 0.5% were severely deficient. The prevalence of vitamin A in children 6-59 months of age in Afghanistan is a severe public health problem according to WHO standards (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Iron

Iron deficiency is one of the primary causes of anemia, which has serious health consequences for both women and children.

Pregnant women should take iron supplements, eat iron-rich foods, and should prevent parasites and malaria infections. The AfDHS 2015 included questions to ascertain whether mothers had received iron supplements during pregnancy. Only 7% of women who gave birth in the five years before the survey took iron supplements for 90 days or more, as recommended. More than half of women (55%) did not take iron supplements at all (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

NNS 2013 results also revealed a high prevalence of iron deficiency anemia in children and women. Twenty-four percent of WRA and 26.1% of children aged 6-59 months were observed iron deficient, and prevalence of iron deficiency anemia in children 6-59 months of age and WRA was 13.7% and 13.8%, respectively (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013). The AfDHS reports that nearly 30% of the children consumed iron-rich foods in the 24 hours before the interview (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Zinc

While severe zinc deficiency is rare, mild to moderate deficiency is common, especially in populations with low consumption of zinc-rich animal-source foods. Zinc intake is particularly important for mothers as maternal zinc deficiency may compromise infant development and lead to poor birth outcomes. Deficiencies in children increase the risk of infections and diseases such as diarrhea. Other important roles attributed to zinc include maintenance of adequate immune function and brain development. Zinc is required by the body in trace amounts for the activity of certain enzymes and thus for the maintenance of normal body metabolism and growth. NNS 2013 revealed that prevalence of zinc deficiency in children 6-59 months of age was 23.4% and 15.1% in women of reproductive age (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Vitamin D

Multiple studies have linked vitamin D deficiency to adverse health outcomes in both children and pregnant women that extend beyond bone health. It is an essential vitamin needed for facilitating absorption of other nutrients, such as calcium and phosphate, that play a vital role in ensuring bone health. The human body endogenously produces vitamin D when exposed to sunlight. Vitamin D-rich foods are milk, meat, and fish. WRA are most susceptible to vitamin D deficiency as not only does pregnancy and lactation create a higher need, their body generates less vitamin D on its own due to cultural limitations of WRA staying indoors, observing purdah, and consequently lower exposure to the sun.

In the NNS 2013, of the 1,190 WRA who were assessed for vitamin D levels, a majority (64.7%) suffered from severe deficiency, while 30.8% were moderately vitamin D deficient. Sixty-four percent of children 6-59 months of age were moderately vitamin D deficient, and an additional 16.8% had a severe deficiency (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Presence of iodized salt in the households

Iodine is an essential micronutrient, and iodized salt prevents goiter and other thyroid-related health problems among children and adults. The AfDHS 2015 tested for the presence of iodine in household salt. Among households in which salt was tested, 57% had iodized salt, which was higher in urban areas (82%) than in rural areas (48%). The presence of iodized salt was also much higher in wealthier households: 88% of those from the highest quintile compared to 26% in the lowest quintile (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Causes of undernutrition

Health status

Since the end of the Taliban regime in 2001, health services have significantly improved in Afghanistan. Established clinics and hospitals allowed an increase in health coverage from 9% (in 2003) to almost 90% in 2013. About 50% of the population lives within a one-hour walking distance of a health facility, while 37% of the population lives within two hours walking distance (Islamic Republic of Afghanistan Ministry of Public Health, 2015).

Also a study conducted by the MOPH and supported by Johns Hopkins University on Afghanistan's Health Sector performance corroborates that between 2004 and 2006 attendance and commitment of the health workforce were improving as was the availability of health services (Ministry of Public Health General Directorate of Policy and Planning Monitoring & Evaluation Department; Johns Hopkins, 2006).

However, despite this progress, the healthcare system still falls short of ideal absolute levels and needs to be developed to achieve adequate and quality health services. Limitations to human resources, especially female health workers, and infrastructure, inadequate facilities, and poor domestic revenue sources that necessitate reliance on donor-funded service provision are some key challenges in the sector (FAO & WHO, 2012).

Early childhood mortality

The AfDHS explores reports from the five years preceding the survey (in 2015) to calculate mortality rates in different age groups. The following presents a summary:

Table 3. Mortality rates by age groups.

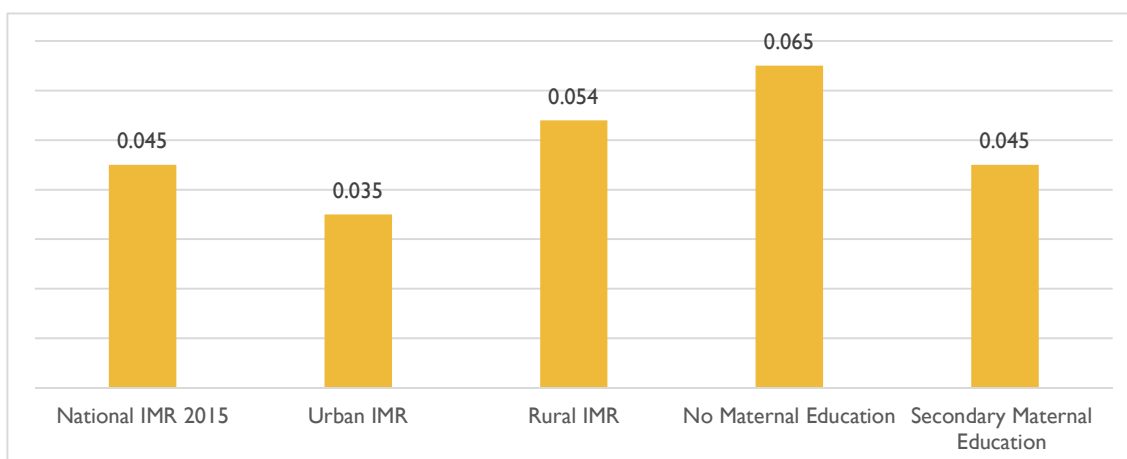
Neonatal mortality rate	22 deaths per 1,000 births
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Infant mortality rate	45 deaths per 1,000 live births
Under-five mortality rate	55 deaths per 1,000 live births

Source: (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Four-fifths of all deaths in the first five years of life occurred during infancy, and two-fifths occurred during the first month of life (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Figure 6. Comparison of infant mortality rate by background characteristics.



Source: (Central Statistics Organization; Ministry of Public Health; ICF, 2017). Acronyms: IMR, infant mortality rate.

The data from the AfDHS 2015 identifies a positive time trend for under-five mortality: the rate was 87 deaths per 1,000 live births in the 10-14 years prior to the survey and has fallen to 55 deaths per 1,000 live births in the five years preceding the survey. The under-five mortality rate also has a negative correlation with household wealth, from 81 deaths per 1,000 live births in the lowest wealth quintile (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Diarrheal disease

According to the AfDHS survey, 29% of children under age five had diarrhea and 4% had diarrhea with blood in the stool (Central Statistics Organization; Ministry of Public Health; ICF, 2017). The results are comparable to the findings of the NNS 2013, which found 35.5% of children that had suffered from diarrheal diseases two weeks prior to the survey (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

The prevalence of diarrhea rises rapidly once a child reaches six months of age, which coincides with the introduction of complementary foods. This trajectory continues to increase and peaks at 38% as the child reaches 12-23 months of age. This is roughly around the time when children begin to walk and are exposed to greater contamination from the environment and also when children are weaning and new foods and liquids are introduced (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Children in households that use a shared toilet facility are slightly more likely to suffer from diarrhea than those using an improved toilet facility that is not shared (31% versus 28%). The prevalence of diarrhea is also much lower among children whose mothers have more than a secondary education than among children whose mothers have a primary education (18% versus 32%) (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Fifty-four percent of children with diarrhea were taken to a health facility or provider for advice or treatment; this practice was higher for children with bloody diarrhea (68%) than for children with

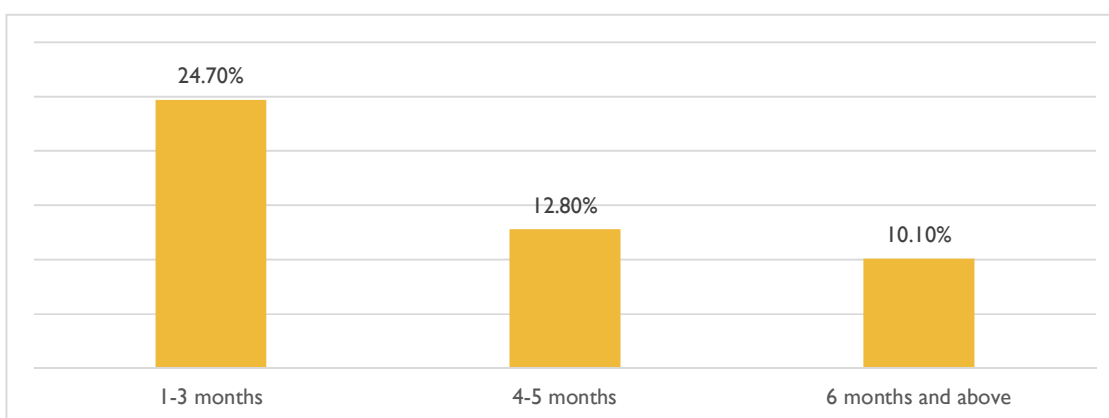
non-bloody diarrhea (52%). Only half of the children suffering from diarrhea (50%) received some form of oral rehydration therapy. Among other treatments, 21% of children received antibiotics, 3% were given anti-motility drugs, and 10% received zinc supplements, which can reduce the duration and severity of diarrhea. Nearly two in five children with diarrhea (39%) were treated with a home remedy while 17% of children with diarrhea did not receive any treatment (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Although urban and rural children with diarrhea are equally likely to be taken to a health facility or provider for advice or treatment, rural children are more likely to receive home remedies than urban children (42% versus 32%). Help-seeking for diarrhea varies greatly by province: only 20% of children with diarrhea in Ghazni were taken to a health facility or provider, as compared with 94% in Paktika. The proportion of children who received no treatment ranges from less than 1% in Badghis and Paktika to 39% in Kandahar. Women with a secondary education (78%) are more likely to know the importance of using an oral rehydration solution than women with no education (63%). By province, women in Kandahar (21%) and Nuristan (23%) are least likely to have heard about oral rehydration solutions (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Reproductive health

Antenatal care is essential for safe delivery. A WHO recommended practice is to have a minimum of four antenatal care visits in the case of pregnancy without complications. While antenatal care is accessed in Afghanistan (48.1% of women received antenatal care in their last pregnancy), only 16.4% of women applied the WHO recommendation. The likelihood of making a minimum of four visits increases significantly with education: 44.8% of women with high school and above education had four or more antenatal visits compared to 28.8% for women with some school education and 13.4% for illiterate women. Similarly, a higher proportion of women (30.2%) from the highest wealth quintile had four or more antenatal visits as compared to those from the lowest quintile (5.8%) (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

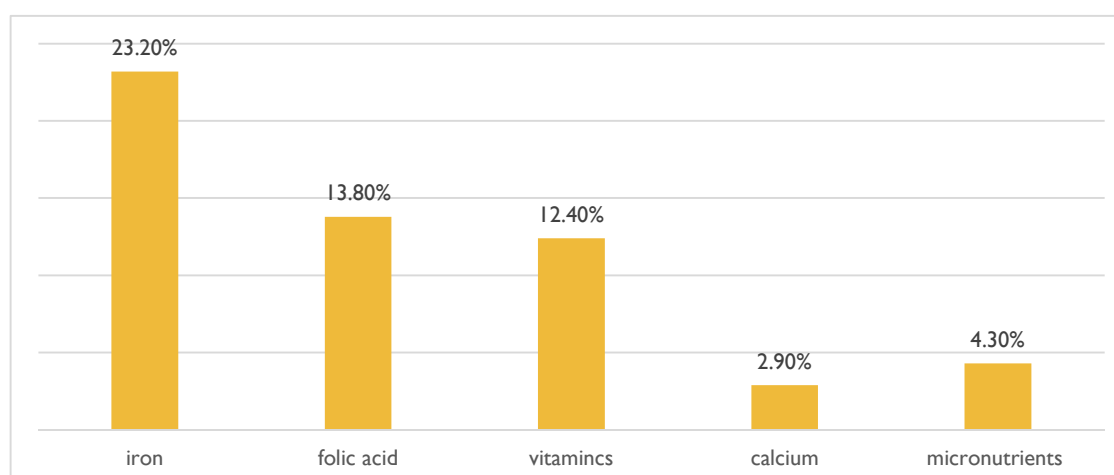
Figure 7. Timing of first antenatal care visit.



Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Even regarding the timing of antenatal care visits, the effect of education was apparent: 54.5% of literate (high school and above) women made their first antenatal visit during the first trimester of pregnancy.

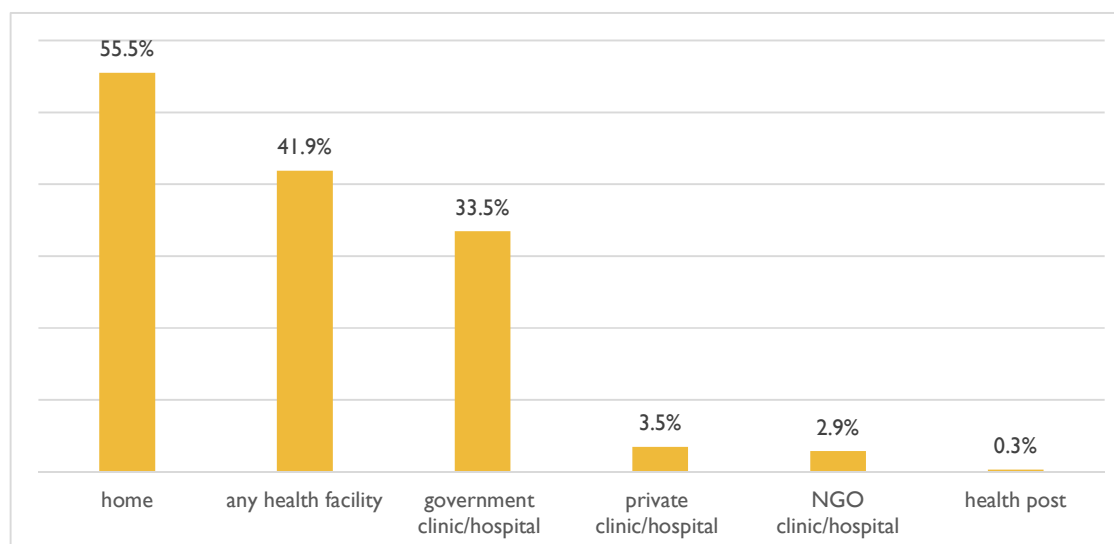
Figure 8. Use of supplements during pregnancy.



Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Women with high school and above level of education (43.9%) and women from the highest wealth quintiles (36.0%) were more likely to have iron supplements during their pregnancy than women with less education and from lower wealth quintiles. Similar trends were observed in other vitamin/mineral supplementations (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Figure 9. Place of birth.



Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Twenty-eight percent of deliveries were supported by traditional birth attendants, 26.2% by nurses/midwives, 22.5% by older family members, and 12.1% by government doctors. Most (55.0%) married women did not receive any postnatal check-up, and even among those who did receive it, 35% were checked in the immediate postpartum period (within six hours of birth).

As evident from global research, there is a close association between early and frequent pregnancies and high rates stunting at early childhood. Though the knowledge about family planning and contraceptives are high in Afghanistan, the use of is very limited. Less than one-quarter of married

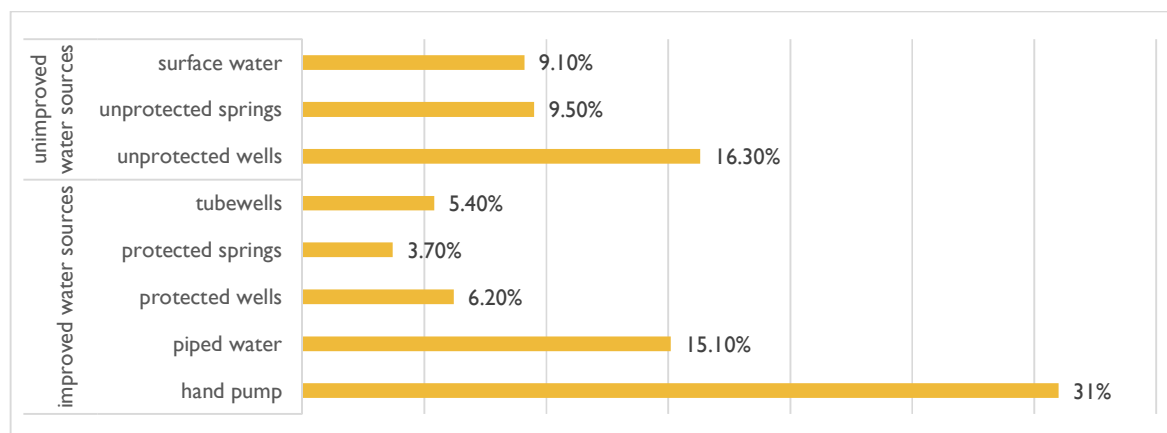
women use contraceptives (23%) (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Water, sanitation and hygiene

Access to water

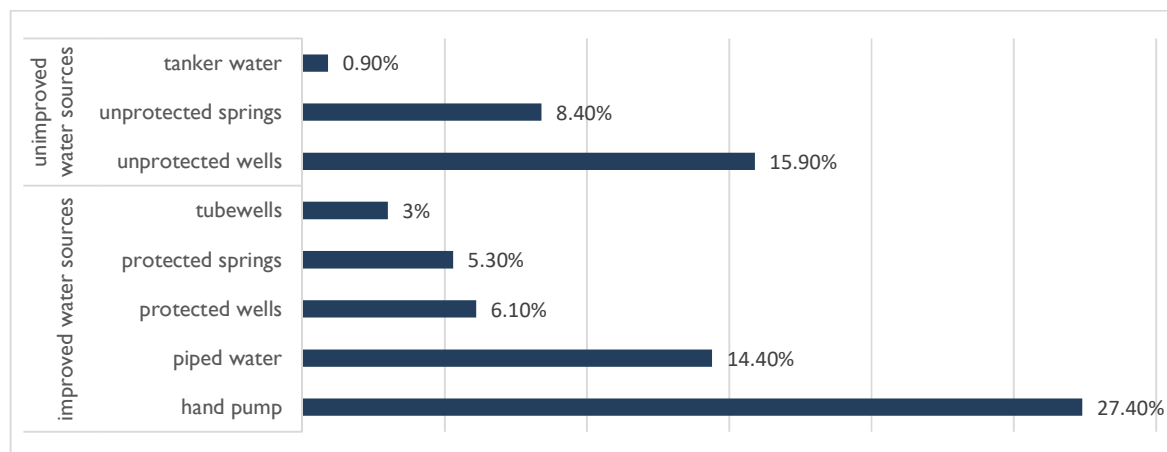
Almost two-thirds of households (61.4%) used drinking water from an improved source. They have access to either a deep well operated with a hand pump, piped water, a protected well or spring, or a tube-well.

Figure 10. Source of drinking water.



Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Figure 11. Source of water for other uses.



Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

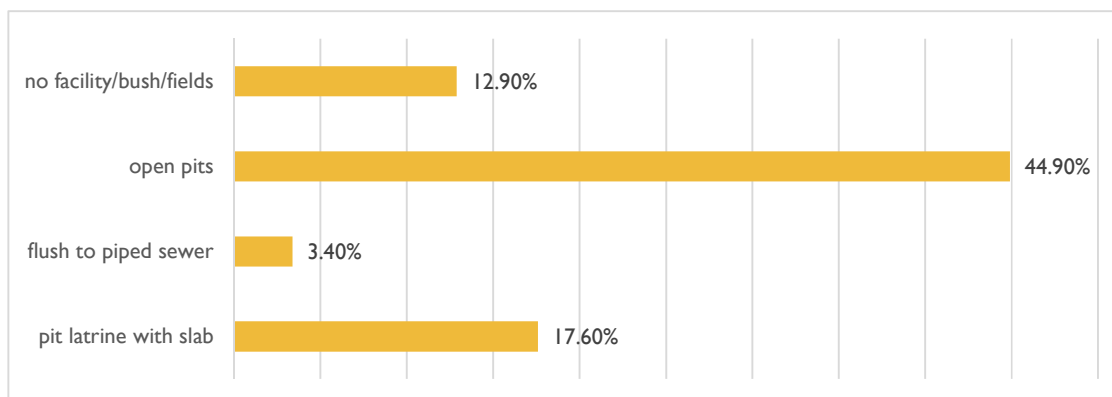
According to the results of the NNS 2013, 89.7% of households did not treat water to make it safer. Only 10% of households pre-treated drinking water to make it safer, and they reported boiling as the most commonly used method (4.7% households).

A family member fetched drinking water in 53.4% of households. For most (43.6%) households, the distance of the water source from the household was 30 minutes or less. In 39.5% of households, an adult female household member collected water from a source outside the home. In one-third of the households, this task was performed by an adult man (30.2%) and in 26.6% of households by children (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Sanitation

A majority (58.9%) of households in Afghanistan did not have access to an improved sanitation facility. Only 40.4% of households used an improved facility. Sharing of latrines with other households was reported by 17% of respondents. Among these, 86.1% shared the toilet with one, two, or three other households (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Figure 12. Type of sanitation facility.



Source: (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Hygiene

At the national level, 89.7% of women reported washing hands with soap after defecation, ranging from 28.5% in Nuristan to 99.4% in Sar-e-Pul province. Likewise, 90% of women usually washed hands before preparing the meals—provincial variations ranged from 60.0% in Balkh to 99.2% in Takhar province. However, only 45.1% of households had soap at the place used for washing hands, and handwashing places could not be observed by teams for 18.0% of households (Islamic Republic of Afghanistan Ministry of Public Health; UNICEF, 2013).

Food and agriculture

A high proportion of Afghanistan's 28 million people face chronic and transitory food insecurity. Food insecurity based on the food consumption score and food-based coping strategies is estimated at 33% (9.3 million people) of the total population. Among them, an estimated 3.4 million (or 12%) are severely food insecure, and 5.9 million (or 21%) are moderately food insecure (Central Statistics Organization, 2014a).

Of the current food insecure population, 2.4 million people are severely food insecure while 2.2 million people are very severely food insecure. The AFSeN-A also stresses the pressing nature of the food insecurity problem and highlights that those mainly affected by food insecurity are children under five, in particular when living in rural areas in Northeast, Central, and Southwest provinces (Islamic Republic of Afghanistan, 2017).

There are several underlying dynamics that result in ultimate food insecurity, including limited availability of food, lack of access to food, instability of food supplies, and poor food utilization.

Food availability: Declining food production, low productivity, and increased dependence on imports

While Afghani agricultural production is extremely sensitive to weather conditions, even in years of good harvests, Afghanistan remains a cereal deficient country. Wheat is the most commonly consumed cereal and accounts for 70% of cereal consumption (other cereal crops are rice, maize,

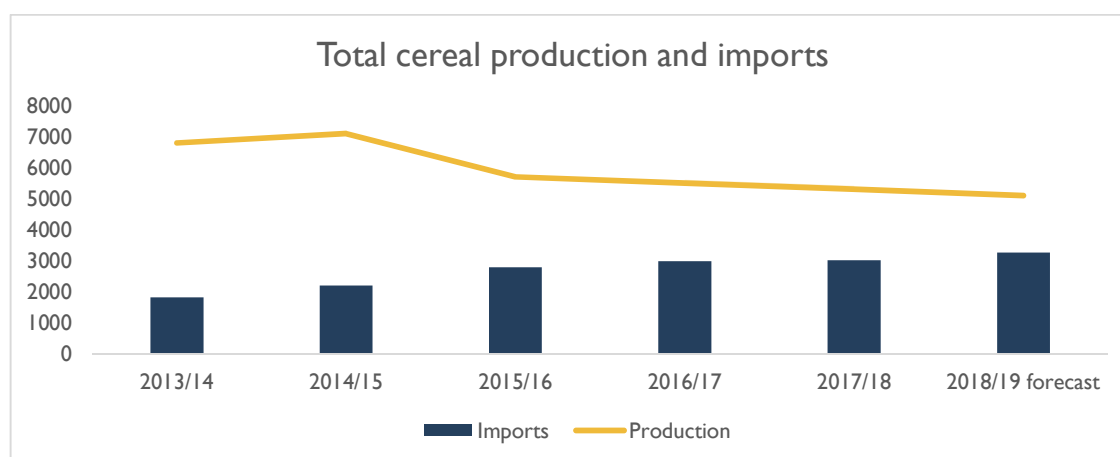
and barley). Wheat is grown on roughly 57% of cultivated land in Afghanistan. Of this, 45% is irrigated land while the remaining majority depends entirely on rainfall. The productivity differs vastly between irrigated and rain-fed areas with irrigated land having a more than double yield. Irrigation has become less available over time. In the 1970s, 3.3 million hectares were cultivated using irrigation methods but today only 1.8 million hectares are irrigated (Islamic Republic of Afghanistan, 2017).

