Islamic Republic of Afghanistan

Ministry of Public Health

National Public Nutrition Policy and Strategy

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FOREEWORD

Good nutritional status is fundamentally important for ensuring and maintaining health and enhancing physical and cognitive capacity of populations. Thus, the economic growth and social development of a nation is highly dependent on a well-nourished population.

In contrast, nutritional deficiencies lead to increased morbidity and mortality among the population and retard economic growth. More than one-third of deaths among children under five years old worldwide are attributed to malnutrition, and the World Bank estimates that many countries lose at least 2 – 3 percent of their Gross Domestic Product (GDP) due to malnutrition. Thus, in 2008, the Copenhagen Consensus, composed of world renowned economists, selected five nutrition interventions among the top 10 most cost-effective national investments in developing countries. Yet again, the 2012 Copenhagen Consensus rated interventions to reduce malnutrition in children <5 years old as the top investment priority for developing countries.

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

To effectively improve the nutritional status of the population over time, evidence-based intervention must be sustainably implemented with adequate quality and high coverage into the foreseeable future, and tracked through a systematic program monitoring and surveillance system. Therefore Ministry of Public Health (MoPH) considers nutrition as a fundamental priority, and has listed nutrition interventions as the first pillar of MoPH's Strategic Plan for 2011-2015. In addition to the MoPH is advocating for and supporting food based interventions through public-private sector partnerships, the delivery of preventive and therapeutic nutrition services through the health care system is one of the seven components of the Basic Package of Health Services (BPHS) and part of the Essential Package of Hospital Services (EPHS). The MoPH continues to strengthen the capacity of its Public Nutrition Department (PND) through the recruitment and development of competent staff at the central and provincial levels. The role of the MoPH is integral and committed to the successful implementation of almost all inter-sectoral strategies and efforts toward improved nutrition for every Afghan.

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

1) Implement evidence-based nutrition-specific interventions of high quality and coverage with more emphasis on preventive nutrition programs and services that target females of childbearing age and young children, especially those <24 months old.

2) 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 <24 months old.

3) Advocate for public nutrition policies and adequate resources to support quality and high coverage interventions as essential components of the national development agenda.

4) Improve multi-sectoral coordination to help increase coverage of quality nutrition-specific and nutrition-sensitive interventions.

5) Develop human resource capacities in planning, implementation and evaluation of nutrition interventions and strengthen the role and capacity of the PND.

6) Strengthen the national capacity to track the quality, coverage and impact of public nutrition interventions and services to guide future policies and strategies.

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

Best regards,

Dr. Ferozudin Feroz

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

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

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General Director of Preventive Medicine

Ministry of Public Health

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LIST OF ABBREVIATIONS/ACRONYMS

ACF	Action Contre la Faim
AFSANA	Afghanistan Food Security and Nutrition Agenda
AISPA	Afghanistan Iodized Salt Production Association
ANDS	Afghanistan National Development Strategy
ANPHI	Afghanistan National Public Health Institute
ANSA	Afghan National Standards Authority
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behaviour Change Communication
BFHI	Baby-Friendly Hospital Initiative
BHC	Basic Health Centre
BMI	Body Mass Index
BMS	Breast Milk Substitutes
BPHS	Basic Package of Health Services
CAH	Child and Adolescent Health
CBHC	Community-Based Health Care

