PUBLIC NUTRITION POLICY AND STRATEGY: 2003-2006

PUBLIC NUTRITON DEPARTMENT
MINISTRY OF HEALTH

FINAL DRAFT FOR COMMENT

Contents:

Section I: Background

The health and nutrition situation in Afghanistan is one of the poorest in the world. Infant, child and maternal mortality rates are extremely high. Much of the morbidity and mortality is as a result of preventable communicable diseases, malnutrition, complications associated with pregnancy and delivery as well as war-related injuries. Poverty, loss of access to productive assets, food insecurity and poor access to basic social services are key underlying factors, compounded by traditional and cultural practices, the status of women and the impact of almost three decades of war.

The Transitional Islamic State of Afghanistan (TISA) and donors have stated their commitment to invest in the strengthening of health services, through improving national policies in various sectors, establishing national guidelines, promoting evidence-based decision-making in policy and practice, as well as facilitating the development of improved capacity and skills of human resources through formal and informal training. Investing in health and nutrition for the entire population but with particular emphasis on the poor, is seen as a means to enhance productivity and ensure the future stability and socio-economic development of the country.

Over the last year the Ministry of Health (MOH) has embarked on a process of rehabilitation and reform. Health priorities and targets for the next three years have been articulated in the National Development Budget and Framework narrative , the interim National Strategic Plan[1] and the Basic Package of Health Services (BPHS)[2], amongst other MOH policy documents. The National Development Framework stresses the importance of investing in health and nutrition to ensure a more equitable and effectively functioning society. The MOH has also articulated their overall goal through a Mission Statement (2003), specifically;

> "The Mission of the Ministry of Health, Transitional Islamic State of Afghanistan is to lay the foundations for equitable, quality health care for the people of Afghanistan, especially women and children; through capacity building in, (1) defining the context, direction and scope of work for all stakeholders, (2) strategic planning and co-ordination and (3) actions that make the best use of the limited resources, (4) exerting influence through stewardship, regulation and advocacy, and (5) collecting and using information for evidence-based decision making and practices".

Public Nutrition is one of the key priorities for the MOH, as described in the interim MOH Health Policy (2002)[3];

> "..MOH, in collaboration with partners will… participate extensively in identifying, preventing and reducing malnutrition …..promote food and nutrition security for all….to accelerate improvement in the high prevailing rates of morbidities and mortality…….and to accelerate poverty reduction and reinforce human and national development……."

As part of the strategy towards strengthening the MOH capacity to effectively meet the health and nutrition needs of Afghan people), a Public Nutrition Department has been established within the MOH in 2002 **(*Annex 1)***. The Public Nutrition Department has and will continue to collaborate with other Departments within MOH as well as with other Ministries and partners, to effectively address the diverse nutritional problems in Afghanistan by adopting a Public Nutrition approach. A Public Nutrition approach represents a paradigm shift from clinic-based treatment

of malnutrition to the broader food security, social and care environment and the public health aspects addressing the underlying causes of malnutrition. It also encompasses an understanding of the economic, political and social factors that affect nutritional status. This well known relationship between malnutrition and the underlying and basic causes is best captured in the conceptual model of malnutrition (**Figure 1**).

This Policy and Strategy document has been designed as a flexible document to guide the State's short and medium term multi-sectoral response to malnutrition over the period 2003-2006. The next section of this document provides a brief description of the nutritional context in Afghanistan. Section III describes the MOH Public Nutrition Policy and the Objectives for the period 2003-2006 are described in Section IV. Guiding principles for a public nutrition approach are detailed in Section V. The priority strategies to achieve these objectives and the related activities are outlined in Section VI. Mechanisms for collaboration, partnership and integration are proposed in Section VII and finally, a brief outline for monitoring implementation of the Policy and Strategy is given in Section VIII.

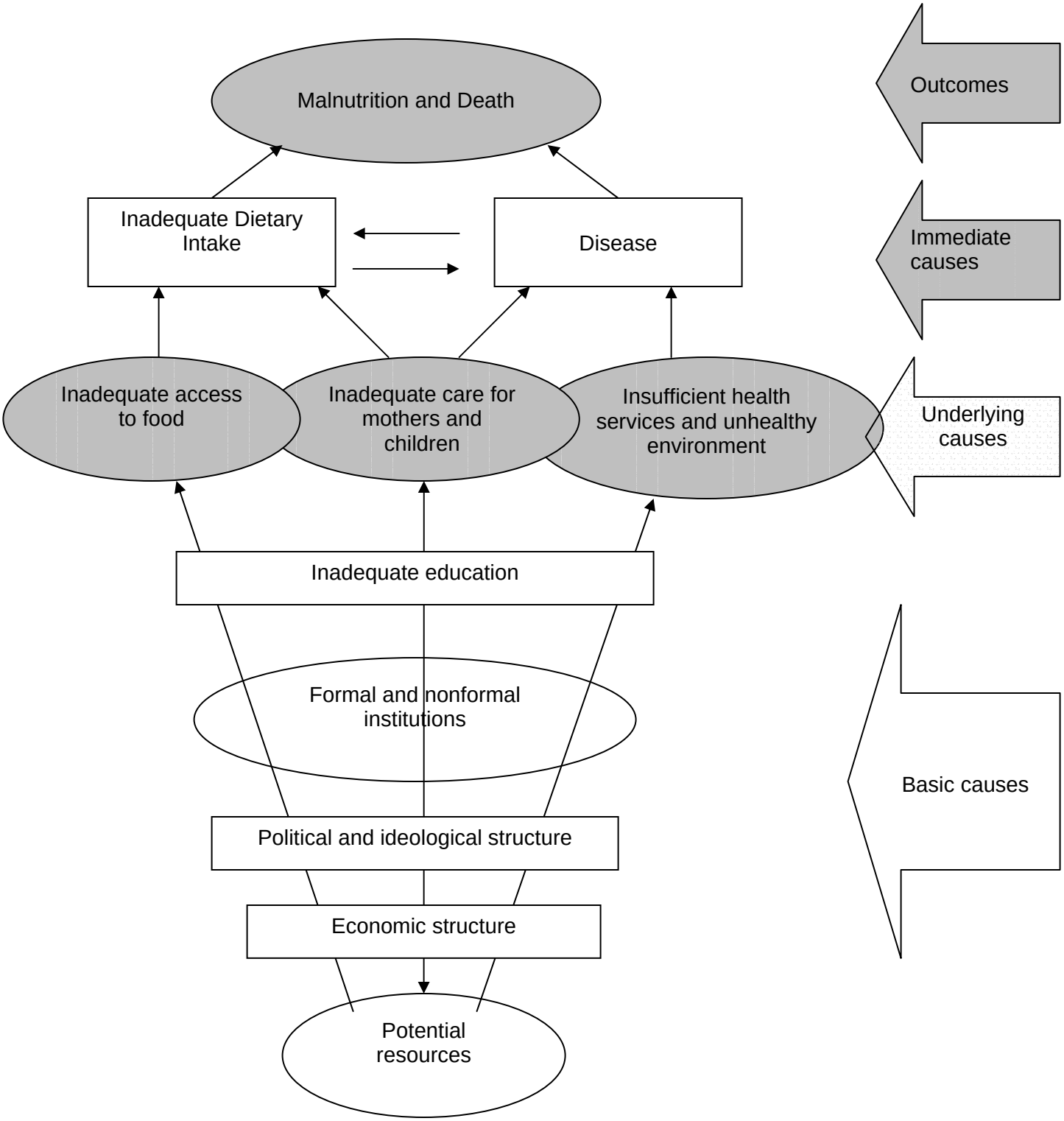


Figure 1: Conceptual model of causes of malnutrition

Section II: Nutritional situation in Afghanistan: outcomes, underlying causes and risk factors

The nutritional situation in Afghanistan is characterized by extremely high prevalence of chronic malnutrition, also referred to as stunting (45-59 percent, <-2 z-score height for age)[4-10], high mortality rates among children under five years old and widespread occurrence of micronutrient deficiency diseases. Despite widespread and severe food insecurity, levels of acute malnutrition remain relatively low (between 6 and 10%, <-2 score weight for height) [4-10]. While information is extremely limited, results from nutritional surveys suggest that mothers, infants less than six months as well as young children between 6months and 24 months may be at particular risk in Afghanistan [x].