Low yields because of rain-fed wheat production, droughts, and impact of civil conflict on irrigation networks, infrastructure, and livelihoods has had a strong adverse impact on Afghanistan's wheat production, and consequently on the country's self-sufficiency in wheat. The gap between domestic cereal production and demand is met by imports, which averaged 1.5 million tons annually between 2002 and 2011. The trend of declining production and increasing imports continued over recent years.

Figure 13. Afghanistan cereal production and imports.

	2013-2017 average	2017	2018 forecast	Change 2017/2018
	tons			percent
Wheat	4,809	4,280	3,500	-18
Rice (paddy)	642	500	465	-7
Barley	428	400	429	7
Others	321	315	321	2
Total	6,201	5,495	4,715	-14

Source: (FAO, 2018). Note: percentage change calculated from unrounded data.



Source: (FAO, 2018). Notes: Total cereal includes rice in milled terms. Split year refers to individual crop marketing years.

Thus, while the declining food production is largely made up by food imports, ensuring availability to cover the market demand for food, Afghanistan still experiences a 'nutrition gap' (i.e. the difference between total available food for consumption and the amount of food needed in the country to support a 2,100-per capita caloric intake). The 'nutrition gap' is an expression of insufficient access to food for parts of the population and was estimated at two million tons in 2008, when food prices were high, and 144,000 tons in 2012 (Islamic Republic of Afghanistan, 2017).

A small part of the food imports, about 100,000 tons annually, are provided as food aid—mainly by the World Food Program (World Food Program, 2017b).

Insufficient access to food

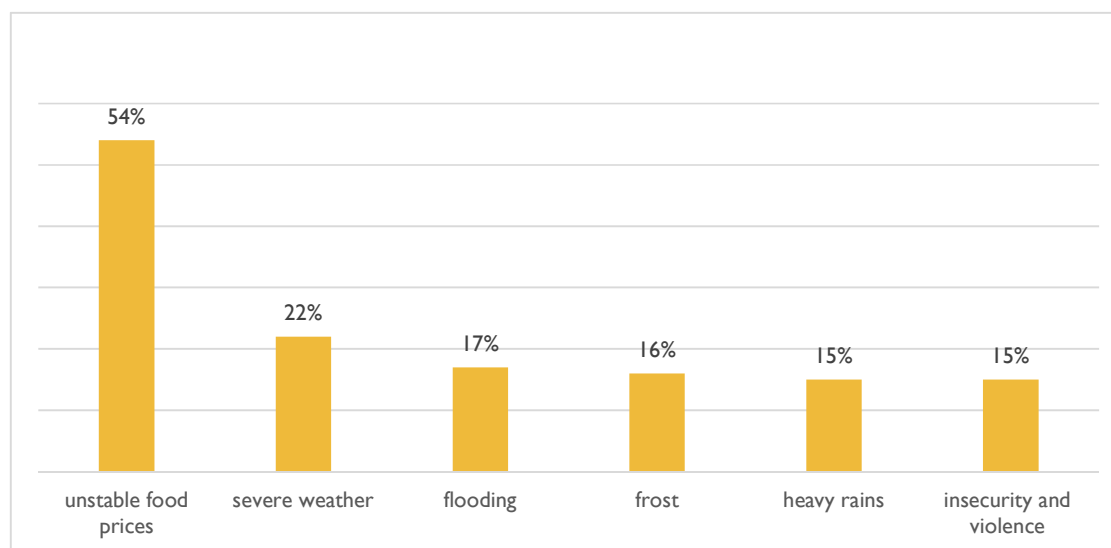
Poverty means insufficient economic access to food. Therefore, poverty and food insecurity are very closely correlated; nearly 70% of the poor suffer from food insecurity, and the incidence of different aspects of food insecurity (caloric deficiency, protein deficiency and insufficient dietary diversity) is significantly higher in poor households. In line with the increase in poverty rates across the country, from 38% in 2011/12 to 55% in 2016/17, the number of food-insecure households went up from 30% to 45% during the same period (Central Statistics Organization, 2016). Thus, although food insecurity affects much of the country's population, the 2017 Afghanistan Zero Hunger Strategic Review indicates that particularly women, children, displaced persons, returnees, woman-headed households, persons with disabilities, and poor people are the groups most at risk.

Market purchases are the main source of wheat flour for 65% of rural households and 91% of urban residents (Islamic Republic of Afghanistan, 2017). However, markets are not always easily accessible: 80% of urban residents can access a market within one hour by foot or animal, but only 26% of the rural population reported a similar possibility. While rural populations need to use transportation to access markets more often, they also do not have universal access to public transportation, which further compounds issues of access. While small local markets often do exist, food availability is often limited because of the subsistence nature of production and the tendency for extra-market exchanges (i.e. sharecropping, land rent, and other obligations, such as religious taxes). Food prices are predominantly dependent on regional markets.

Instability of food supplies

Household food and nutrition insecurity is also compounded by temporary shortages in production arising from seasonal factors, natural disasters, conflicts, poorly functioning markets, and price shocks.

Figure 14. External shocks to food consumption and production.



Source: (Islamic Republic of Afghanistan, 2017).

The agricultural calendar influences household food supplies. Spring and summertime are considered a 'hungry season' because household food stocks from previous harvests begin to dwindle. Seasonal shortages also occur in mountainous regions during winters where snow can hinder road access. This is particularly problematic for provinces, such as Ghor, Daykundi, Bamyān, Badakhshan, Ghazni,

and Wardak, located in high altitudes where restricted access further compounds problems of food availability due to limited harvests, arable land, unstable markets, and poor infrastructure.

Another contributor to food instability are natural disasters, such as floods and droughts, aggravated by climate change. According to the AFSeN-A, up to 400,000 people annually are affected by some form of natural disaster.

The instability of food prices also poses a challenge for food and nutrition. In 2007/08, for example, the food price hike was extreme: wheat flour more than doubled in price and the urban food consumer price index rose by 60% compared to an inflation of 10% in non-food related items (Islamic Republic of Afghanistan, 2017). These fluctuating prices are most problematic for the already poor and food-insecure households as they are then forced to make a quality-quantity trade-off, reduce dietary diversity and nutrient-rich food, and increase intake of cereals and grains to meet caloric needs.

Poor food utilization, health and nutrition

Limited dietary diversity, poor food quality control, infectious diseases, and limited access to healthcare are among some of the foremost causes of Afghanistan's malnutrition. Cereals and tubers, oil and fats, and sugar products provide 80% of calories, and Afghans consume these food items almost every day of the week. Urban households tend to have relatively more diverse diets that include meat and fish, pulses and lentils, dairy products, fruits and vegetables consumption compared to rural areas.

Several infectious diseases also worsen the health and nutritional status of the Afghan population. Acute respiratory infections, diarrhea, and measles are some of the most common diseases. The poor hygiene and sanitation facilities further compound the problem and make people more susceptible to nutrition-related diseases, particularly in rural areas. Access to healthcare services is also a key impediment to the optimal utilization of food and nutrition. Although health services have seen marked improvements in recent years, from 9% of households in 2000 to 65% in 2006 (Islamic Republic of Afghanistan, 2017), inadequate access and substandard care are serious problems.

Several aspects of food safety inadequacies and gender inequity also contribute to malnutrition in Afghanistan through their direct impacts on food security. Food quality control is weak due to the absence of recognized standards, legislation, regular inspection systems, and border controls. Gender inequity is manifested in women's inadequate access to services, control over resources, and unfortunately, economic opportunities in the health, education, and agricultural sectors.

Further and underlying causes

Many factors have contributed to the grave state of food insecurity and undernutrition in Afghanistan, often interlinked, mutually compounding and further aggravating the precarious food and nutrition situation. This refers to issues such as conflict, violence and insecurity, poverty, unemployment, recurrent disasters, migration, low agricultural production and productivity, and poor public services, as previously noted. The "Problem Tree" of the AFSeN-A background document, presented in Annex 3, gives a comprehensive picture of the hierarchy of causes and effects of food and nutrition insecurity in Afghanistan.

Status of women

Particularly crucial for food and nutrition is the role of women. Their role and contribution to family welfare, food security, and nutrition cannot be overrated. They produce and harvest food crops, manage livestock, prepare meals, generate family income from household products, collect water

and firewood, ensure household sanitation, collect provisions from nature, such as wild foods and medicinal plants, care for family health and wellbeing, and educate their children on health and nutrition issues (UNEP, 2009). Due to persisting gender inequity, particularly in regards to education, economic, and social status, women face major challenges in complying with all these essential functions.

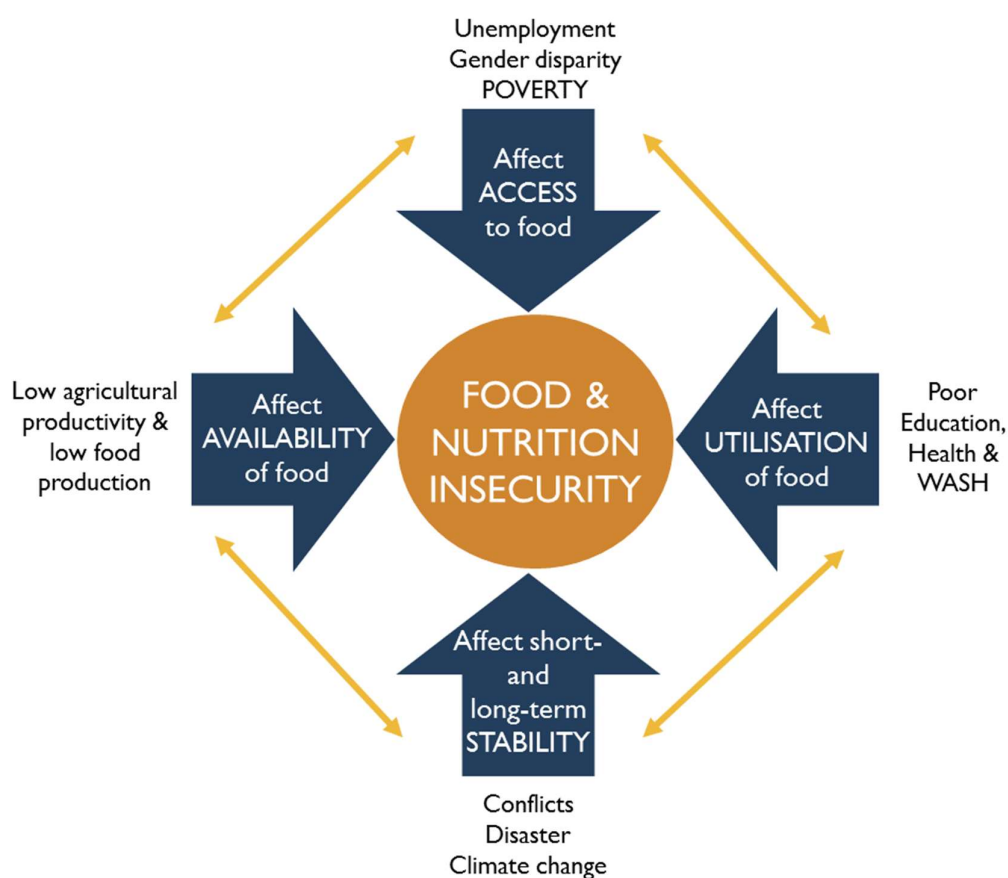
After many years of tireless efforts, today the political participation of women in the Government has reached significant levels, and women form 10% of people in managerial positions in the Government. Despite these gains, women are still victims of discrimination and violation all over the country, as in numerous instances, existing laws are not being duly implemented and the perpetrators of violence, harassment, and discrimination against women are not brought to justice (Ministry of Economy, 2017).