CDC	U.S. Centre for Disease Control and Prevention
CHW	Community Health Worker
CIDA	Canadian International development Agency
CSO	Central Statistics Office
DEWS	Disease Early Warning Surveillance
DFATD	Department of Foreign Affairs, Trade and Development
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
GAIN	Global Alliance for Improved Nutrition
GCMU	Grant Contracts Management Unit
GI	Gastro Intestinal
HMIS	Health Management Information System
HNPS	Health and Nutrition Policy and Strategy
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
IRB	Institutional Review Board
IYCF	Infant and Young Child Feeding
JPRM	Joint Program Review Mission
MAIL	Ministry of Agriculture, Irrigation and Livestock
MAM	Moderate Acute Malnutrition
MDG	Millennium Development Goals
MI	Micronutrient Initiative
MoCI	Ministry of Commerce and Industry
MoE	Ministry of Education
MoEc	Ministry of Economic
MoF	Ministry of Finance
MoHE	Ministry of Higher Education
MoI	Ministry of Interior
MoICY	Monistry of Information, Culture and Youth Affairs
MoJ	Ministry of Justice
MoLSA	Ministry of Labour and Social Affairs
MoM	Ministry of Mines
MoPH	Ministry of Public Health
MoRA	Ministry of Religious Affairs
MoU	Memorandum of Understanding
MoWA	Ministry of Women's Affairs
MRRD	Ministry of Rural Rehabilitation and Development
NAF	National Action Framework
NGO	Non-Governmental Organization
NIDs	National Immunization Days
NMSS	Nutrition Monitoring and Surveillance System
NRVA	National Rural Vulnerability Assessment
NTD	Neural Tube Defect
ORS	Oral Rehydration Solution

PN	Public Nutrition
PND	Public Nutrition Department
PNTF	Public Nutrition Task Force
QA	Quality Assurance
QC	Quality Control
RH	Reproductive Health
SAM	Severe Acute Malnutrition
SC	Save the Children
SUN	Scaling Up Nutrition
ToR	Terms of Reference
UI	Urinary Iodine
UNICEF	United Nations Children's Fund
USI	Universal Salt Iodization
WFP	World Food Programme
WHO	World Health Organization

Part I

BACKGROUND

A. Global Perspective

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

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

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

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

Intervention Category

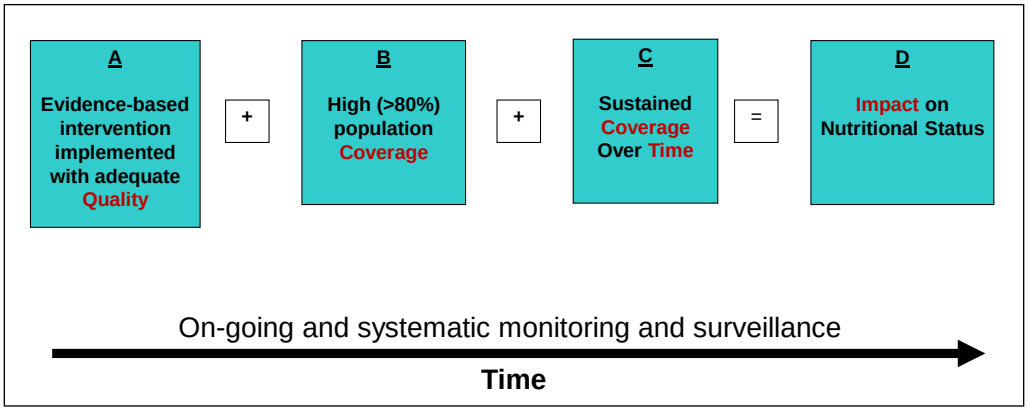
[1] Horton S, et al. Scaling up Nutrition: What Will it Cost? The World Bank, Washington DC, 2010.
[2]United Nations. The Millennium Development Goals Report: 2013. New York, New York, 2013.
[3]The Lancet, "Maternal and Child Undernutrition," Special Series, January, 2008.
[4]Scaling Up Nutrition: A Framework for Action.http://scalingupnutrition.org/wp-content/uploads/pdf/SUN_Framework.pdf. (Accessed 23 February, 2014).
[5] Scale Up Nutrition. http://scalingupnutrition.org/. (Accessed 28 February, 2014).
[6]Copenhagen Consensus Center.http://www.copenhagenconsensus.com/projects/copenhagen-consensus-2008/outcome. (Accessed 21 February, 2014).
[7]Copenhagen Consensus 2012.http://www.copenhagenconsensus.com/sites/default/files/Outcome_Document_Updated_1105.pdf. (Accessed 21 February, 2014).