The general micronutrient status of the population is poor, largely as a result of the lack of diversity of food in the diet and over-reliance on the staple food commodity wheat. Iodine deficiencies disorders are highly prevalent, particularly in mountainous provinces in the north, north-western and central highlands. The prevalence of clinical cases of goitre is reported to be between 20% - 63% with the prevalence reaching up to 70% in some particular areas[11-13]. During 2001/2, access to iodized salt was estimated to be <1% for the country[14]. The limited localized data for other micronutrient deficiencies show prevalence of 50-70% anemia among young children and their mothers and up to 20% night blindness among women[5]. In addition, over the past few years outbreaks of scurvy have occurred repeatedly in the winter months with severe clinical signs observed in up to 10% of the population in some remote districts during the winter season[4,15].

The underlying causes of malnutrition in Afghanistan are complex and are by no means homogenous throughout the country nor constant over time. These are determined by a diverse range of factors including; different patterns of agricultural production (variation in the length of the growing season, different access to certain agricultural inputs or preferences for productive labor patterns), varying opportunities for cash and trade, opportunities for production and sale of legal and illegal cash crops, limited access to assets (land, water), variation in access to geographical access to health services and markets particularly with respect to urban and rural differences as well as seasonal differences, cultural taboos and practices regarding nutrition and health seeking behavior, influence of strong social kinship networks and informal laws that govern peoples obligation to support others within the community, as well as variable exposure to disease through the seasons .

Food access and availability:
While food security has recently improved throughout the country, the large majority of the population in Afghanistan still faces some degree of food insecurity, both in terms of quality and quantity of food[16,17]. Food insecurity is widespread largely as a consequence of several years of severe drought (1999 – 2002) coupled with decades of civil conflict. The limitations on population movements as a result of poor security in some parts of country, poor transportation infrastructure and seasonal obstacles (e.g. harsh winters), a dramatic depletion of productive assets at the community and household level and a lack of employment opportunities, continue to be some of the major ongoing threats to food security in the country.

The population in Afghanistan has characteristically demonstrated a remarkable resilience to the recurrent threats to food security. However, some of the most vulnerable communities in

Afghanistan, the capacities and coping strategies to respond to these threats have been exhausted. For example: during the recent drought, incurring a debt in order to pay for necessities carried greater risk in the face of increasingly high interest rates; family structure and labour force were disrupted by prolonged separations as family members sought informal labour opportunities across the border in Pakistan or Iran or in urban towns and cities within Afghanistan; girls were reported to be married at unusually young ages as a means of securing income for the household. Loss of access to land and water as well as lack of access to a diverse diet are some indications to suggest that people's capacity to cope with threats has been depleted [16-18]. While population displacement is relatively difficult to measure in Afghanistan (i.e. differentiating between temporary versus permanent); a recent survey indicated that an estimated 37% of households are displaced largely to urban centres[19]. In particular, pastoralist groups, such as the Kuchi, face threats to their livelihoods, including loss of access to pastures, loss of livestock through disease or distress sales as well as lack of employment opportunities, and consequently these groups face higher nutritional risks[20]. Additionally, reports of widespread outbreaks of livestock diseases and the reduction of veterinary services and vaccination programmes as a result of breakdown in services, negatively impact both numbers and quality of livestock and livestock products [21].

Despite satisfactory harvests reported during 2002-3, due mainly to improved and well distributed precipitation in major agricultural areas, a considerable number of Afghan people continue to need food aid assistance. While food is available, it is not accessible, due in large part to a lack of employment opportunities and income. Furthermore, a drop in market prices for wheat, which have fallen sharply in some main producing areas recently, may result in financial difficulties for some farmers who have to sell their current harvest at below value[21]. Furthermore, the drop in market price for wheat creates a disincentive for future wheat production as some farmers will choose to cultivate more profitable poppy as a high-income cash-crop in preference to wheat.

Susceptibility to the threats to household food security is a multifaceted condition, determined by individual household characteristics such as level of indebtedness, access to social networks, ability to access credit and ownership of productive assets[22]. In this way, some households will be more or less vulnerable to these threats to household food security. Given that coping strategies are for the most part depleted, however, it is fair to say that the majority of the population in Afghanistan will continue to face challenges in the near future with respect to food access and availability.

Social and care environment:

The infant mortality rate in Afghanistan of 165 deaths per 1000 live births and the under five mortality rate of 257 per 1000 live births are, in each category, the fourth highest in the world[23]. In one study, 50% of mortality among children under five years occurred among infants less than one year of age[4]. Inadequate infant feeding and caring practices, as well as poor nutritional status of women and the many constraints that women face in Afghanistan, are likely to be a major contributory factors.

Furthermore, the maternal mortality ratio (MMR: maternal deaths per 100,000 live births) in Afghanistan is 1600 per 100,000 live births[24]. This is one of the highest levels of maternal mortality reported globally. A lack of access to adequate health care for women, particularly during their delivery, is an important determinant.

While the prevalence of breastfeeding is reported to be very high, the prevalence of exclusive breastfeeding to six months is much lower, ranging from 12.5% - 33%[5-8]. Similar to other

developing countries, the prevalence of acute malnutrition is characteristically much higher among young children between 12 and 23 months, suggesting that complementary feeding practices are inappropriate[5-7]. The mother-in-law has a strong influence on child feeding practices, both in positive and negative ways. The ability to access assistance through social kinship support for women during pregnancy and lactation is a strong determinant of whether or not these women can rest and eat more during pregnancy, or have sufficient time for breastfeeding etc. Additionally, women have a limited influence on decision-making within the household, particularly with respect to how resources are spent and what foods are purchased as these decisions are largely taken by men.

While there is significant variability in caring practices throughout the country, the main social and care practice issues are low prevalence rates of exclusive breastfeeding, use of pre-lacteal foods, early or late introduction of complementary foods, an absence of active feeding, swaddling and lack of psychosocial stimulation, and inability to meet nutritional needs and care for the mother during pregnancy and lactation[7]. Devising ways to meet these problematic issues needs to take into consideration the context of the many challenges that women face in the context of Afghanistan.