According to the Ministry of Women's Affairs data, 56% of women (ever partnered) and women aged 15 or more have experienced at least one instance of violence by their husband or fiancé during last the 12 months. While the number of women aged 15 or more that have experienced violence by people other than their partner is lower at 53% (Ministry of Economy, 2017). Eighty percent of women and 72% of men believe that a husband is justified in beating his wife in at least one of five specified circumstances, particularly if she goes out without telling her husband (67% and 61%, respectively) (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Decision-making powers and ownership of assets also have a strongly skewed distribution. Only 13% of currently married women are employed, as compared with 97% of currently married men. About two in five currently married women who receive cash earnings report deciding for themselves how their own earnings will be used, and one-third say they decide on the use of their earnings with their husband. Seventeen percent of women independently own a house and another 10% own land, while almost half of the men own a house and about a third own land. Only 5% of women make decisions alone about their own healthcare, while 44% report that their husbands make the decisions for them (Central Statistics Organization; Ministry of Public Health; ICF, 2017).

Figure 15 summarizes the main factors contributing to food and nutrition insecurity in Afghanistan.

Figure 15. Factors causing or aggravating food insecurity in Afghanistan.



Source: (Metz, Manfred & Toe, 2012).

Policy Context

A brief overview of the key policies and strategic documents guiding development in food and nutrition, and the related fields of food security, agriculture, health, women empowerment, and poverty reduction is given below.

National development

The Constitution of Afghanistan, 2004

The Afghan constitution embraces the values of democracy, freedom, and equality of rights. It enshrines principles providing equitable treatment to all groups and promoting industry, which ultimately create a conducive environment for growth and development. The constitution also specifically outlines provisions for health. Some relevant articles from the Afghan constitution are:

Article 6: The state shall be obligated to create a prosperous and progressive society based on social justice, preservation of human dignity, protection of human rights, realization of democracy, attainment of national unity as well as equality between all peoples and tribes, and balance development of all areas of the country.

Article 13: The state shall design and implement effective programs for developing industries, expanding production as well as protecting activities of craftsmen to raise the standard of living of the people.

Article 14: The state, within its financial means, shall design and implement effective programs to develop agriculture and animal husbandry, improve economic, social, and living conditions of farmers, herders, and settlers as well as the nomads' livelihood.

Article 52: The state shall provide free preventative healthcare and treatment of diseases as well as medical facilities to all citizens in accordance with the provisions of the law. Establishment and expansion of private medical services as well as health centers shall be encouraged and protected by the state in accordance with the provisions of the law. The state shall adopt necessary measures to foster healthy physical education and development of the national as well as local sports.

Article 54: Family is the fundamental pillar of the society and shall be protected by the state. The state shall adopt necessary measures to attain the physical and spiritual health of the family, especially of the child and mother, upbringing of children, as well as the elimination of related traditions contrary to the principles of the sacred religion of Islam (Islamic Republic of Afghanistan, 2004).

Sustainable Development Goals within the Afghan context

The SDGs strongly advocate the understanding that a multisectoral approach towards achieving the goals, including the nutritional goals, is very crucial. The Global Nutrition Report 2016 states that 12 out of the 17 SDGs have indicators highly relevant to nutrition. SDGs closely related to nutrition are:

Goal 1. End poverty in all its forms everywhere.

Goal 2. End hunger, achieve food security and improved nutrition, and promote sustainable agriculture.

Goal 3. Ensure healthy lives and promote well-being for all at all ages.

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

Goal 5. Achieve gender equality and empower all women and girls.

Goal 6. Ensure availability and sustainable management of water and sanitation for all.

In Afghanistan, the 2030 SDG Agenda is understood as 'One Nation, One Voice', and provides the foundation for the socioeconomic development of the country. A nationalization process of the SDGs' targets and indicators has been completed, bringing global targets into the national context and adjusted to circumstances, defined under the Afghanistan SDGs (A-SDGs). This process was completed in May 2017 and followed by a process of alignments and integration completed by December 2017—while the period 2018 to 2030 is considered as the implementation phase.

The GoIRA's Ministry of Economy (MoEc) leads the coordination of the SDGs with relevant sectoral Ministries and partners. Each Ministry has adopted its relevant SDG target and indicators to be achieved by 2030. MoPH and the Ministry of Agriculture, Irrigation and Livestock (MAIL) have adopted specific nutrition and food security targets and indicators in line with SDG 2. The Afghan National Health Policy 2015-2020, for example, takes into account the SDG targets on health and

related issues. Similar examples exist for other ministerial policies. The AFSeN-A and its Strategic Plan under preparation will closely cooperate with the SDG committee.

The approach is not to launch separate or standalone programs, but to streamline and integrate the SDG targets into national policies and programs, in particular into the ANPDF.

Besides the sectoral efforts that support accelerated efforts to achieve A-SDGs, the GoIRA has recently launched new initiatives contributing to the A-SDGs that are also highly relevant to addressing the root causes of malnutrition, and hence, support the AFSeN-A vision. Examples include good governance, gender equality, fighting narcotics and corruption, and eliminating violence against women and children in the country. Hence, close cooperation with the coordination of the AFSeN-A and its Strategic Plan has great potential to enhance the impact of both. A detailed description of the mechanisms applied to reach the A-SDGs is provided in the A-SDG Progress Report dated July 2017 (Ministry of Economy, 2017).

Afghanistan National Peace and Development Framework, 2017-2021

The ANPDF is a five-year strategic plan for achieving self-reliance. It builds on the earlier Afghanistan National Development Strategy 2008-2013, which outlined an approach to achieving development through the Millennium Development Goals.

By referring to the SDGs, the ANPDF explicitly sets out sustainable job creation, improved welfare, effective poverty reduction, and investments to ensure a healthy and educated population from early childhood as development priorities. Enabling women to participate in the economy and society to a greater extent is a further priority according to the ANPDF.

The ANPDF will be implemented through **National Priority Programs (NPPs)**². Although nutrition is not explicitly mentioned in the ANPDF, the following three priority programs, yet to be finalized, will be particularly important for improving the food security and nutrition situation:

- 1) Under a **Comprehensive Agricultural Development Program**, public investment shall focus on agricultural sectors that show the largest potential for economic growth. Improved seeds, better farm technology, and more storage and cold chain facilities will help smallholders increase food security and move from subsistence to surplus production for domestic and export markets. A summary is presented in the chapter “Policy Context - Agriculture and Rural Development”.
- 2) The ANPDF further indicates that a **Citizens’ Charter National Priority Program** will improve mechanisms for service delivery in education, health, basic rural infrastructure, and agriculture services.
- 3) The **National Priority Program for the Economic Empowerment of Women**, will ensure, among other objectives, women’s full access to education and health services. A summary is presented in the chapter “Policy Context – Crosscutting Themes”.

One of the economic and fiscal goals outlined in the ANPDF is to increase development sector budget by 10-15% to expand the delivery of health and education services.

² The new NPPs presented above are being developed recently for implementing the ANPDF. They are replacing the previous and older NPPs, e.g. the NPP of the MoPH, Health for All Afghans, which had been developed for implementing the former national development strategy, Afghanistan National Development Strategy.

While aiming to reduce dependence on foreign aid from currently 70% to some 40-50% by 2020, the Government points out in the ANPDF that it will further rely on and promote development partnerships with donors and civil society organizations (CSOs).

Food, health, and, nutrition

Food security and nutrition are subject of two major national policy and strategic frameworks that were developed in 2012, the AFSeN-A³ and the Nutrition Action Framework (NAF). While AFSeN-A serves as overall umbrella policy framework on national food security and nutrition issues, NAF particularly focused on a multisectoral approach to combat undernutrition during the first 1,000 days from conception through the first two years of life (The Islamic Republic of Afghanistan, 2012).

A word of caution: Although the policies and strategies on food, health, and nutrition generally address highly important and the most relevant issues, often they remain unattended and not brought into tangible action. Like other sector policies and strategies in Afghanistan, they are not, or at best, partially implemented, due to lack of capacities, lack of funds, and the volatile security situation. Due to the same reasons, monitoring and evaluation of implementation and results, usually set out as a component of the policies and strategies, rarely takes place.

Afghanistan Food Security and Nutrition Agenda, 2012-2017

The AFSeN-A is the basis for the development of the AFSeN-A's Strategic Plan. The AFSeN-A is a document dedicated to ensuring that no Afghan goes hungry or suffers from malnutrition. It is a policy statement by the GoIRA categorically addressing hunger and malnutrition accompanied by a comprehensive framework for achieving the vision. AFSeN-A outlines the roles and responsibilities of government and nongovernment stakeholders and identifies coordination structures at the central and subnational level to facilitate the implementation of the policy statement.

The AFSeN-A document outlines four strategic goals (Islamic Republic of Afghanistan, 2017):

Objective 1: Assure the availability of sufficient food for all Afghans. **Target:** Increase food production by 20% within five years.

Objective 2: Improve economic and physical access to food, especially by vulnerable and food-insecure population groups. **Target:** Decrease, by 5% per annum through 2020, the proportion of people who suffer from hunger.

Objective 3: Ensure stable food supplies over time and in disaster situations. **Target:** Establishment of effective disaster preparedness and response mechanisms including a strategic grain reserve with an initially targeted volume of 200,000 metric tons and strengthened resilience of the rural population against shocks.

Objective 4: Promote healthy diets, adequate food utilization, and better nutrition particularly, by women and children. **Target:** Reduce stunting in children aged 0-24 months by 5% by the end of 2016.

As to Objective 4, AFSeN-A explicitly refers to the NAF, by linking and integrating measures aimed at improving food security and nutrition with the specific nutritional objectives and interventions stipulated under the NAF.

³ The original document, presented as draft in 2012 and titled AFSANA, was officially endorsed by the Government under the title AFSeN-A in October 2017.

AFSeN-A is based on the following principles:

- 1) Food security and nutrition is multidimensional and cross-sectoral, involving multiple stakeholders at all levels of governance.
- 2) Current policies, programs, and institutional structures relevant for food security and nutrition are to be considered and lessons learned are to be leveraged in designing new ones.
- 3) Strategic actions for reversing food and nutrition insecurity must be flexible to enable elaboration at the onset of implementation.
- 4) Roles assigned to key stakeholders should reflect their institutional mandates and evolving comparative advantage.
- 5) Mainstreaming gender ensures fair consideration of the specific needs of both men and women during the prioritization of strategic actions and their equitable participation in monitoring and evaluation activities.

In connection with the official Government approval of AFSeN-A in October 2017, a coordination structure for implementing the policy was established under the leadership of the Director General of the Council of Ministers' and the high-level steering committee for food security and nutrition overseen by the Executive Board, chaired by H.E. Dr. Abdullah Abdullah the Chief Executive. Coordination platforms are established at the national level and proposed for the provincial level. MoPH and MAIL, the two major players in the fields of food security and nutrition within the Government, have developed food security and nutrition-related policies and strategies and are executing some related programs and actions. The AFSeN-A document and approach is the basis for the development of the Strategic Plan. Hence, the Strategic Plan will provide directions to relevant sectors, departments, and stakeholders at the central and decentralized levels.

This contextual analysis, to be complemented by a stakeholder mapping, will provide updated and comprehensive information to inform the development of the AFSeN-A's Strategic Plan.

Nutrition Action Framework, 2012-2016

The NAF was drafted in 2012, and its objective is to guide the development and implementation of nutrition strategies and programs among five government Ministries, including public health, agriculture, commerce, education, and rural development.