I	II	III	IV
Promoting Good Nutritional Practices	**Provision of Vitamins and Mineral for Pregnant Women and Young Children**	**Provision of Fortified Foods**	**Therapeutic Feeding for Malnourished Children**
1. Timely initiation and exclusive breastfeeding until 6 months of age	4. Vitamin A supplements for children	10. Iodized salt	12. Prevention or treatment of moderate acute malnutrition
2. Provision of vitamin and mineral-rich complementary foods to infants after 6 months of age	5. Zinc supplements for treatment of diarrhea	11. Iron fortification of staple foods	13. Treatment of severe acute malnutrition (with ready-to-use therapeutic foods)
3. Appropriate hygiene practices, including handwashing, by caregivers of infants and toddlers	6. Use of multi-micronutrient powders (as "in-home" food fortificants) 7. De-worming drugs for children (to improve nutrient absorption) 8. Iron-folic acid supplements for pregnant women to prevent & treat anemia 9. Iodized oil capsules where iodized salt is unavailable		

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

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

*Figure 1. ."Formula" to describe the implementation of an effective nutrition intervention.**



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

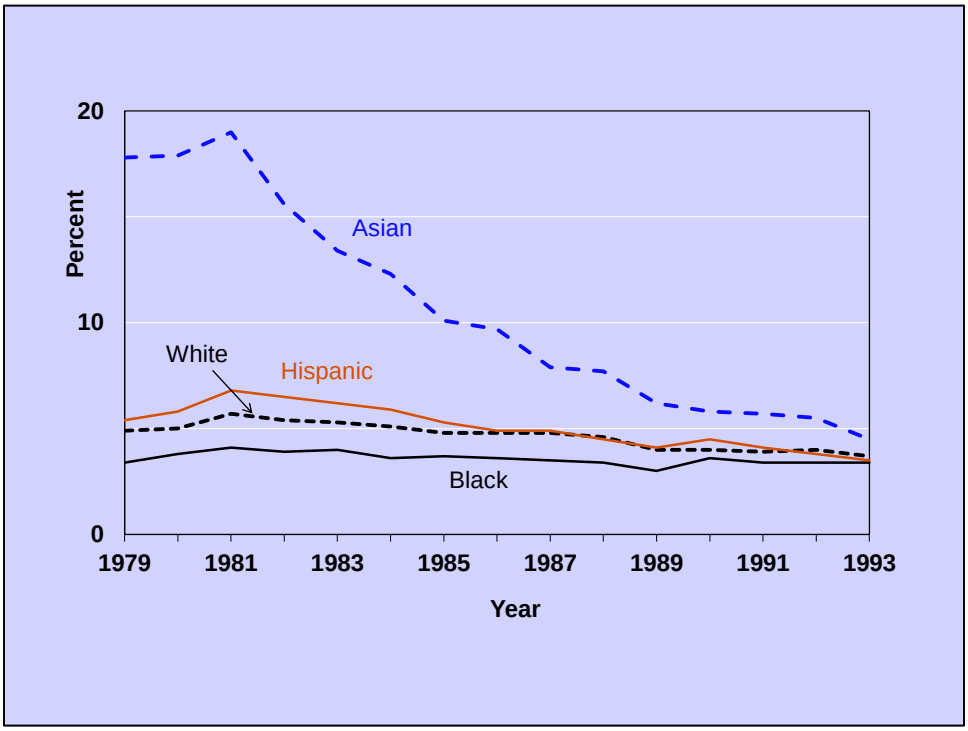
2. Some level of "initial impact" may be detected after one or three years of an intervention depending on the indicators that are tracked. To achieve "maximum sustained impact" of the intervention will require multiple years of sustained effort. For example, as illustrated in **Figures 3**, in the United States it took well over a decade of implementation of a large-scale, well-financed public nutrition program[8] to help reduce stunted growth among low income SE Asian immigrant children to the target levels of about 5%.