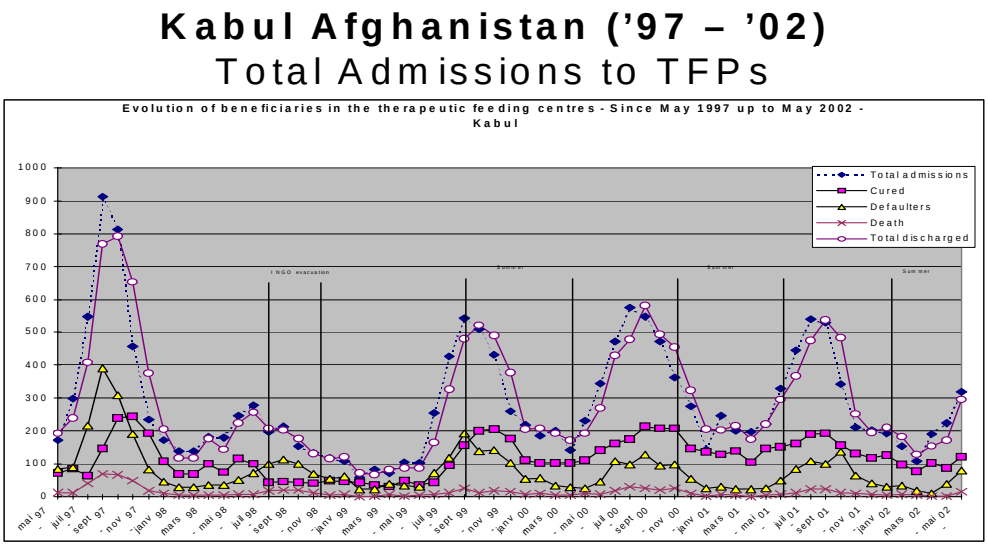
The strong formal and informal social network systems that exist within Afghanistan is undoubtedly an important contributory factor for preventing a dramatic deterioration in nutritional status. Complex solidarity and social networks ("*qawms*"), acting within and between communities in Afghan society, are an important social capital and have rendered many communities self-reliant [28] . Building on these existing social networks in design of nutrition and food security interventions will be important.

Access to health services and health environment:

Access to health care is very limited and only about 3% of GDP is devoted to health[24]. Only 25% - 35% of Afghans have access to basic health services[19]. Current data show a seriously mal-distribution in the workforce in the health sector. Staffing patterns are distorted by an overproduction of doctors, mainly situated in the urban areas, whilst there is a serious shortfall of nursing and other intermediate health personnel in both rural and urban areas. The main burden of health service provision in the districts falls on community health workers however, falls on community health workers and auxiliary staff who are largely unsupported in terms of resources, supervision, and training[26]. Consequently, access to adequate health care is significantly biased towards urban settings.

Generally, measles immunization coverage is now high (90-95%). The main reported causes of death among children under five years old are respiratory illness (31.2%), watery diarhoea (27.2%) and bloody diarrhea (26.5%)[19]. Diarhoeal disease is particularly common in the summer season, causing a characteristic seasonal increase in the prevalence of acute malnutrition (**Figure 2**). Survey findings indicate that 75% of households in Afghanistan use unsafe water source for drinking[19]. Lack of access to a clean water source and poor sanitation are major contributory factors to poor health outcomes.

Figure 2 Seasonal patterns of malnutrition in Kabul



While each of these sectors of underlying causes has been discussed independently of each other, there is a clear inter-connectedness between them. For example, food insecurity may predispose women to participating in income generating activities e.g. carpet weaving, negatively affecting caring practices. Strong social support structures may positively affect women's capacity to access (physically and financially) health services.

The high prevalence of chronic malnutrition is explained by the extremely poor maternal nutritional status. For example, two studies conducted in IDP camp in Kandahar and Zabul rural populations showed women with BMI< 18.5 to be 34.3% and 22.4% respectively and using MUAC <22cm 28.9% and 14.3% respectively[5]. Poor maternal nutritional status will contribute to poor intrauterine growth, low birth weight, poor complementary feeding practices and micronutrient deficiencies coupled with high incidence of diarrhea, and subsequent undiversified and limited food intake of the child leading to another generation of mothers who are malnourished and who will replicate this cycle **(Figure 3)**. This cycle of malnutrition will only be broken by comprehensive public health and food security interventions that effectively address these underlying causes, and that are delivered in such a way as to reach the main target group, specifically women. The need for innovative, context-specific and integrated programmes should not be under-estimated.

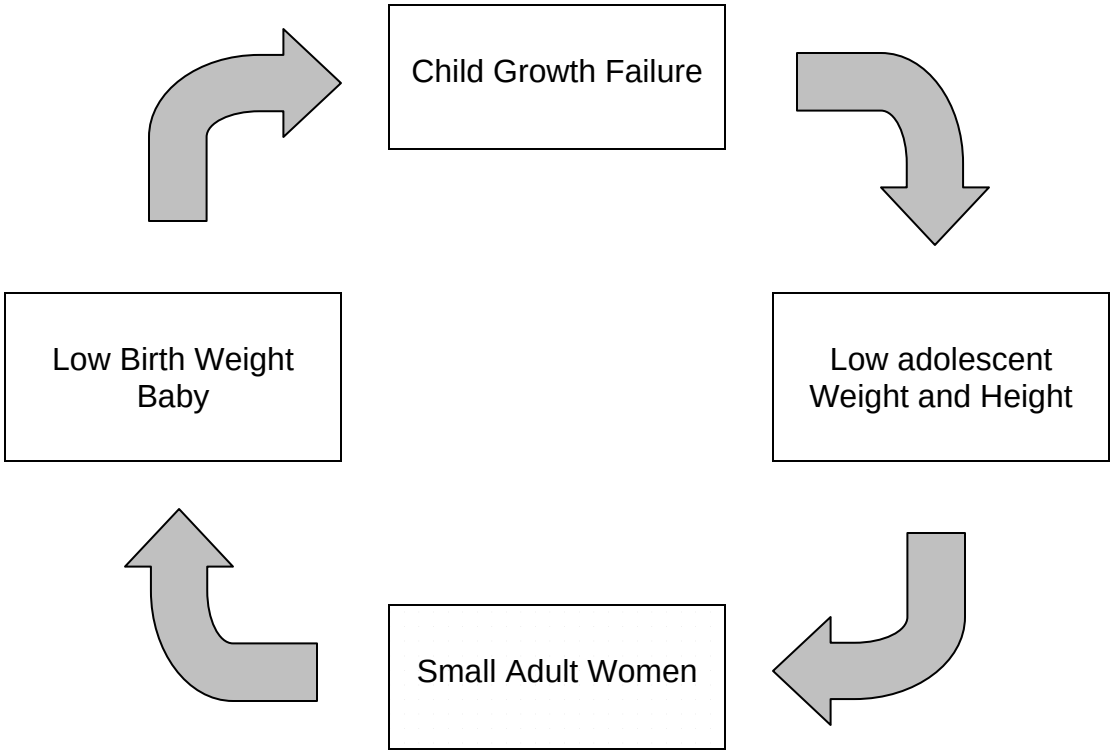


Figure 3: The Intergenerational Cycle of Malnutrition

Section III: Public Nutrition Policy

> "To live a life without malnutrition is a fundamental human right. The persistence of malnutrition, especially among children and women, in this world of plenty, is immoral. Improvement in nutrition anywhere in this world is not a charity but a societal, household and individual right…..With collective efforts at international, national and community levels, ending malnutrition is both a credible and achievable goal. "
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> ACC/SCN Report, Food and Nutrition Bulletin; Vol. 21;3. 2000

The Transitional Islamic State of Afghanistan is committed to promote, protect and fulfill the rights of all people to adequate food and nutrition as stated in the International Declarations and Conventions of Human Rights. It is recognized that the social and economic consequences of malnutrition in Afghanistan are enormous and efforts to reduce this national burden are a priority.