The overarching objective of the NAF is to reduce the prevalence of stunting by addressing the 1,000-day window of opportunity, from conception to two years of life, across Afghanistan. This document suggests an integrated approach to addressing this concern among key areas, including food security, nutrition, WASH, and food trade and related regulations. To achieve their objective, the framework suggests a multipronged approach including: 1) establishing a food and nutrition secretariat under the leadership of the Second Vice President; 2) establishing a secretariat in each Ministry to oversee the implementation of the framework; 3) strengthening current activities and creating new ones directed toward improving food security and nutrition, and 4) strengthening coordination and monitoring and evaluation of all relevant interventions.

Although some of the actions defined under NAF have been taken up by stakeholders, particularly MoPH, United Nations (UN) organizations and nongovernmental organizations (NGO), the foreseen institutional arrangement and systematic monitoring have not been implemented. Nevertheless, objectives and approaches set out in the NAF are considered an integral part of AFSeN-A and have also become elements of the Food and Nutrition Security Strategy of MAIL and the new National Public Nutrition Policy and Strategy (The Islamic Republic of Afghanistan, 2012).

National Public Nutrition Policy and Strategy, 2015-2020

The Public Nutrition Department of MoPH has developed the Public Nutrition Strategy for 2015-2020, in order to address nutrition problems identified in NNS 2013. In addition, experience with the former nutrition policy and strategy (2009-2013) and actions defined in NAF have been considered. Several consultations have been conducted with relevant Ministries (e.g. MAIL, the Ministry of Rural Rehabilitation and Development) and development partners, including UN and NGOs to finalize the strategy. It highlights the implementation of evidence-based nutrition-specific interventions of high quality and coverage with more emphasis on preventive nutrition programs and services that target WRA and young children, especially those less than 24 months old. The strategy has five overarching components:

- 1) Inform the public about the role of nutrition in physical health and cognitive development and promote dietary practices to prevent malnutrition and its related health consequences, especially among children less than 24 months old.
- 2) Advocate for public nutrition policies and adequate resources to support quality and high coverage interventions as essential components of the national development agenda.
- 3) Improve multisectoral coordination to help increase coverage of quality nutrition-specific and nutrition-sensitive interventions.
- 4) Develop human resource capacities in planning, implementation, and evaluation of nutrition interventions and strengthen the role and capacity of the Public Nutrition Directorate.
- 5) Strengthen the national capacity to track the quality, coverage, and impact of public nutrition interventions and services to guide future policies and strategies.

The focus of this strategy is to implement nutrition interventions in accordance with the latest international guidance and recommendations as well as lessons learned from nutrition programs implemented by MoPH, UN agencies, and other NGOs.

The Public Nutrition Strategy also presents an update on the existing laws (e.g. protection of breastfeeding) and presents a framework for strengthening the laws and regulations required to introduce standards and protect consumers (i.e. fortification, standardization) and the role of other Ministries and partners to establish the required regulatory framework (Ministry of Public Health, 2014).

National Nutrition Communication Strategy 2015 – 2010

The Public Nutrition Department of MoPH has developed a National Nutrition Communication Strategy for 2015-2020, supported by a community-based nutrition package with the support of United Nations Children's Fund (UNICEF), which suggests all partners adopt this package for all their community-based nutrition programs. The goal of the Communication Strategy to improve maternal and child nutritional status through communication programs that will ultimately improve nutrition during the first 1,000 days of life—that involve educating and benefiting a broader segment of the population (Ministry of Public Health; Islamic Republic of Afghanistan, 2015). It promotes optimal nutritional behaviors and practices with a focus on under-five children and women, especially adolescents, pregnant, and lactating mothers. Its strategic goals are advocating among policymakers and service providers, ensuring social mobilization at all levels, policy and decision-makers as well as at community level, and changing behaviors and practices among priority target groups. National, provincial, and community-level implementation arrangements present the engaged sectors, Ministries, and departments, service providers and the network of supporting partners. A monitoring strategy is being presented as well.

The strategy provides excellent strategic as well as operational and technical guidance. It presents the desired outcomes, explains current behaviors and practices, key barriers or challenges, and approaches and actions to improve practices. It furthermore lays out the required advocacy, communication, social mobilization and implementation approach, and service delivery mechanisms.

The Strategy, in combination with the very recent and up-to-date Nutrition Policy of the MoPH, is to be perceived as the health sector's contribution and are central to the development of a broad, intersectoral approach to nutrition under the AFSeN-A (Ministry of Public Health; Islamic Republic of Afghanistan, 2015).

National Reproductive, Maternal, Child, and Adolescent Health Strategy, 2017-2021

In the past, the introduction of several government interventions had contributed to improvements in health indicators (BPHS, Essential Package of Hospital Services, and community health workers). However, since 2010, progress in the improvement of health status has plateaued, and the effectiveness of these previous interventions is declining. The contributions of community health workers to treating sick children, for example, have been declining; and while the specific reasons may not be clear, distance, access to transport, cost, and motivation of health workers remain some of the key barriers. This strategy aims to improve health and nutritional status of mothers, children, and adolescents by ensuring that appropriate preventative and curative information and services are available to all communities.

The strategy has outlined specific goals for the next five-year period:

- Reduce neonatal mortality by 25%.
- Reduce post-neonatal mortality by 30%.
- Reduce child mortality by 35%.
- Reduce maternal mortality by 30%.
- Increase the use of modern contraceptives by 30%.

To achieve these goal, MoPH has highlighted six strategic areas: 1) quality improvement of existing services in health facilities; 2) rejuvenation of community-based reproductive, maternal, child, and adolescent healthcare; 3) improved and innovative approaches to referral systems; 4) a fresh approach to health communication; 5) collaboration with the private sector; and 6) expanded school health programs for children and adolescents (MoPH, 2017).

National Health Policy, 2015-2020

The National Health Policy outlines an approach toward health provision that reflects the priorities of the National Unity Government. It highlights the need to create a balance between providing both curative and preventative health service delivery. Another area of emphasis is the need for greater oversight, monitoring, and evaluation of work and using the results to inform evidence-based decision making.

The National Health Policy outlines five key policy areas: governance, institutional development, public health, health services, and human resources. Within public health, the policy also specifies combatting malnutrition as a key policy priority area. As an approach to strengthening preventative healthcare, the policy also stresses improving nutritional status. The nutrition policy subcomponent stresses the need for the MoPH to work more closely with other Ministries to address the underlying determinants of poor nutrition and to improve community approaches targeting

behavioral change to achieve improved nutritional status. Other high priority areas outlined are infant care and feeding practices and micronutrient deficiencies.

National Health Strategy, 2016-2020

In the context of the National Health Policy, 2015-2020, ANPDF, SDGs, and other macroeconomic policies of the National Unity Government, the National Health Strategy aims to strengthen, expand, and sustain the performance of the health system by enhancing its efficiency.

The strategy outlines six strategic areas for implementing its vision: 1) governance; 2) institutional development; 3) public health; 4) health services; 5) human resources for health; and 6) monitoring and evaluation, learning, and evidence-based practices.

Within its strategic emphasis on public health, a sub-component highlighted in the Strategy is the improvement of nutritional status of the population and addressing health concerns, which directly impact nutrition, such as the prevalence of communicable diseases and reproductive and maternal health. It also defines reducing the incidence of acute and chronic malnutrition as one of the strategic results (Strategic Result 3.1) in its overall results framework.

Agriculture and rural development

MAIL's Food and Nutrition Security Strategy, 2015-2019

In order to make AFSeN-A implementable and to achieve its food security and nutrition objectives, the overall framework set out in AFSeN-A needs to be broken down into sector strategies and programs. Since the majority of vulnerable and food-insecure people live in rural areas and depend on agriculture and livestock as their main source of livelihood, MAIL has a highly important role to play in supporting the farmers and their families to improve their food security and nutrition situation. Acknowledging its mandate and responsibility in this field, MAIL has formulated this strategy, which is based on the comprehensive concept of food security and nutrition and outlines relevant fields of action by MAIL, which also contribute, besides production, to the other aspects of food security and nutrition.

Particularly in regards to nutrition, this Strategy sets out the objective to ***promote healthy diets, adequate food utilization, and good nutrition practices, particularly by women and children*** and addresses the following main issues:

- Promotion of diversification of production with regard to nutrition-sensitive products.
- Promotion of home-based farming practices in rural, semi-urban, and urban environments.
- Demonstrations (school gardens, home gardens, home-based food processing, and conservation).
- Information campaigns on food and nutrition issues.
- Nutrition education and training, including nutrition issues in primary, higher, and adult education curricula.
- Food safety standards and control (Ministry of Agriculture Irrigation and Livestock, 2015).

National Comprehensive Agriculture Development Priority Program (Agriculture NPP), 2016-2020

The National Comprehensive Agriculture Development Priority Program is a five-year strategic framework envisaged by the MAIL. This document lays out the direction that MAIL will undertake in coming years and emphasizes a shift away from the institution-oriented approach to a more farmer-centric view for agricultural development. This direction is set through the identification of seven

priority areas: 1) irrigation; 2) wheat and cereal production; 3) horticulture value chain; 4) livestock production; 5) climate-sensitive natural resources management; 6) food security and nutrition and resilience building; and 7) institutional reform and capacity development.

Under priority area 6, the NPP specifically aims to address issues of food utilization and food safety. It aims to achieve improvements in these areas by advocating dietary diversity through kitchen/commercial gardening, use extension workers and home economists to improve feeding and food preparation practices, introduce nationwide initiatives to reduce threats to rural livelihoods and improve coping mechanisms, and strengthen early warning signals to enhance disaster preparedness (Ministry of Agriculture Irrigation and Livestock, 2016).

Crosscutting themes

Women's Economic Empowerment National Priority Program, 2016

The National Priority Program on Women's Economic Empowerment builds poor women's capacity to strengthen the economy of their households, communities, and the entire nation. This NPP aims to support economic participation as a means to increase women's agency in development. Formal constraints to women's economic participation are addressed through legal reform and statistical improvements, while four investment components are highlighted, including 1) agriculture, 2) access to finance, 3) creative industries and 4) basic skills and capacity building. By investing in these areas, women's productivity can be enhanced, and they will become better equipped to utilize available factors of production. The overall design of the NPP is intended to provide the physical forums, access to information, and design flexibility to give men and women more agency in negotiating new views on gender that are better aligned with their changing economic environment.

Specifically, with relevance to nutrition, one of the objectives of the NPP is to enable a transition from subsistence farming to surplus production to improve food security and increase household income.

National Gender Strategy, 2012-2016

A National Gender Strategy has been developed by MoPH primarily to support its effort to ensure equitable health provision for the people of Afghanistan. Its goal is to ensure that health and nutritional status improves across Afghanistan among both the male and female populations. It specifically looks into the gender-related dimensions of health provision and other crosscutting themes, including reproductive health, child and adolescent health, integrated management of childhood illness, the expanded program on immunization, public nutrition, communicable and non-communicable diseases, disability, mental health, disaster relief, personal hygiene and environmental health, access to quality medicine, and gender-based violence.

National Action Plan for the Women of Afghanistan, 2007-2017

The National Action Plan for the Women of Afghanistan (NAPWA) aims to advance the status of women in Afghanistan and promote their citizenship rights with an understanding that strengthening greater equity can be in favor of all Afghan society. It actively promotes institutions and individuals to be responsible implementers of women's empowerment and gender equality by providing clear focus, direction, and coordinated action. NAPWA aims to achieve gender equality and women empowerment through participation, support, and partnership between women and men. To do so, NAPWA adopted a three-fold approach: 1) elimination of discrimination against women; 2) development of women's human capital; and 3) promotion of women's leadership.

NAPWA highlights the need to address the incidence of malnutrition among women and stresses the need to focus on women's health beyond maternal health. It also advocates the collection of sex-disaggregated data to monitor key health indicators, such as infant mortality, usage of health facilities, household medical/health expenditures, and nutritional status and their use as an indispensable part of the health system.

Emergency response mechanisms

Over recent years, the humanitarian situation in Afghanistan continues to remain critical. In 2017, the people in need and affected by emergencies due to security mainly ranged between 9.3 million to 7.4 million (UNOCHA, 2017b).