3. When data are reliable, and the prevalence an anthropometric indicator of pediatric malnutrition (e.g. height-for-age Z-score (HAZ)<-2.0) is substantially higher than that of the World Health Organization (WHO) standard prevalence of about 2.3%, the entire Z-score distribution will be "shifted to the left" of the standard[9] (**Figure 4**). This indicates that even among children who do not fall below the Z-score cutoff, a large majority have likely not achieved their optimal growth. Thus, targeting interventions only at children with low height-for-age Z-scores will not alter the nutritional profile of entire population of children. The same principle applies to the distribution of weight-for-age and weight-for-height Z-scores, and for that of hemoglobin (Hb) measurements used to screen children or women for anemia (in comparison with the associated reference population's Hb distribution). Thus, it is essential that evidence-based preventive nutrition interventions, such as those listed in **Table 1**, are accessible by essentially all children and women of childbearing age.

[8]Women, Infants, and Children (WIC) Supplemental Nutrition Program.Food and Nutrition Service, U.S. Department of Agriculture (http://www.fns.usda.gov/wic/women-infants-and-children-wic. Accessed 23 March 2014

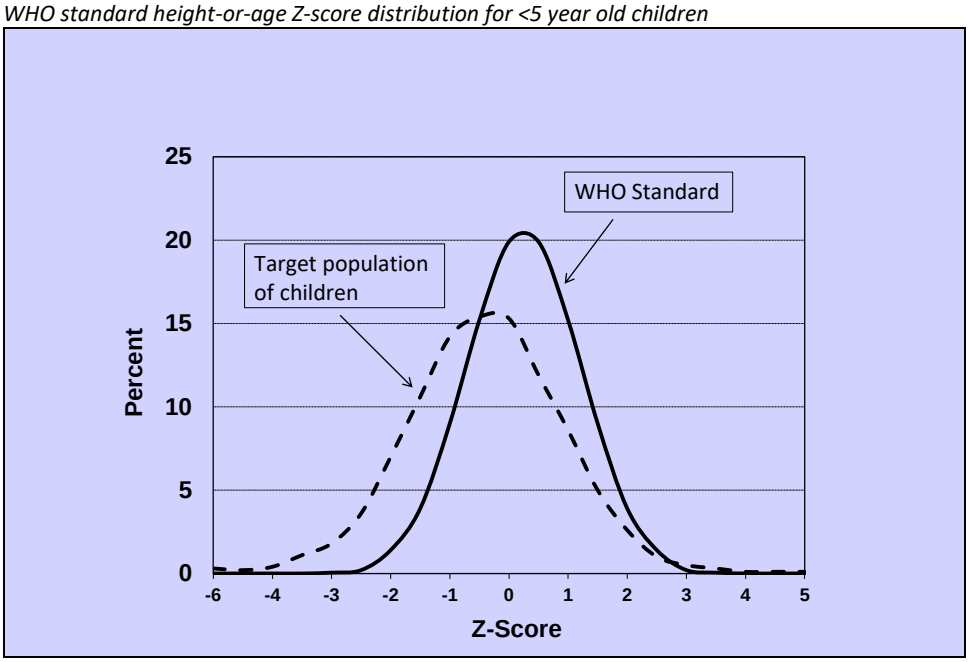
[9]WHO. WHO child growth standards: length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age: methods and development. WHO, 2006.