The Ministry of Health recognizes that an improvement in the nutritional status of the population, especially among women and children will; accelerate a reduction in the high prevailing rates of morbidity and mortality, accelerate poverty reduction and reinforce human and national development. The overall goal of the MOH therefore, is to reduce malnutrition of all types including micronutrient deficiency diseases through integrated and coordinated programming. In collaboration with partners, the MOH will take leadership in identifying, preventing and reducing malnutrition. Furthermore, the MOH will promote food and nutrition security for all by adopting a public nutrition approach involving broad-based multi-sectoral interventions that address the underlying causes of malnutrition - including food insecurity, inadequate social and care environment, inadequate access to heath services and poor health environment. This work will be based on best practice in the field of nutrition, integrated through the BPHS for the most part, with an emphasis on close collaboration with food security analysis and interventions and focusing at the community level.

Section IV: Objectives for 2003-2006

1. Ensure that the prevalence of acute malnutrition or wasting (< -2 z-score, weight for height), is reduced to and remains below 5% for all children under five years old throughout the year.

2. Ensure that more than 90% of households have access to iodized salt throughout the country.

3. Prevent and control outbreaks of micronutrient deficiency diseases, particularly scurvy.

4. Improve nutritional status of women of childbearing age and reduce risk of low-birth weight (LBW).

5. Increase prevalence of exclusive breastfeeding for 0-6 months from 35-35% to over 60%.

6. Reduce mortality associated with severe malnutrition, specifically in relation increasing access to treatment facilities and to reducing case-fatalities to acceptable targets within treatment facilities for severe malnutrition.

7. Increase knowledge, awareness, skills and capacity in public nutrition among the general population as well as among all nutrition related service providers including those involved in agriculture, health, rural development, economic development, trade.

This policy covers the period from 2003- 2006 (3 years). The objectives described in this policy and strategy document are not entirely based on quantitative changes in outcome indicators such as a change in the prevalence of different types of malnutrition. This is for two reasons: (1) a lack of baseline information on the key indicators and (2) a three year period is too short a period in which to see significant improvements in prevalence rates of stunting, underweight, low-birth weight and anemia for the country. See ***Annex 2*** for a list of proposed targets for these indicators over a longer time period (2004-15). Baseline levels for the country will be determined in 2004 when a national survey is conducted. These proposed targets may be revised subsequently.

Section IV: A public nutrition approach; guiding principles

A public nutrition approach is required in Afghanistan because it is one which combines technical considerations with practical and political aspects of programme implementation. Public nutrition provides important tools for overcoming the challenges in effectively addressing the problems of malnutrition, including the tools for analysis, for promoting learning and designing programmes, taking into account of policies and wider determinants such as political and cultural frameworks[27] . Public nutrition is a broad-based problem solving approach that:

Recognizes the multi-causal nature of malnutrition The causes of malnutrition are multifold and are context-specific. They can be broadly categorized into three groups including food security, social and care environment and health (access and environment). There is significant interaction and synergistic effects between the different causes. While health interventions are an important component, malnutrition cannot be effectively addressed through health interventions alone but require broad-based interventions.

Reflects an understanding of political, economic, social and cultural factors The categories of underlying causes, are determined in turn by economic, agricultural, and trade policies. Additionally, cultural and social norms influence people's ability to access food as well as their food consumption patterns.

Focuses on populations not individuals Analogous to the difference between curative and public health, public nutrition does not focus only on treatment of individuals but emphasizes an approach that addresses population needs.

Places nutrition firmly in the public domain: Public nutrition does not belong to any single sector or expertise. Professionals from a broad range of sectors – including health professionals, agriculturists, economists, anthropologists, educators, community development workers in addition to nutritionists - need to contribute to the design and implementation of programmes in public nutrition. Public nutrition needs to be integrated into communities, legislation, the private sector and the political domain.

Focuses on action-oriented strategies: Assessment to describe the extent and severity of the problem of malnutrition, including a description of the risks and causes, are conducted in order to inform the design or revision of interventions. This process is a dynamic one, i.e. Assessment, Action and Analysis (triple A) concepts are applied throughout the implementation process. This assumes a dynamic process of ongoing review and analysis of process, effectiveness and impact. This understanding will determine appropriate action to be taken.

Reflects universally accepted best practice and knowledge and reinforces learning: Programme design reflects demonstrated understanding of universally accepted best practice from scientific and non-scientific literature. A process of learning is required, which is evidence-based, involves wide dissemination of lessons learnt and demonstration of translating policies into practice.

Section V: Priority Strategies and Activities

The following section first describes the priority strategies required for each of the objectives. Next some of the main activities are described for each strategy following the summary below.

1. Ensure that prevalence of acute malnutrition or wasting (< -2 z-score, weight for height) is reduced to and remains below 5% for all children under five years old throughout the year.

Strategy 1: Development of a national food security and nutritional surveillance system that is linked to the national health information system and couples nutritional status with risk factors, providing an early warning system for impending food and nutrition crises.

Strategy 2: In order to rapidly and accurately determine nutritional status, ensure that nutritional surveys are conducted using universally accepted methodologies in line with MOH Guidelines, using standardized indicators, to allow for comparisons between locations and over time.

Strategy 3: Improve household food security specifically in relation to improving access, availability and diversity of food.

Strategy 4: Ensure food aid, which aims to meet nutritional needs, is safe, is adequate in quality and quantity and is effectively targeted to the most vulnerable groups.

Strategy 5: Where there is significant nutritional risk or demonstrated deterioration in nutritional status, ensure the timely and appropriate implementation of Emergency Supplementary Feeding Programmes (SFPs).

Strategy 6: Ensure that specific population groups with greater nutritional risk are given higher priority for nutrition assistance, especially in the context of limited resources.

Strategy 7: Reduce health risks associated with malnutrition, specifically the control and prevention of diarrhoeal disease.

2. Ensure that more than 90% of households have access to iodized salt throughout the country.

Strategy 8: Prevention, reduction and elimination of Iodine Deficiency Disorders (IDDs) through Universal Salt Iodization (USI).

3. Prevent and control outbreaks of other micronutrient deficiency diseases, particularly scurvy

Strategy 9: Prevention, reduction and treatment of other Micronutrient Deficiency Diseases including Vitamin A Deficiencies (VAD), iron deficiency anemia (IDA), Vitamin C deficiency (scurvy) and Vitamin B deficiencies through integrated strategy of treatment, supplementation, fortification, education and food based approaches.

4. Improve nutritional status of women of childbearing age and reduce risk of low-birth weight (LBW).

Strategy 10: Reduce nutritional risks for women throughout their life-cycle through implementation of integrated health, nutrition and food security interventions.

5. Increase prevalence of exclusive breastfeeding for 0-6 months to over 60%,

Strategy 11: Support and promote optimal practices for infant and young child feeding, including appropriate caring practices.

6. Reduce mortality associated with severe malnutrition, specifically in relation to increasing access to treatment facilities and to reducing case-fatalities to acceptable targets within treatment facilities for severe malnutrition.

Strategy 12: Establish appropriate services for management and treatment of severe malnutrition.

7. Increase knowledge, awareness, skills and capacity in public nutrition among the general population as well as among all nutrition related service providers including those involved in agriculture, health, rural development, economic development, trade.

Strategy 13: Ensure that appropriate social mobilization, nutrition education and communication and advocacy are use used to promote improved nutritional status through general media and through all levels of health facility, as defined by the BPHS.

Strategy 14: Ensure human resource capacity development and training at the central, provincial and district levels.