The humanitarian response is coordinated by UNOCHA through nine humanitarian clusters, including nutrition, health, WASH, food security and agriculture, protections and others. UNOCHA also performs inter-cluster coordination, support crosscutting themes, e.g. reporting, monitoring, needs assessment, and facilitates the financial resources through its emergency funding mechanism.

In 2017, humanitarian partners delivered life-saving assistance to approximately 40% of the people in serious need due to conflict and natural disasters, sudden population movement, and the effects of decades of underdevelopment and chronic poverty. Humanitarian assistance focuses primarily on medical care and emergency survival supplies of food, water, and shelter to displaced and returnee populations, including cash grants and sectoral support, such as cash-for-food and cash-for-rent. However, in addition, it is noted that humanitarian resources also filled gaps in the provision of basic services, including nutrition.

The nutrition cluster in Afghanistan is led by UNICEF and comprises of more than 20 partners. The focus is to provide emergency nutrition support to prevent further deterioration of the nutritional situation, for example, through the management of acute malnutrition, provision of multi-micronutrients, protection of breastfeeding, and nutritional support to mothers. It also conducts vulnerability mapping, rapid nutrition assessments, and coverage surveys and manages a nutrition information system to analyse the situation among emergency-affected populations and track service provision. The nutrition cluster support has a long history in Afghanistan, and hence, over the years, has built important capacities to plan and manage nutrition emergency programs and develop guidelines, protocols, and tools (Afghanistan Nutrition Cluster, 2017).

While aiming for a longer-term and sustainable approach addressing root causes of malnutrition, the nutrition emergency partners and their response experience, as well as their developed guidelines and tools, are vital and important to be considered for various reasons. It is important to build on the emergency response experience while gradually progressing towards a model that can be integrated and implemented through the public sector's development approach. Furthermore, a developmental approach and the emergency response will need to be closely coordinated to continue effective support to emergency-affected populations.

Governance structure for food security and nutrition

The AFSeN-A Governance Structure

The GoIRA launched the AFSeN-A on 16 October 2017 and joined the global SUN Movement to put an end to hunger, achieve food security, improve nutrition, and promote sustainable agriculture.

To coordinate AFSeN-A and the development and implementation of the Strategic Plan with all relevant sectors and partners, the following governance structure has been established:

- 1) High-level Food Security and Nutrition Steering Committee.
- 2) Food Security and Nutrition Executive Committee chaired by MAIL and MoPH on a rotational basis.
- 3) Nutrition and Food Security Development Partner Working Group.
- 4) Food Security Working Group chaired by MAIL.
- 5) Nutrition Working Group chaired by MoPH.
- 6) Advocacy and Public Awareness Working Group chaired by the Ministry of Industry and Commerce.

Besides national AFSeN-A structures, Provincial Food Security and Nutrition Committees have been established to engage local authorities and nongovernmental stakeholders to actively articulate and coordinate the AFSeN-A at the provincial level.

The Director General of the Council of Ministers' Secretariat leads the overall process. The AFSeN-A Secretariat coordinates the AFSeN-A core group of line Ministries, mainly, but not limited to, MoPH, MAIL, the Ministry of Rural Rehabilitation and Development, Ministry of Women's Affairs, Ministry of Finance, the Ministry of Hajj and Islamic Affairs, the Ministry of Industry and Commerce, and other relevant government authorities, UN and development partners, and CSOs. Throughout the process, their main role is to contribute to the common objective, share information, provide inputs and contributions, and commit to support the development and implementation of the Strategic Plan.

High-Level Food Security and Nutrition Steering Committee

The purpose of this committee is to ensure the highest political commitment for nutrition and food security in the country. It is overseen by the Executive Board, chaired by H. E. Dr. Abdullah Abdullah the Chief Executive of the GoIRA. This committee meets every six months and provides policy guidance and recommendations to improve the AFSeN-A and its implementation.

Executive Committee

The core objective of the Executive Committee is to discuss and review AFSeN-A related sectoral policies, strategies, programs, and technical and operational aspects to ensure coherence and alignment of AFSeN-A related actions with the ANPDF, Afghanistan SDGs, and NPPs.

Nutrition and Food Security Development Partner Working Group

The objective of this working group is to harmonize and align development partners' efforts, support the development and implementation of the Strategic Plan, mobilize and allocate resources and increase funding through effective and evidence-based advocacy, and improve coordination and communication of the development and humanitarian aid for nutrition and food security among development partners and outside the donor community. The overall aim of this working group is to provide advisory support on nutrition and food security to development partners in line with the ANPDF, AFSeN-A, National Nutrition Strategy, and Food and Nutrition Security Strategy and to coordinate focus of nutrition and food security activities in the country.

Food Security Working Group

The Food Security Working Group is a high-level platform that assembles key stakeholders to work together to promote and achieve the objectives of AFSeN-A and those regional and global networks where Afghanistan is a member, such as the SUN Movement and regional and global initiatives of evidenced-based policy advocacy, such as the Integrated Food Security Phase Classification. The overall purpose of the Food Security Working Group is to provide a platform to guide and coordinate inputs of the members for the implementation of food security and nutrition policies and

strategies in the country. The group is intended to support and report to the AFSeN-A Executive Committee and to facilitate rather than take on the work of individual actors and stakeholders. The Food Security Working Group is established to bring relevant stakeholders together and mobilize them to promote and support food security and nutrition through joined and coordinated efforts.

Nutrition Working Group

The Nutrition Working Group is a high-level platform of technical experts that assembles key stakeholders to work together to promote and achieve the objectives of the AFSeN-A. The overall purpose of the Nutrition Working Group is to provide a platform to guide and coordinate inputs of the members in the design and implementation of nutrition policies and strategies in the country and meet the commitments made for the SUN Movement in the country.

Advocacy and Public Awareness Working Group

The overall purpose of the working group is to provide a platform to guide and coordinate the inputs of the partnership members in the design and implementation of strategies to advocate and increase public awareness and hence generate resources and action for food security and nutrition in the country.

Coordination platforms highly relevant to the AFSeN-A

MoPH's Public Nutrition Directorate (sectoral, ministerial)

The Public Nutrition Directorate is the coordinating authority under the MoPH. It coordinates the development of the MoPH's sectoral nutrition policy and strategy and facilitates implementation. Current guiding documents are the 2015-2020 National Public Nutrition Policy and Strategy and the Nutrition Communication Strategy. The Directorate has a multi-stakeholder coordination platform in place, including the operational nutrition coordination committee technical working groups on selected themes, such as the IYCF working group. It also cooperates closely with other sectors contributing to nutritional objectives and co-chairs the humanitarian cluster for nutrition. Most of these coordination bodies are operational with well-established and active members within the stakeholder community. Under the AFSeN-A, it holds responsibility to coordinate and facilitate health sector-specific nutrition interventions, such as maternal nutrition, IYCF, nutrition emergency response, and integration of nutrition into the basic healthcare package. Hence, the Directorate plays a crucial role to support and facilitate the health sector's nutrition interventions under the AFSeN-A.

MAIL's Food and Nutrition Security Coordination arrangements (sectoral, ministerial)

For implementing MAIL's Food and Nutrition Security Strategy, MAIL is establishing a related coordination unit and a technical working group. The coordination unit also serves as the focal point for liaising and coordinating with AFSeN-A. Furthermore, related subnational structures will also be established (Ministry of Agriculture Irrigation and Livestock, 2015).

SDG's Intersectoral Coordination Structure to achieve the Sustainable Development Goals

There are close linkages between the A-SDGs and the AFSeN-A, and hence, there is strong potential to closely align, coordinate, and cooperate (even with regard to the governance structure) the various coordination mechanisms, institutional arrangements, partnerships, and networks. The MoEc leads and coordinates the A-SDGs, while the SDG Secretariat works under the supervision of the MoEc General Directorate of Policy and facilitates the process. The Executive Committee and High-Level Board include the Ministers/Deputy Ministers of Economy and the ministerial SDG focal

points, and international stakeholders are supported by a national coordination committee with Ministers and Deputy Ministers of the Government. Planning and implementation is further supported and facilitated by the National Coordination Committee and the Technical Coordination Committees.

Reporting, monitoring, evaluation, learning, and accountability

Reporting and monitoring

A limitation to this contextual analysis is the lack of information on progress and achievements of previous policies, strategies, and programs in Afghanistan. However, some sectoral and program-based reporting and monitoring mechanisms are in place (e.g. the MAIL food supply and market surveillance system, the MoPH district health information system, and the education sector's management information system). In addition, programmatic reviews and evaluations are available for some sectoral programs, such as the health sector's BPHS review and the review of the MoPH's Growth Monitoring System.

Any analysis of the progress achieved depends on comparison of results obtained from periodic, mainly sectoral or cross-sectional surveys, such as the AfDHS, NNS, NRVA, or the humanitarian assessment and cluster reporting systems, such as SMART, iMMAP, United States Agency for International Development/Office of Foreign Disaster Assistance's Reliefweb, or the nutrition information system of the nutrition cluster, focusing on the reporting of service provision. Until today, there are no systems or approaches that would guide decisions at the intersectoral level.

The establishment of the SDG reporting and monitoring system is an important step towards an intersectoral and interministerial system, that will benefit the required reporting and monitoring on the AFSeN-A as well. The MoEc, through its General Directorate, results-based monitoring system, and partners, is mandated to establish a central monitoring and reporting system to track progress on the SDG achievements. There are similarities with the SDG tracking, monitoring, and reporting system to follow progress on the intersectoral approach addressing malnutrition (e.g. multisectoral nature, key sectors and indicators by sectors, relevant sectors, departments and partners as well as the institutional arrangements, technical capacities, and facilities required). Hence, there is substantial scope for very close coordination and cooperation, which will avoid duplication and ensure effective and efficient use of resources and capacities.

Evaluations, research, and learning

In view of effective implementation of multisectoral actions addressing malnutrition, a sound reporting and monitoring system is essential and is planned to form an integral part of the AFSeN-A Strategic Plan. Similarly, regular evaluations, mid-term and end-line evaluations, and systematic impact evaluations are essential to provide in-depth information on progress, achievements and impacts, intended and unintended side effects, major challenges, and opportunities. Such information and results allow for systematic institutional learning and provide the basis for plan adjustments and improvements. This requires the establishment of baseline data and the development of the methodology of the intended evaluation approach at the onset of the plan's implementation. Potential investment areas include support to diversify vulnerable households' food production, its pathways and impact on stunting within the given context, but their impact has to be demonstrated and verified. Design and implementation of operational research accompanying small-scale and pilot implementation are options to create evidence for scale up. Another focus of operational research is comparative cost-effectiveness of different approaches to manage acute malnutrition. Results from

such research will help to develop feasible and sustainable approaches to be implemented through the public sector.

Accountability mechanisms

Similar to the findings of the Afghan SDG Progress Report (Ministry of Economy, 2017), the contextual analysis identified a serious gap in terms of accountability mechanisms. Over recent years, various highly relevant policies and strategies have been developed, yet there is no consistent follow-up on commitments and targets set. Allocation of financial resources to nutrition and related interventions is a serious shortcoming. Hence, the foreseen Strategic Plan for the implementation of the AFSeN-A requires the establishment of mechanisms that allow tracking of commitments and to hold institutions accountable for their stated commitments.

Conclusion

Malnutrition and food insecurity continue to jeopardize Afghanistan's socioeconomic development and prolong the process to build peace and stability.

The precarious nutrition situation in Afghanistan calls for substantial and immediate efforts for improvement. Any way forward, including the development of a Strategic Plan for improving food security and nutrition, has to be both ambitious and realistic at the same time as being concrete—taking into account the particular features, capacities, and challenges as well as potential of the current Afghanistan economic, social, and cultural environment.

Positive trends for selected indicators: The availability of consistent information over time is very limited. However, comparing results of surveys applying similar methodologies (e.g. NNS 2004 and AfDHS 2013), a positive trend is indicated for some indicators, particularly at the aggregated and national levels (e.g. reduction of stunting, infant and child mortality, school enrollment). This shows that there have been promising initiatives and approaches both in the past and currently under implementation that need to be identified, strengthened, and scaled up.