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



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

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

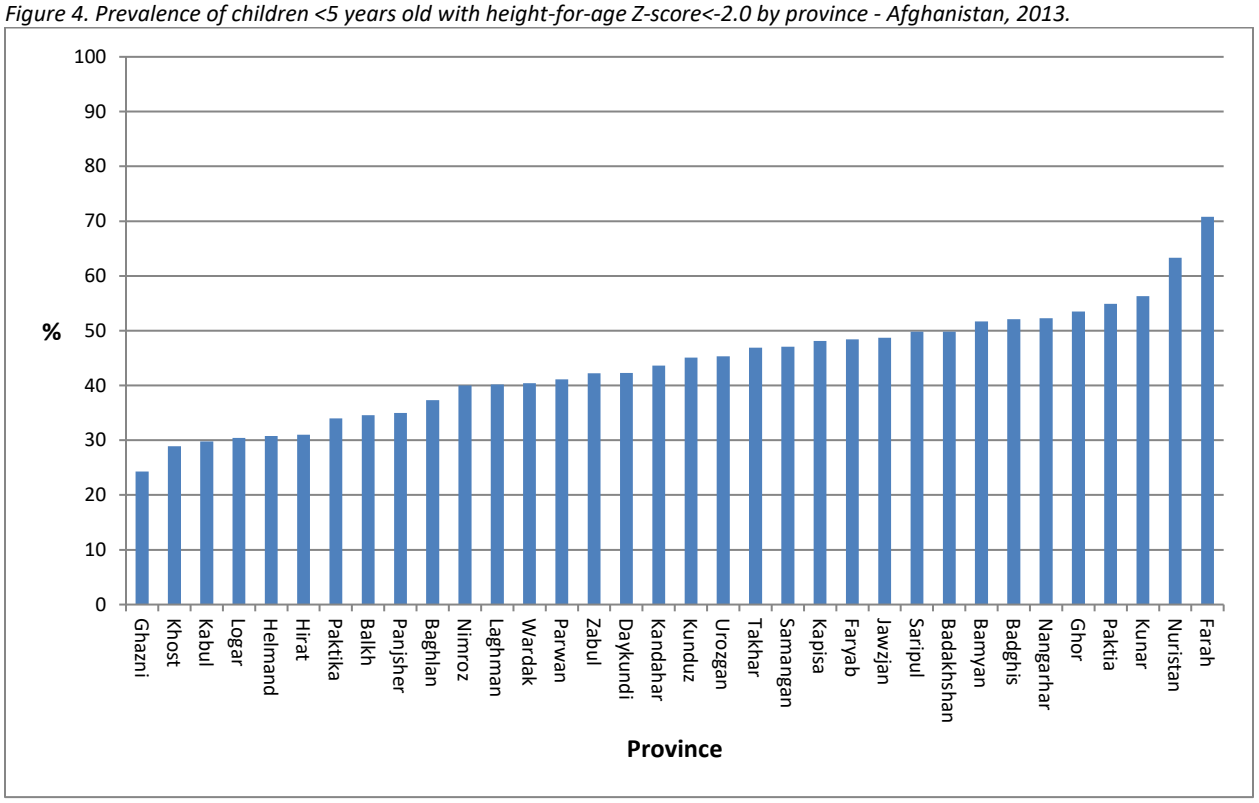


B. Public Nutrition Situation in Afghanistan

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

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

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



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

[10]National nutrition survey Afghanistan 2013. Survey report

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

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

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

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

b. Although the prevalence of acute malnutrition (or wasting) (weight-for-height <-2 Z-score) did not substantially change in 2013 (9.5%) compared to 2004[12] (8.7%) nationwide, very large differences in the prevalence of this indicator were found across the country's provinces in 2013 – from <4% in Faryab to ~22% in Urozgan.

c. Vitamin and mineral deficiencies are highly prevalent among women of childbearing age and young children in Afghanistan (Table 4). However, the iodine status of the population appears to be substantially improved, and the prevalence of iodine deficiency among women of childbearing age and children 7 – 11 years old (urinary iodine (UI) <100 µg/L) has declined from about 75% and 72% respectively in 2004[13], to about 41% and 30%, respectively in 2013[14]. This is most likely due to the impact of the national salt iodization program which started in 2003, and now includes 30 iodized salt production facilities in 12 provinces of the country. The 2013 survey data indicate that 66% of household nationwide consume salt containing ≥15 ppm iodine.