Strategy 15: Promote and evidence-based decision-making, research and learning in public nutrition

Strategy 1: Development of a national food security and nutritional surveillance system, that is linked to the national health information system, that couples nutritional status with risk factors and provides early warning for impending food and nutrition crises

Activities include:

1. MOH contributes and participates in data collection, analysis, interpretation and use of data National Nutritional Surveillance System (NSS) in collaboration with MRRD, MAAH and partners.
2. Clinic-based nutritional surveillance is implemented in all Comprehensive Health Centres (CHCs) in all Districts and Basic Health Centres (BHCs), in collaboration with HMIS.
3. NSS and HMIS systems are closely linked and information is used to assist with policy review and programme development within the MOH and other related Ministries.

Strategy 2: In order to rapidly and accurately determine nutritional status, ensure that nutritional surveys are conducted using universally accepted methodologies in line with MOH Guidelines, using standardized indicators to allow for comparisons, between locations and over time

Activities include:

4. All nutritional surveys, conducted at Provincial and District levels are in line with existing "MOH Guidelines on Nutritional Surveys" and findings appropriately interpreted.
5. A data-base of all nutritional surveys is maintained within MOH.
6. Appropriate nutritional indicators will be collected and used in the NRVA.
7. For the purposes of baseline, policy development and monitoring, National Nutrition surveys will be conducted by the MOH every 2 – 4 years for determining prevalence of acute (weight for height), chronic (height for age) and underweight (weight for age), the prevalence of micronutrient deficiency diseases.

Strategy 3: Improve household food security specifically in relation to improving access, availability and diversity of food.

Activities include:

8. In collaboration with MAAH, support household food production strategies, specifically home-gardening, citrus production, livestock and food diversification (not only wheat).
9. Support household food practices e.g. storage and processing, which allow access to diverse foods through out the year particularly during winter.
10. Improve household capacity to access diverse foods through improved market access (micro-credit, employment schemes etc).
11. Nutrition inputs and outcomes are integrated with all household food security programmes.

Strategy 4: Ensure food aid, which aims to meet nutritional needs, is safe, is adequate in quality and quantity and is effectively targeted to the most vulnerable groups

Activities include:

12. In collaboration with MRRD and WFP, development of targeting criteria for food aid for most vulnerable groups of the population.
13. Monitor the adequacy of food aid basket to ensure that it is appropriate in quantity and quality, is fit for human consumption, meets the needs of young children and is appropriately fortified.

14. Ensure that Ready-prepared foods and high energy protein biscuits are only used in situations of emergencies e.g. where populations are on the move or under carefully supervised situations.
15. In collaboration with WFP, develop adequate systems for food management, including stock control, distribution and monitoring within MOH hospital facilities.
16. Advocate that where food is distributed in schools, it should not undermine community-perceptions of education, is nutritious and uses locally available foods where possible, involves the community, is given on site and not for take-home, monitoring systems are in place to limit food diversion, and school feeding programmes are only implemented in the context where resources allow for food security interventions which target most food insecure households within the communities

Strategy 5: Where there is significant nutritional risk or demonstrated deterioration in nutritional status, ensure the timely and appropriate implementation of Emergency Supplementary Feeding Programmes (SFPs).

Activities include:

17. SFPs are implemented in line with the MOH Emergency SFP Guidelines.
18. The need for emergency SFPs in all Districts is reviewed by MOH every four to six months and exit strategies will be put in place where appropriate.
19. Partners with skills and capacity are identified in each Province and District in preparation for emergency response.
20. Monitor, evaluate, maintain data-base of SFPs and conduct training where required to support best practice.

Strategy 6: Ensure that specific population groups with greater nutritional risk are given higher priority, especially in the context of limited resources.

Activities include:

21. The physiologically vulnerable, including women of reproductive age (15 – 49 years), infants less than six month months and children under five years old are given priority in assessments and action.
22. Sub-population groups including marginalized groups, those who have lost their livelihoods and those who have lost access to social support structures, are given priority in assessments and action.

Strategy 7: Reduce health risks associated with malnutrition, specifically the control and prevention of diarrhoeal disease.

23. Ensure that water and environmental sanitation progrmmes are put in place with appropriate hygiene education.
24. Ensure that health staff at all levels of health facility and mothers have the skills and capacity to recognize signs of diarrhoea and dehydration and have knowledge and skills to provide oral rehydration.

Strategy 8: Prevention, reduction and elimination of Iodine Deficiency Disorders (IDDs) through Universal Salt Iodization (USI).

Activities include:

25. Formation of National IDD Elimination Committee led by MOH and including other stakeholders (MOTC, MOMI, UNICEF) to monitor overall national USI strategy.
26. IDD Elimination Committee replicated at Provincial level.

27. Together with MOMI and MTC, support installation and operation of at least eight salt iodizing factories throughout the country.
28. Development and endorsement of national salt iodization logo.
29. Monitoring of salt iodization process at levels of production, packaging, markets and household.
30. Social mobilization, advocacy and communication for promotion of iodized salt through television, radio and at all health facility levels (hospitals, CHC BHC and HP) and particularly through CHWs.
31. Development and endorsement of national legislation for production of iodized salt with other related ministries.

Strategy 9: Prevention, reduction and treatment of other Micronutrient Deficiency Diseases including Vitamin A Deficiencies (VAD), iron deficiency anemia (IDA), Vitamin C deficiency (scurvy) and Vitamin B deficiencies through integrated strategy of treatment, supplementation, fortification, education and food based approaches.

Activities include:

32. MOH guidelines for diagnosis and treatment of VAD, IDA, IDDs and scurvy are used in all hospitals, CHC and BHCs and HPs.
33. Vitamin A supplements are provided all children 6 - 59 months during National Immunization days (NIDs) and systems are established for integration into routine health service facilities.
34. Iodine supplementation is given in areas with high prevalence of IDDs and where access to iodized salt is not feasible within the next 2 years.
35. In identified areas of high risk for scurvy outbreaks, Vitamin C supplements are provided to women and children for 2- 3 months during winter season.
36. Strategy (pilot) for fortification of wheat is designed and implemented in partnership with WFP, MRRD and MAAH through local decentralized milling facilities.
37. In collaboration with MAAH, advocate, facilitate and support food-based approaches to allow high risk groups to increase access to micronutrient-rich foods through improved food production, diversification, food processing, food storage and food preparation.
38. Appropriate communication and education is used in all health facilities on sources etc of micronutrient rich foods.

Strategy 10: Reduce nutritional risks for women throughout their life-cycle through implementation of integrated health, nutrition and food security interventions.

***Activities include*:**

39. Facilitate and support increase in women's daily food intake during pregnancy, in terms of quality and quantity, through improved household food security and appropriate intra-household distribution.
40. Folic/iron supplements are provided throughout pregnancy and iron supplements are provided for three months beyond pregnancy through antenatal care.
41. Provision of Vitamin A supplements to women soon after birth (and before eight weeks post-partum) through antenatal care.
42. Facilitate and support improved access to micronutrients for women through food diversification (equitable intra-household distribution, market access, improved household food security), parasitic control, improvement in hygiene behaviors.
43. Facilitate and support access to iodized salt for women.
44. Support women to exclusively breastfeed for six months, to contribute to longer birth-spacing.

45. In extremely food insecure areas, support and promote distribution of dry ration food supplement to women through pregnancy and until infant's reaches 6 months of age.
46. Contribute to further understanding effective interventions to improve women's nutritional status in Afghanistan.
47. Undertake research to document prevalence and aetiology of low-birth weight (LBW) and formulate appropriate response to address the problem.