Emergency context and response: The situation in areas with difficult access and affected by conflict is characterized by particularly high levels of malnutrition. The humanitarian clusters, especially the nutrition, health, food security, and WASH clusters, are functional and operational. Inter-cluster coordination is organized and ensured by UNOCHA. The clusters, financed by donors, guide and facilitate the humanitarian response, and numerous partners are reaching out to the disaster affected and vulnerable populations. The cluster responses comprise short-term assistance and immediate relief in the most-affected and accessible locations. With regard to nutrition-specific interventions, the response focuses on conducting assessments and identification of vulnerable populations to support children suffering from acute malnutrition and their households. The focused and well-defined emergency response helps to prevent further deterioration of the situation. It provides good opportunities for lessons learned to build on and to graduate towards longer-term and sustainable development approaches. Graduation from relief to development is desirable for all clusters and sectors. This requires particular efforts on building local capacities to plan, manage, and monitor interventions that more strongly focus on improving social and behavioral changes and preventive approaches.

Policies, implementation, and monitoring and evaluation: Over the previous years, GoIRA has developed and endorsed several policies, strategies, and programs providing a suitable and

sustainable framework to address malnutrition and its underlying causes (NAF, MAIL's Food and Nutrition Security Strategy, and MoPH's Nutrition Strategy) and has aligned its efforts to the SDGs and other global declarations. Yet their implementation has not been followed up consistently, information or in-depth analysis of their implementation status is missing, and progress, achievements, and main challenges are limited. A consistent, multisectoral and multi-stakeholder monitoring and evaluation framework is not yet in place. Lessons are to be learned from past failures and successes in the field of food security and nutrition in order to progress in a more effective manner in the future. Hence, the establishment of a functional monitoring and evaluation system to ensure consistent learning and to inform plan adjustments must be an essential component of the AFSeN-A Strategic Plan.

Multisectoral approach, governance structure, and commitment: Global as well as local experience from Afghanistan shows that food security and nutrition require a multisectoral approach, multi-stakeholder support and high-level political commitments. Effective coordination between sectors and programs is essential. Under the AFSeN-A, the GoIRA has established suitable platforms, with representations by and linkages to all relevant sectors and partners, including different government Ministries, international and donor organizations, international and local NGOs, and CSOs. The AFSeN-A is led by the Director General of the Council of Ministers and the high-level steering committee for food security and nutrition. The latter is overseen by the Executive Board, chaired by the Chief Executive H.E. Dr. Abdullah Abdullah—ensuring high-level political commitment and strategic guidance to accelerate actions to reduce malnutrition. It is of utmost importance to ensure that the established coordination and cooperation platforms are functional throughout the processes of planning, coordinated implementation, monitoring, evaluation, and resource mobilization.

The next steps to progress towards better nutrition and improved food security are to develop and agree on a Strategic Plan, engaging all relevant sectors to streamline efforts towards a common goal and tangible well-coordinated actions to be led by the AFSeN-A.

References

- Afghanistan Nutrition Cluster. (2017). *Nutrition Cluster 2017 Strategic Response Plan*.
- Afghanistan Nutrition Cluster. (2018). *2017 Annual Report*.
- Asian Development Bank. (2019). Afghanistan: Economy. Retrieved from <https://www.adb.org/countries/afghanistan/economy#tabs-1-1>
- Central Statistics Organization; Ministry of Public Health; ICF. (2017). *Afghanistan Demographic and Health Survey 2015*. Retrieved from <http://cso.gov.af>
- Central Statistics Organization. (2014a). *Afghanistan Living Conditions Survey 2013-2014*.
- Central Statistics Organization. (2014b). *National Risk and Vulnerability Assessment 2011-2012 (Afghanistan Living Conditions Survey)*. 238. Retrieved from <http://www.af.undp.org/content/dam/afghanistan/docs/MDGs/NRVA REPORT-rev-5 2013.pdf>
- Central Statistics Organization. (2016). *Afghanistan Living Conditions Survey 2016-17 (Vol. 14)*.
- Education, I. R. of A. M. of. (2016). *Education in Emergencies Response Plan for Afghanistan*.
- FAO. (2018). *GIEWS Country Brief, Afghanistan*. Retrieved from <http://www.fao.org/giews/countrybrief/country/AFG/pdf/AFG.pdf>
- FAO & WHO. (2012). *International Conference on Nutrition – 20 Years Later (ICN+20) [In National Nutrition and Food Security Country Paper: Afghanistan]*.
- Ghiasy, R., Zhou, J., & Hallgren, H. (2015). Afghanistan's private sector. In *Sipri*. Retrieved from <https://www.sipri.org/publications/2015/afghanistans-private-sector-status-and-way-forward>
- Horton, S., Shekar, M., McDonald, C., Mahal, A., & Brooks, J. K. (2010). Scaling Up Nutrition. What will it Cost? In *Imperial College, London (Directions, Vol. 1)*. <https://doi.org/10.1596/978-0-8213-8077-2>
- International Alert. (2015). *Peace through Prosperity: Integrating peacebuilding into economic development*. Retrieved from https://www.international-alert.org/sites/default/files/Economy_PeaceThroughProsperity_EN_2015.pdf
- Islamic Republic of Afghanistan. (2004). *The Constitution of Afghanistan*. https://doi.org/10.29171/azu_acku_pamphlet_knf2050_c668_2004
- Islamic Republic of Afghanistan. (2017). *Afghanistan Food Security and Nutrition Agenda [AFSeN-A]*.
- Islamic Republic of Afghanistan Ministry of Public Health; UNICEF. (2013). *Afghanistan National Nutrition Survey 2013*. Retrieved from [https://reliefweb.int/sites/reliefweb.int/files/resources/Report NNS Afghanistan 2013 \(July 26-14\).pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/Report NNS Afghanistan 2013 (July 26-14).pdf)
- Islamic Republic of Afghanistan Ministry of Public Health. (2015). *Afghanistan National Healthy Policy*.
- Metz, Manfred & Toe, C. (2012). *Analysis of the Food Security and Nutrition Situation in Afghanistan, Background Document to the Afghanistan Food Security and Nutrition Agenda (AFSeN-A)*. Kabul, Afghanistan.
- Ministry of Agriculture Irrigation and Livestock. (2015). *Food and Nutrition Security Strategy (2015-2019)*.
- Ministry of Agriculture Irrigation and Livestock. (2016). *National Comprehensive Agriculture Development Priority Program 2016-2021*.

- Ministry of Economy. (2017). *Voluntary National Review at the High Level Political Forum: SDGs's Progress Report-Afghanistan*. (July), 1–81.
- Ministry of Public Health; Islamic Republic of Afghanistan. (2015). *National Nutrition Communication Strategy 2015-2020*.
- Ministry of Public Health; UNICEF. (2004). *Afghanistan National Nutrition Survey 2004*.
- Ministry of Public Health. (2008). *National Infant and Young Child Feeding Strategy and Policy, 2009-2013*. Kabul, Afghanistan.
- Ministry of Public Health. (2014). *National Public Nutrition Policy and Strategy (2015-2020) [Draft 8]*.
- Ministry of Public Health. (2017). *Afghanistan National Nutrition Surveillance Bulletin*.
- Ministry of Public Health General Directorate of Policy and Planning Monitoring & Evaluation Department; Johns Hopkins. (2006). *Afghanistan Health Sector Balanced Scorecard National and Provincial Results*.
- MoPH. (2017). *National Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy, 2017-2021*. Retrieved from <https://rmncah-moph.gov.af/wp-content/uploads/2017/11/National-RMNCAH-Strategy-2017-2021-English-Final.pdf>
- The Islamic Republic of Afghanistan. (2012). *Nutrition Action Framework (2012-2016)*.
- The Islamic Republic of Afghanistan. (2017). *Afghanistan National Peace and Development Framework 2017-2021 (ANPDF)*. https://doi.org/10.29171/azu_acku_pamphlet_jz5584_a33_a673_2017
- The World Bank. (2017). *Afghanistan Development Update*.
- The World Bank. (2019). *The World Bank in Afghanistan: Overview*. Retrieved from <https://www.worldbank.org/en/country/afghanistan/overview>
- UNAMA. (2018a). *Afghanistan: 10,000 Civilian Casualties in 2017 - UN Report Suicide Attacks and IEDs Caused High Number of Deaths and Injuries*. Retrieved from <https://unama.unmissions.org/afghanistan-10000-civilian-casualties-2017-un-report-suicide-attacks-and-ieds-caused-high-number>
- UNAMA. (2018b). *Quarterly Report on the Protection of Civilians in Armed Conflict: Afghanistan*.
- UNEP. (2009). *Women and Natural Resources in Afghanistan*.
- UNHCR. (2017). *Afghanistan Fact Sheet*.
- UNICEF. (n.d.). *Afghanistan Statistics*. Retrieved from https://www.unicef.org/infobycountry/afghanistan_statistics.html
- UNICEF. (2013). *Afghanistan - Multiple Indicator Cluster Survey 2010-2011: Final Report*. In *Survey Report*.
- UNOCHA. (2017a). *Afghanistan: Conflict Induced Displacements [as of 30 November 2017]*. Retrieved from <https://www.humanitarianresponse.info/en/operations/afghanistan/idps>
- UNOCHA. (2017b). *Afghanistan Humanitarian Response Plan-Annual Review [January-December 2017]*. (December).
- UNOCHA. (2017c). *Humanitarian Needs Overview: Afghanistan*.
- World Bank; Islamic Republic of Afghanistan. (2013). *Afghanistan Poverty Status Update: Progress at risk*.
- World Food Program. (2017a). *Afghanistan Zero Hunger Strategic Review*. Retrieved from <https://docs.wfp.org/api/documents/WFP-0000072266/download/>

- World Food Program. (2017b). *World Food Program Afghanistan Country Strategic Plan, 2018-2022*. Kabul, Afghanistan.
- World Health Organization. (2000). *The management of nutrition in major emergencies* (Vol. 8). <https://doi.org/10.1590/s1020-49892000000800017>
- World Health Organization. (2008). Indicators for assessing infant and young child feeding practices. *Consensus Meeting, 6-8 November 2007 in Washington D.C., USA*. Retrieved from http://apps.who.int/iris/bitstream/10665/43895/1/9789241596664_eng.pdf
- World Population Review. (2019). Afghanistan Population 2018. Retrieved from <http://worldpopulationreview.com/countries/afghanistan-population/>

Annex 1: Progress in Nutrition and its Determinants

Level	Indicators and causes	Situation/Change	Remarks
Outcome indicators			
Stunting		Improved from 60.5% to 40.9% (2004-2013)	
Wasting		Worsened (from 9% to 9.5%)	
Underweight (Children)		Improved from 34% to 25%	
Underweight (Women)		Improved from 20.9% to 9.2%	
Micronutrient deficiencies			
Iron deficiency (women)		Improved from 48% to 24%	
Iron deficiency (Children)		Improved from 71.5% to 26%	
Mortality (Child)		Improved from 97 per 1,000 live births to 55 (2010-2015)	
Mortality (Infant)		Improved from 76 per 1,000 live births to 45 (2010-2015)	
Maternal mortality			
Direct causes			
Food intake	Breastfeeding		
	Early initiation of breastfeeding	Improved from 35% to 69%	
	Exclusive breastfeeding	58.4% according to NNS 2013 but we do not have data for this indicator in previous surveys.	
	Complementary feeding	Minimum diet diversity and minimum meal frequency in children 6-23 months (26.8% and 43.9%)	
	Household food consumption (quantity/diversity)	Food insecurity based on calorie consumption 30.1% in 2011-12 while it increased to 44.6% in 2016-17	
	Micronutrient intake		
Health status	Infectious diseases		
	Diarrheal diseases	In 2011-12, 22.2% of children had diarrhea in the last month of interview	
	Acute respiratory infections	In 2011-12, 13.7% of children had an infection in the last month of interview	
	Maternal health		
Underlying causes			
Food security		Food insecurity based on calorie consumption went up from 30.1% in 2011-12 to 44.6% in 2016-17.	
Total cereal production		Decreased by 18% (2015-2017)	
Wheat production		Decreased by 15% (2014-2017)	
Access to food		Kcal intake in % based on Food Consumption Score: 59% use adequate, 13% borderline and 28% very severe to moderate deficit in 2011-12. In 2016-17, 33% of the population have either severe or moderate deficit.	
Availability of food			
Food diversity			
Food production			