[11]WHO and UNICEF, 2009. WHO child growth standards and the identification of severe acute malnutrition in infants and children: A Joint statement by the World Health Organization and the United Nations Children's Fund.

[12]MoPH, UNICEF, CDC, INRAN, Tufts Univ. 2004 Afghanistan national nutrition survey.

[13]MoPH, UNICEF, CDC, INRAN, Tufts Univ. 2004 Afghanistan national nutrition survey.

[14]National nutrition survey Afghanistan 2013

d. The 2013 data indicate that nearly one-fourth of women and young children in Afghanistan are iron deficient, based on low serum ferritin levels 24 % women of reproductive age and 26.1% of children 6-59 months of age have iron deficiency .Because zinc protophyrin (ZPP) was used to assess iron deficiency in 2004 national nutrition survey, and it was only possible to collect data on 15 survey clusters nationwide then, it is not possible to adequately compare those findings with the 2013 prevalence estimates.

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

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

e. Half of children less than 5 years old in Afghanistan are still vitamin A deficient. Thus, a review of the implementation of the national high-dose vitamin A capsule distribution program is warranted.

f. As shown in Table 4, nearly all women of childbearing age are vitamin D deficient, while over 80% of young children affected by such deficiency. A combination of diets low in vitamin D, combined with very low exposure of people's skins to sunlight due to wearing of conservative clothing is the cause of such deficiency.

g. Unofficial data from the RabiaBalkhi Hospital (RBH) in Kabul indicate a NTD birth prevalence of ~ 43 per 10,000 births (personal communication, Dr. David Gahn, Afghanistan Safe Birth Project, 2009), which is about 7 times higher than that in the United States[15].

Causes of malnutrition and framework for interventions

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

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

[15]CDC. Morbidity and Mortality Weekly Report. CDC grand rounds: Additional opportunities to prevent neural tube defects with folic acid fortification. August 13, 2010; 59:980-984.

[16] Afghanistan National Nutrition Survey, 2013

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

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

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

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

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

Due to the consumption of unsafe water and exposure to poor sanitary conditions and behaviors, young children are highly prone to frequent bouts of diarrheal disease and other infectious illnesses. Based on the 2006 Afghanistan Health

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[17]Central Statistics Organization. National Risk and Vulnerability Assessment 2011-12. Afghanistan Living Condition Survey. Kabul, CSO. 2014.

[18]Central Statistics Organization. National Risk and Vulnerability Assessment 2011-12. Afghanistan Living Condition Survey. Kabul, CSO. 2014.

[19] Summary of the National Risk and Vulnerability Assessment 2007/8: A Profile of Afghanistan. ICON-Institute (http://ec.europa.eu/europeaid/where/asia/documents/afgh_brochure_summary_en.pdf, accessed 22 March, 2014).

Survey[20], 46% of children less than five years old suffer from diarrhea. Severe and repeated bouts of diarrhea are the primary causes of pediatric acute malnutrition in the country.

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

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

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

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

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

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[20]MoPH. Afghanistan Health Survey 2006: Estimates of Priority Health Indicators. Kabul, Afghanistan.

[21]Relief Web.60% of Afghan children infected by intestinal parasites. 20 Oct. 2010. (http://reliefweb.int/report/afghanistan/60-afghan-children-infected-intestinal-parasites; accessed 22 March, 2014).

[22] CDC. Helicobacter pylori and Peptic Ulcer Disease: The Key to Cure. http://www.cdc.gov/ulcer/keytocure.htm#howcommon. Accessed 30 March, 2014.