Strategy 11: Support and promote optimal practices for infant and young child feeding, including appropriate caring practices

***Activities include*:**

48. Advocate for and monitor implementation of MOH Interim Policy in all levels of health facility and storage warehouses.
49. Finalize, endorse and implement National Code on Marketing of Breast-milk Substitutes for Afghanistan.
50. Establishment of a National Advisory Board to oversee implementation of the law, monitor violations of the Code and take corrective action.
51. Baby Friendly Hospital Initiative (BFHI) is implemented in at least 15 hospitals.
52. Protect, support and promote exclusive breastfeeding for 6 months through behaviour change strategies, in all levels of health facilities.
53. Promote use of appropriate complementary feeding practices and behavior change strategies using locally available foods.
54. Define role and effectiveness and develop guidelines for Growth Monitoring and Promotion (GMP) in Afghanistan and identify the conditions and resources required for effective interpretation and follow-up action for health workers and carers.
55. Strengthen nutrition components of Integrated Management of Childhood Illness (IMCI).
56. Promote and support use of locally available fortified nutritious mixes for older infants and young children e.g. "*Superflour*".

Strategy 12: Establish appropriate services for management and treatment of severe malnutrition.

***Activities include*:**

57. Support and facilitate implementation of hospital-based treatment of severe malnutrition (Part I) and out-patient treatment (Part II).
58. Ensure MOH Guidelines for hospital-based treatment of severe malnutrition are applied in relevant provincial and district hospitals.
59. Support, monitor and maintain data-base for hospital-based treatment facilities.
60. Appropriate drugs and food commodities (e.g. F75 and F100 etc) are included within MOH central stock procurement, distribution and control system with an appropriate monitoring system.
61. Define, develop and implement strategy and protocols for out-patient/community-based treatment of severe malnutrition to be implemented with district hospitals and CHCs (Part II).

Strategy 13: Ensure that appropriate social mobilization, nutrition education and communication and advocacy are use used to promote improved nutritional status through general media and through all levels of health facility.

***Activities include*:**

62. An inter-sectoral and interdisciplinary approach is adopted for nutrition education and communication, specifically involving the sectors of agriculture, water and sanitation, health and education.
63. Nutrition education and communication materials are prepared and delivered using a logical planning framework (conceptualization, formulation, implementation and evaluation).
64. Nutrition education and communication is implemented only in the context of strengthening household's assets (capacity to change), that is, taking into consideration, the cultural and economic factors that prevent families from changing their behavior even if their knowledge and skills are improved.
65. Priority is given to the following nutrition and communication behavior messages (1) infant and young child feeding (2) maternal nutritional status (2) consumption of iodized salt (3) access to a diverse diet (access, production, storage, processing and preparation) (4) sanitation, hygiene and prevention and management of diarrhoreal diseases.
66. In collaboration with IEC and other partners, standard nutrition education and communication guidelines are endorsed to ensure consistency and standardization, using participatory and traditional communication methodologies as formal education.

Strategy 14: Ensure human resource capacity development and training at the central, provincial and district levels.

***Activities include*:**

67. A competency-based skills development strategy is applied to relevant MOH staff members, specifically National and Provincial Nutrition Officers, to facilitate improvement in required skills and knowledge in knowledge.
68. A network of national staff, among Ministry, UN and NGO partners, with knowledge and skills in public nutrition, is developed throughout the country.
69. MOH training modules in public nutrition, specifically community-based food security, supplementary feeding, management and treatment of severe malnutrition, infant feeding and surveillance, are finalized, disseminated and used for training.
70. Support and facilitate relevant training workshops and courses in public nutrition.
71. Advocate for greater awareness of public nutrition among all stakeholders and all levels of Government.
72. A resource centre is established within the Public Nutrition Department.

Strategy 15: Promote and support evidence-based decision-making, research and learning in public nutrition.

Activities include:

73. Programme development is based on demonstrated context-specific analyses and understanding of underlying causes of malnutrition using universally-accepted best practice research methods.
74. Successes and failures of other countries within the region, with similar nutritional problems and challenges, are applied appropriately.
75. Programme evaluations are carried out regularly, shared and disseminated widely.
76. MOH nutrition guidelines are developed and revised based on lessons learnt.
77. Effectiveness and impact studies are in place to systematically document impact and justify use of limited resources.

Section VII: Mechanisms for collaboration, partnership and integration

By definition, effective public nutrition interventions can only be achieved with the close collaboration, co-ordination and partnership of relevant partners. This section describes the mechanisms for collaboration and integration within the MOH, with other Ministries and with national and international partners as well as the integration of nutrition into important overriding policies such as BPHS.

Within Ministry of Health:

Central MOH
The recently established Public Nutrition Department is positioned with the Health Care and Promotion Directorate (***Annex 1).*** The Department collaborates with all Departments within MOH Kabul with a focus on a specific number of Departments/Units ***(Annex 3)***

At central level, the co-ordination mechanism is largely through:

- Public Nutrition Task Group, a forum for consultation, information sharing, problem analysis and development of best practice. This process is conducted through different inter-agency and inter-Ministerial Working Groups.
- Other Task Groups specifically of which nutrition is an important component e.g. IMCI, HMIS etc.
- Information is shared with the wider public health community through the monthly MOH NTCC meeting.

Provincial MOH:
The management structure at the provincial level is the Provincial Management Team. The MOH Provincial Management team (provisionally) includes a Provincial Nutrition Officer (PNO). The PNO will mainly be responsible for:

- co-ordination of nutrition activities within the Province
- dissemination of policies and guidelines
- technical support
- monitoring and evaluation
- integration of nutrition into other health activities
- training
- supporting nutritional surveillance and surveys
- fostering working relationships with various relevant actors within the Ministries
- Supporting and monitoring nutrition components of BPHS.

Information will be shared with the wider public health community at the Provincial level through the monthly Provincial Co-ordination Committee meeting.

District MOH
The management structure of the district health system includes:

- District Health Management Team (DTHM)
- The local Shora (council)

While there may not be any designated person responsible solely for nutrition at the District level, all staff at District-level will be supported by MOH to understand and have skills to implement relevant nutrition activities.

Within the Community
While community-based health care (CBHC) is not new to Afghanistan, the MOH has recently revived, further developed and formally adopted the concept of CBHC in the context of Afghanistan. CBHC, and the related Community Health Workers (CHWs) and traditional birth attendants (TBAs), is a community-based and owned programme with essential technical and support provided by MOH and NGOs.

Public Nutrition forms an important component of the responsibilities of the CHW, specifically in the areas of:

- promotion of vitamin A supplementation for children and post-partum women
- prevention and control of diarhoea
- promotion of early and exclusive breastfeeding and appropriate complementary feeding practices for young children
- promotion of good nutrition (access to diversified foods) for the family and particularly for women
- promotion of use of iodized salt
- referral of children at risk of malnutrition and those suffering from severe malnutrition

Between Ministries
The MOH Public Nutrition Department will have overall leadership for public nutrition but will collaborate and build strong partnership with a number of other Ministries. The MOH Public Nutrition will work closely, but not exclusively, with the Ministries listed in ***Annex 4***.

With international community

Donors The MOH Public Nutrition Department will collaborate and advocate for support for nutrition with all donors in Afghanistan with a specific focus on those supporting health and food security programmes.

United Nations (UN) The MOH Public Nutrition Department will collaborate closely with, but not exclusively, with a number of United Nations (UN) agencies such as UNICEF, FAO, WFP and WHO. Relevant areas of collaboration with each of these are specified in ***Annex 5***.