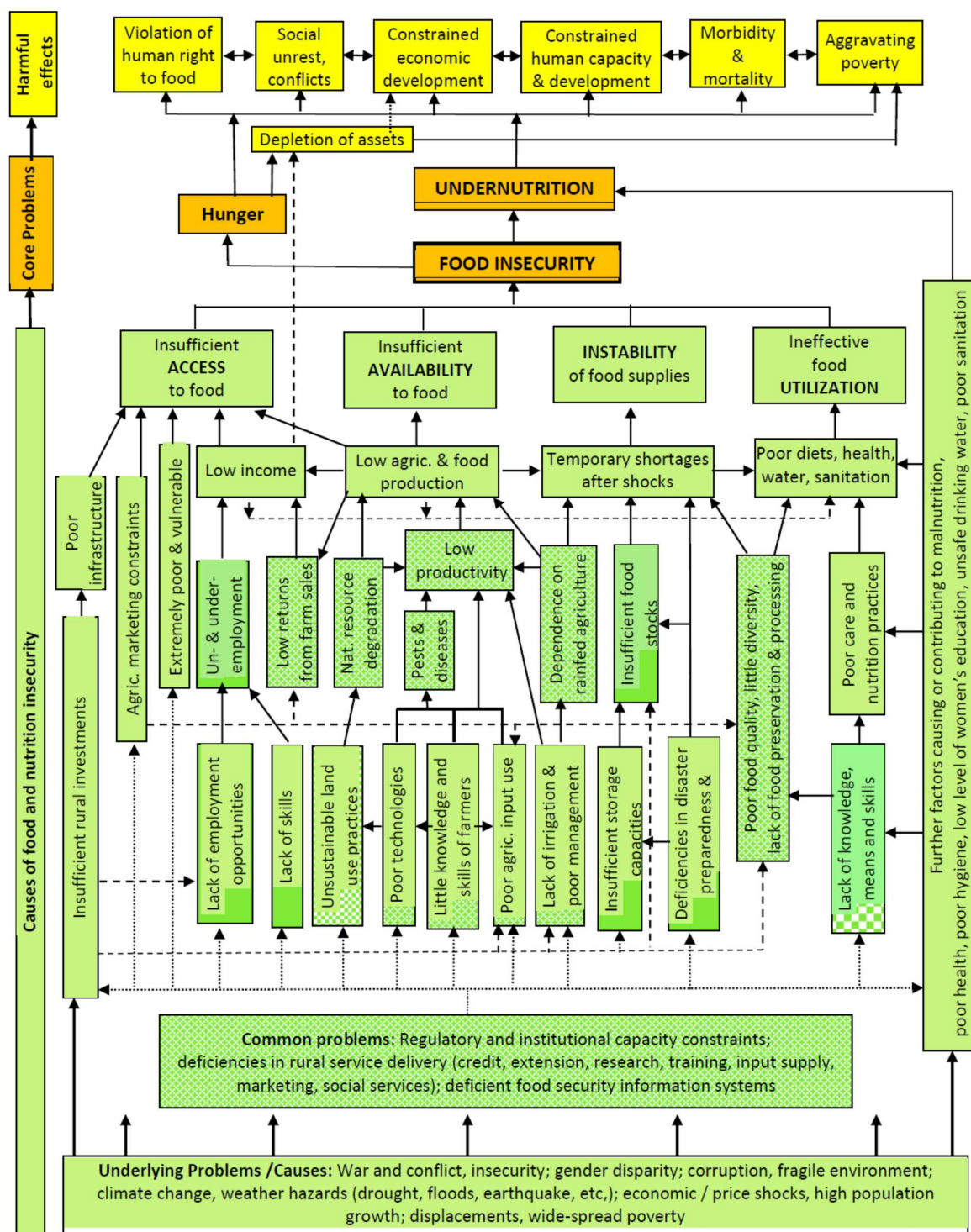
Level	Indicators and causes	Situation/Change	Remarks
Access and use of health services	Pre- and post-natal care	In 2011/12, antenatal care was 51%, skilled birth attendance was 40%, and institutional delivery was 36% while antenatal care increased to 70%, and skilled attendance at birth increased to 53.4% in 2016/17	Reference ALCS 2011-12
	Immunization		
	Access to a public health facility	86.9% of the population had access to a public health facility in less than two hours in 2011/12, which has increased to 89.9% in 2013/14.	
Water, sanitation, and hygiene	Access to water	45.5% using improved drinking water in 2011/12, but it decreased to 36% in 2016/17	
	Use of toilets/latrines	8.3% using improved sanitation facility in 2011/12; Proportion of population using safely-managed sanitation services (basic services) increased to 41.4% in 2016/17	
Education	Access to education (enrollments, female/male ratio)	9.4 million students are currently enrolled in schools where it shows a 2.4% decrease compares to the last year. 40% are girls and 60% are boys.	Due to conflict in some parts of the country the schools are closed
Basic causes			
Socioeconomic context	Poverty	In 2011/12, 36% of the population live under poverty line while it has increased to 54.5% in 2016/17	
	Demographic situation	Total population is estimated 29.2 million: 49% are female and 51% are male. The growth rate is 2.03%	Reference: Central Statistics Organization, ALCS 2016-17 report
	Security context	% of the population in conflict-affected areas	
Enabling environment			
Policy frameworks	Socioeconomic Development	ANPDP, NPPs	
	Intersectoral	AFSeN-A, NAF	
	Nutrition Policies/Strategies	Public Nutrition Policy and Strategy 2009-2013 and the next one developed for 2016-2020; Infant and Young Child Feeding Policy and Strategy 2009-2013; Nutrition Communication Strategy 2016-2020	
	Food Security and Agriculture Policies	MAIL's Food and Nutrition Policy	
	Other related policies, strategies		
	Inter-sectoral	AFSeN-A	
		SDGs	

Level	Indicators and causes	Situation/Change	Remarks
Governance structure for nutrition	Sectoral/Ministerial	MoPH, MAIL	
	Humanitarian Clusters	Nutrition, Health, WASH, Food Security and Agriculture, and others	
Regulatory frameworks	Monitoring	SDGs under MoEc, MoPH	
	Evaluation	SDGs	
	Accountability mechanisms	n/a	
Surveys and evidence generation	Intersectoral	NRVA	
	Health	NNS, AfDHS, MICS	
	Humanitarian	Reliefweb, IMMAP, cluster	

Annex 2. Key Results from 2013 National Nutrition Survey

Nutritional status of children 0-59 months	Percentage
Underweight prevalence	
Moderate and severe (-2 SD)	25.0
Severe (-3 SD)	9.7
Stunting prevalence	
Moderate and severe (-2 SD)	40.9
Severe (-3 SD)	20.9
Wasting prevalence	
Moderate and severe (-2 SD)	9.5
Severe (-3 SD)	4.0
IYCF indicators	
Percentage who ever breastfeed	98.0
Percentage who breastfeed within one day of birth (12 hours)	88.9
Percentage who received a pre-lacteal feed	52.4
Percentage who received colostrum	87.4
Exclusive breastfeeding (0-5 month children)	58.4
Percentage predominantly breastfed (0-6 month children)	76.3
Appropriately breastfed (0-23 month children)	55.2
Initiation of solid, semi-solid & soft foods (all infants 6-8 months)	41.3
Initiation of solid, semi-solid & soft foods (6-8 months with current breastfeed)	30.9
Minimum meal frequency (infants 6-23 months)	52.1
Minimum acceptable diet	12.2
Water and sanitation	
Use of improved drinking water sources	62.9
Water treatment	10.7
Use of improved sanitation facilities	40.4
Maternal and newborn health	
At least one antenatal care visit by skilled personnel	48.1
At least four one antenatal care visits by skilled personnel	16.4
Content of antenatal care (BP measure, urine and blood sample)	7.4
Skilled attendant at birth	45.5
Vitamin A supplementation (children under 5 years)	
Vitamin A supplementation (children under 5 years)	44.6
Micronutrient deficiencies (women of reproductive age)	
Anemia	40.4
Iron deficiency	24.0
Iron deficiency anemia	13.8
Vitamin A deficiency	10.8
Vitamin D deficiency	95.3
Zinc deficiency	23.4
Iodine deficiency	40.7
Micronutrient deficiencies (children 0-59 months of age)	
Anemia	44.9
Iron deficiency	26.1
Iron deficiency anemia	13.7
Vitamin A deficiency	45.8
Vitamin D deficiency	81.0
Zinc deficiency	15.1
Iodine deficiency in school-age children (7-12 years of age)	29.5
Iodized salt utilization	
Reported use of iodized salt for cooking	37.9
Salt with adequate iodine content (rapid test kit)	71.5

Annex 3. Food and Nutrition Insecurity in Afghanistan, Causes and Effects



* Adapted from AFSeN-A Background Document

Annex 4: Nutrition Indicators by Province (in %)

Province	Region	NNS 2013		SMART		
		Stunting %	Wasting %	Stunting %	Wasting %	Remarks to SMART
Kabul	Central	29.8	6.5	51.1	12	IDPs (2016)
Kapisa		48.1	7.4	54.4	7.4	all province (2016)
Lowgar		30.4	6.8	30.7%	7.1	all province (2018)
Panjshir		35	7.2	35.3	8.7	all province (2016)
Parvan		41.1	6.9	45.5	13.5	all province (2016)
Wardak		40.4	16.6	nil	Nil	
Bamian	Central Highlands	51.7	5	42.2	8.6	all province (2017)
Daikondi		42.3	5.3	42.3	14.8	all province (2017)
Kunar	East	56.3	16.2	49.3	14.4	Whole province (2108)
Laghman		40.2	16	47.8	9.8	5 out of 6 districts (2015)
Nangarhar		52.3	21.2	39.5	12.6	all province (2016)
Nurestan		63.3	19.4	61.6	14.6	3 out of 8 districts (2015)
Balkh	North	34.6	5.7	nil	nil	nil
Faryab		48.4	3.7	nil	nil	nil
Jowzjan		48.7	6.3	43.6	10.5	all province (2017)
Samangan		47.1	7.8	35.6	7.8	all province (2017)
Sar-e Pol		49.8	6.2	nil	nil	nil
Badakhshan	North East	49.8	9.3	nil	nil	nil
Baghlan		37.3	9.8	nil	nil	nil
Kundoz		45.1	7.5	39.9	7.8	all province (2018)
Takhar		46.9	7.9	38.1	9.7	all province (2017)
Helmand	South	30.8	14.5	48.7	2.7	5 districts out of 14 districts (2015)
Kandahar		43.6	13.5	43	9.8	5 out of 16 districts (2015)
Nimruz		40	9.4	41.6	6.2	all province (2017)
Uruzgan		45.3	21.6	49	15	all province (2018)
Zabul		42.2	9.4	11.2	45.9	all province (2018)
Ghazni	South East	24.3	9.8	39.2	10.3	12 out of 19 districts (2016)
Khost		28.9	18.2	30.8	6.5	3 out of 12 districts (2015)
Paktia		54.9	16.7	31.7	5.2	4 out of 13 districts (2015)
Paktika		34	8.7	46.2	6.1	5 out of 19 districts (2015)
Badghis	West	52.1	7.3	52.5	6.5	all province (2016)
Farah		70.8	3.9	45.5	10.8	all province (2017)
Ghowr		53.5	5.3	51.3	11.0	all province (2016)
Herat		31	5.6	34.2	6.6	all province (2016)

Note: ACF has conducted 42 SMART and Rapid SMART surveys since 2014 in the country in different provinces. Some of these surveys cover the whole province while some others have been conducted in selected districts of the provinces. The results of these surveys show that the average prevalence of GAM by WHZ and/or Oedema, Stunting and underweight is similar (9.6%, 44.8%, 26.7%) to the results of NNS 2013 but there is some provincial variation. ACF has started to measure a combined estimate (started from 2016) of Acute malnutrition or Wasting by integrating the three criteria of WHZ and/or MUAC and/or Oedema. This estimation has found a significant lack of overlapping of children being Wasted by WHZ and MUAC criteria in Afghanistan and give the total estimate of Wasting burden (MUAC+WHZ).