Non-Governmental Organizations (NGOs) The MOH Public Nutrition Department will collaborate with all NGOs involved with nutrition and will develop strong partnerships with NGOs:

- selected to implement BPHS (PPA) in each Province and District
- with a demonstrated technical capacity and skills in nutrition
- involved in community-based food security interventions

Academic, Research and Global Advocacy Institutions: The MOH recognizes the need to access expertise from internationally recognized organizations. Some of these institutions may include; Tufts University, Centres for Disease Control (CDC), WABA, IBFAN, Micronutrients Initiative (MI) etc.

With Private Sector

The MOH Public Nutrition Department recognizes the potential capacities and contributions of the private sector and will build strong relationships with the private sector, particularly in the areas of:

- production and distribution of iodized salt (co-operatives and salt traders)
- milling and fortification of wheat (millers)
- local production of appropriate complementary foods for young children
- preventing and controlling marketing and promotion of infant formula etc.in health facilities

Integration and Strengthening of Public Nutrition within Basic Package of Health Services (BPHS)

The recently adopted BPHS policy has two purposes:

1. to provide a standardized package of basic services which forms the core of delivery in all primary health care facilities and
2. to promote a redistribution of health services by providing equitable access, especially in underserved areas.

The BPHS provides a comprehensive list of services to be offered at four standard levels of health facilities within the health system including the District Hospital, the Comprehensive Health Centre (CHC), the Basic Health Centre (BHC) and the Health Post. The concept of the BPHS is that all services in the package should be available as an integrated whole rather than as being available as piecemeal of vertical programmes.

Public Nutrition is an important component of the BPHS and is comprised of the following four main components[1] –

- ***Assessment of malnutrition:*** demonstrated understanding the extent and severity of the problems of malnutrition, specifically the prevalence of stunting, wasting and underweight using the correct indicators, as well as the main underlying causes.
- ***Prevention of malnutrition:*** Vitamin A supplementation, control and prevention of diarrhea diseases, treatment of parasitic infection, promotion of exclusively breastfeeding and appropriate complementary feeding, promotion of good nutrition for women, promotion and access to iodized salt, demonstrated understanding of underlying causes of malnutrition and advocacy for areas not addressed, advocacy for improving food diversification and household food security, advocacy for nutritionally adequate general ration where appropriate.
- ***Treatment of malnutrition:*** treatment of clinical cases of MDDs, treatment and management of severe malnutrition, advocacy and implementation of emergency supplementary feeding progrmmes only where appropriate.
- ***Surveillance and referral***: establishment of clinic-based surveillance, support and use of sentinel-site surveillance and referral of children at risk and/or with signs of malnutrition.

Annex 6 provides a summary of the delivery of each of these components at the four levels of health facility level.

[1] This refers to the revised version of the Public Nutrition component in the BPHS.

The BPHS alone is inadequate to address the diverse underlying causes of malnutrition in Afghanistan. The Public Nutrition Department will therefore advocate for, support and strengthen links with those agencies implementing food security interventions to complement the predominantly health focus of the BPHS.

Section VIII: Policy into Practice: Monitoring implementation of Public Nutrition Policy and Strategy

The Public Nutrition Policy and Strategy will be reviewed through the following mechanisms:

Central National Level		
Inter-Ministerial and Inter-agency Public Nutrition Committee	***Participants:*** Deputy Technical Minister MOH (Chair) , Senior representatives from MOH, MAAH, MRRD, MWA, MOTC, MMI, Senior representatives from WHO, UNICEF, FAO and WFP other active partners in MOH policy	***Frequency:*** Annual Review
Nutrition Task Group	***Participants:*** All members of Nutrition Task Group including representatives from other Ministries	***Frequency***: Bi-annually
Provincial Level		
In some selected provinces:	***Participants:*** MOH Public Nutrition, Provincial Management team, PPA NGO, MRRD, MAAH, MOWA, WFP, UNICEF, WHO and FAO.	***Frequency:*** Annual Meeting

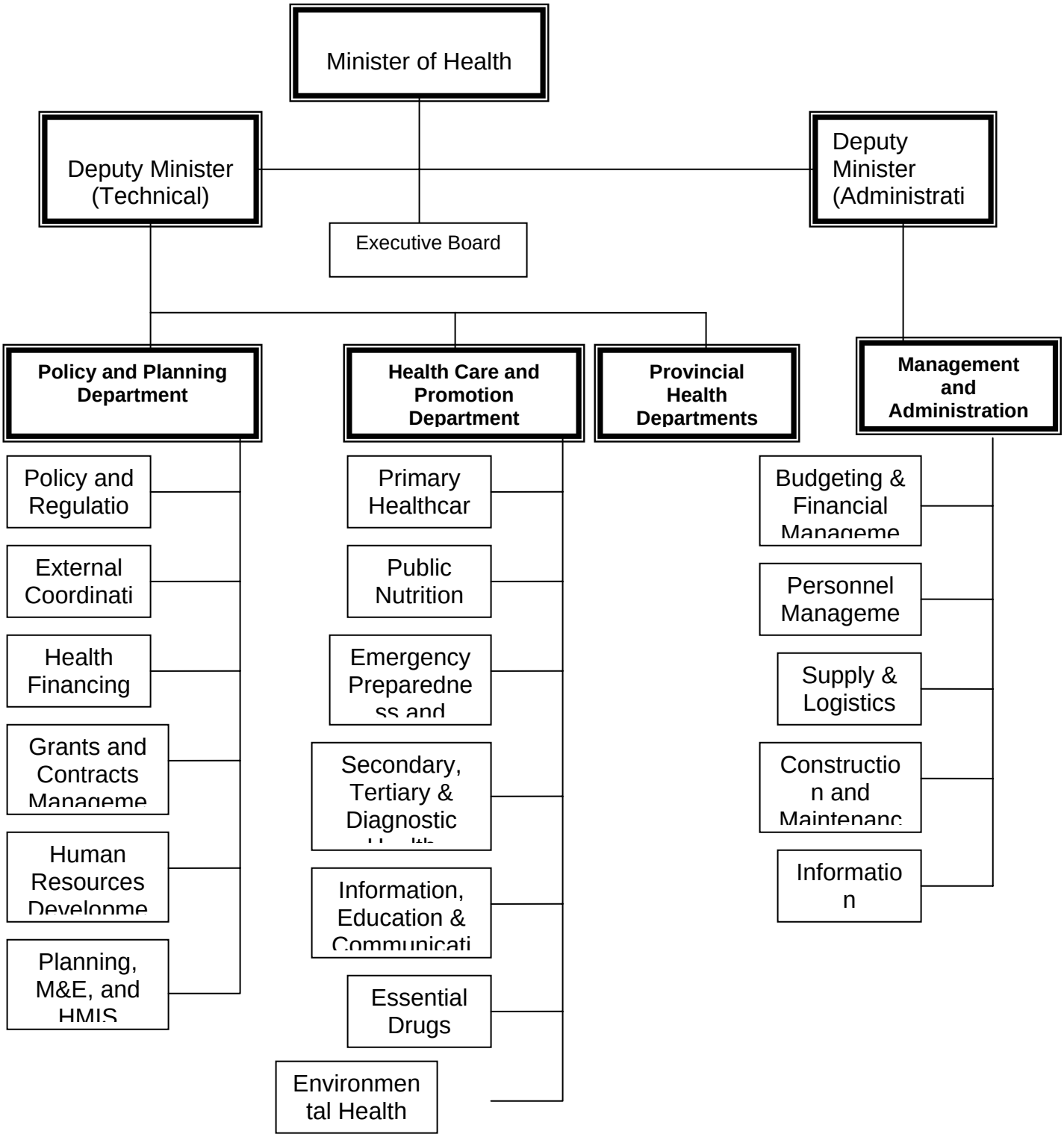
The following sources of information will be reviewed:

1. **Outcomes:** Data on nutritional status from household surveys conducted by PPA NGOs, other nutritional surveys, national survey (April 2004), surveillance data from clinic-based surveillance and national food security and nutritional sentinel site surveillance system (NSS).

2. **Effectiveness:** Standard reports on effectiveness of Therapeutic Feeding Units (TFUs) coverage of Vitamin A supplementation, etc.

3. **Process:** Monthly achievements and activities of Public Nutrition Department and Nutrition Task Group submitted on a monthly basis to Directorate of Health Care and Promotion and NTCC.

Annex 1: Proposed Structure of Central Ministry of Health



Annex 2: Proposed longer term Objectives

Indicator	**1997 (**1)	**2004** (2)	**2010**	**2015** (3)
Low-birth weight % (4)	-	-		<10
Underweight (wt/age) among 6 - 59 months	-	(2)		<15
Stunting (ht/age) among 6 –59 months	48% (5)	(2)		<15
Aneamia among 6 – 59 months	-	(2)		<20
Aneamia among women 15-49 years	-	(2)		<30
Nutritional status of women (BMI < 18.5)	-	(2)		<10%
Prevalence of IDDs (biochemical)	-	(2)		0%

1. Data from MICS Survey (1997)
2. Data from MOH/UNICEF/CDC National Survey (May 2004) to be inserted
3. International norms
4. Data to be obtained from health facilities through surveillance methods
5. Stunting prevalence reported for age group 6-35 months in MICS, other data not reported in MICS survey (1997).

Annex 3: Collaboration with other Departments within MOH Central-level

Department/Unit within MOH	Purpose
Information, Education and Communication (IEC)	• Nutrition information, education and communication
Primary Health Care (PHC)	• Other PHC components e.g. EPI, etc.
Curative Department	• Treatment and management of severe malnutrition • Hospital food management systems
Health Management and Information (HMIS)	• Surveys, clinic based nutritional surveillance and sentinel site NSS
Maternal and Child Health (MCH and Safe-Motherhood Initiative Unit (SMI)	• Maternal nutrition as component of wider health interventions to reduce LBW
Environmental Health	• Food safety
Others HIV AIDs, Young Child and Adolescent Health Unit	• Infant feeding, nutritional needs of HIV-infected and household food security • Young child and Adolescent Health

Annex 4: Collaboration with other Ministries

Ministry	Specific purpose
Ministry of Rural Rehabilitation and Development (MRRD)	• National Surveillance System (NSS) • Emergency • Implementation of interventions to address underlying causes, e.g. water systems • Emergency preparedness in terms of? • Food aid and food security
Ministry of Agriculture and Animal Husbandry (MAAH)	• Home Economics and Nutrition Unit within FAAH • Community-based food security interventions • Agricultural programmes (livestock, production) • Food safety
Ministry of Women's Affairs	• Women, nutrition and communities • Maternal and Infant nutrition-related issues • Community-based food security interventions
Ministry of Trade and Commerce	• Iodized salt production • National legislation for iodized salt • Production of local nutritious complementary food • National Code for Marketing of Breastmilk Substitutes • Food safety
Ministry of Mines and Industry	• Iodized salt production
Ministry of Foodstuffs and Industry	• Iodized salt production • Production of nutritious complementary food
Ministry of Education	• School curriculum development and nutrition education at higher educational levels
Ministry of Justice	• National legislation for iodized salt • National Code for Marketing of Breastmilk Substitutes

Annex 5: Collaboration with UN partners

UN agency	Sectors
UNICEF	• Severe Malnutrition • Salt iodization • Infant and young child feeding • Nutrition surveys • Maternal nutrition • Fortification • IEC
WFP	• Food aid • Emergency Supplementary Feeding • Food for Institutions • Fortification (wheat and “Superflour”) • Hospital food management systems • Information management systems
FAO	• Home Economics and Household Food Security • Information management systems • Food safety • Maternal nutrition • IEC
WHO	• Severe malnutrition • IMCI • Maternal, infant and adolescent nutrition • IEC

Annex 6: Revised DRAFT Version of Summary of Public Nutrition component of BPHS (2003)

Activity	District (and provincial) -level Hospital	Comprehensive Health Centre	Basic Health Centre	Health Post
Assessment of Malnutrition				
Nutritional status Surveys (population-based)	Conducted at district level using universally accepted methodology based on WHO cluster survey methodology (30 clusters) and reported in z-score using indices of weight for height (wasting) , weight for age (underweight) , and height for age (stunting)			
Prevention of Malnutrition				
Vitamin A supplementation: Vitamin A supplementation to all children 6 months to 59 months	No	No	No	Yes (through NIDS
Vitamin A supplementation post-partum: Vitamin A Supplementation post-partum to women (through TBAs)	Yes	Yes	Yes	Yes
Iodized salt: Promotion of iodized salt in all households	Yes	Yes	Yes	Yes
Exclusive breastfeeding: Support and promote exclusive breastfeeding until 6 months.	Yes	Yes	Yes	Yes
Complementary feeding for young children: Promotion for appropriate complementary feeding	Yes	Yes	Yes	Yes
Iron/folic Supplementation ron/folic to pregnant and lactating women	Yes	Yes	Yes	Yes
Growth Monitoring and Promotion For children less than 3 years* with follow-up action and feedback	No	Yes	Yes	No-refers to CHC and BHC
Maternal Nutritional status: Promotion and support for improving maternal nutritional status	Yes – through TFU	Yes	Yes	Yes
Deworming - Antihelminithic drugs and education on hygiene and prevention	Yes	Yes	Yes	Yes
Training: Training for staff in causes and prevention of malnutrition	Yes	Yes	Yes	Yes
Underlying causes: Based on understanding of causes of malnutrition advocate for integration of families into wider programmes	Demonstrated understanding of underlying causes and outline of appropriate interventions to address malnutrition.			
Treatment of Malnutrition				
Training: Training of staff in causes, clinical symptoms and treatment of MDDs	Yes	Yes	Yes	Yes

Micronutrient Deficiency Diseases Treatment of iron deficiency anemia (IDA) , scurvy and vitamin A deficiency (VAD) –	Yes	Yes	Yes	No –referral
Treatment of Severe Malnutrition Based on MOH/UNICEF/WHO protocols 24-hr Care for Phase I; day care/home-treatment for Phase II	Yes	Yes – where possible	No	No –referral
Moderate Malnutrition: Only where acute malnutrition levels higher than 10% with additional risk factors then (1) advocate for inclusion of blended food into general ration programme and (2) implement emergency Supplementary Feeding (<80% and >70% weight for height) with clear phase out strategy.	No	Yes	Yes	No
Surveillance and referral				
Clinic-based surveillance using weight for height: All children U5 years measured for weight for height (HMIS) and refer those severely to hospital or CHC and if applicable to SFPs (moderate wasting)	No	yes	yes	No
Sentinel site Surveillance: NSS (Inter-ministerial MRRD, MOH, MAAH) for monitoring nutritional risk	n/a	n/a	n/a	Yes –through sentinel sites
Screening: Screening and referral of at risk children using MUAC	No	No	No	Refer using MUAC

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