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

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

Figure 5, Unicef conceptual framework

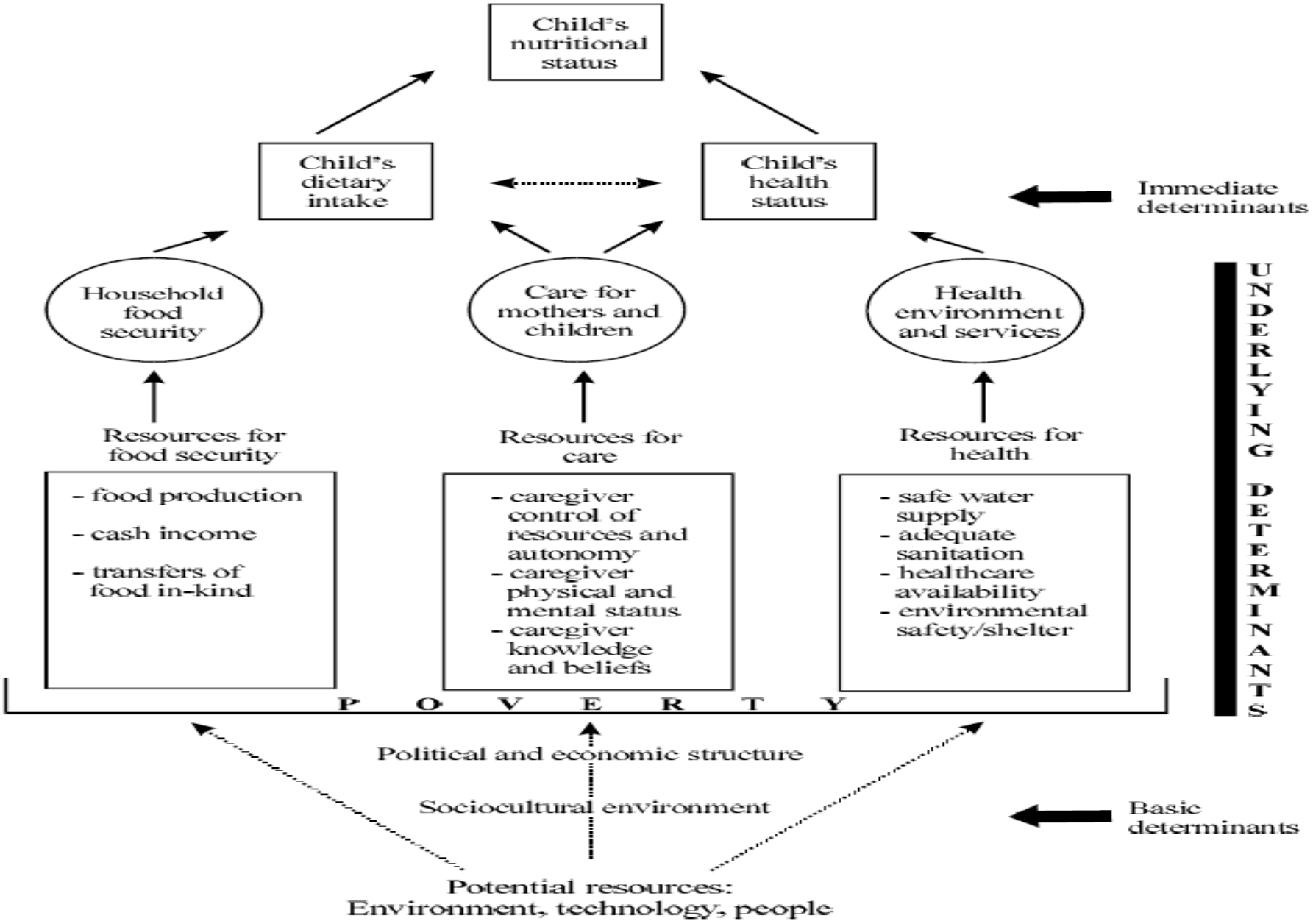
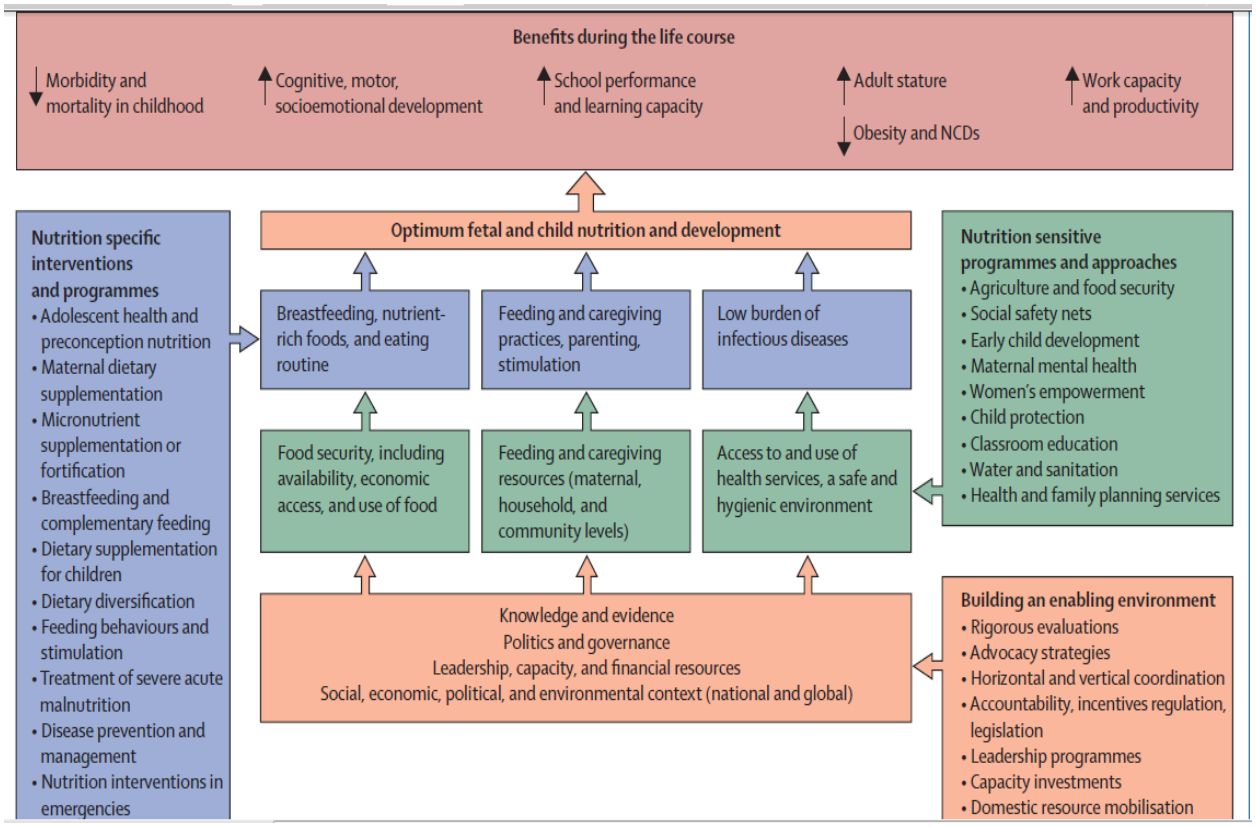


Figure 6, Nutrition Action Framework, Lancet series on maternal and child nutrition, 2013



Consequences of malnutrition:

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

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

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

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

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

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

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

Table 5. Consequences of stunting growth and development

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

C. Review of Nutrition Policy/ strategy 2009-2013 Achievements/ constrains

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

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

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

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

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

Strategic Objective 2 (SO-2): To reduce the prevalence of major micronutrient deficiency disorders; in particular iron, folic acid, iodine, vitamin A and zinc throughout the country and prevent possible outbreaks of vitamin C deficiency illnesses such as scurvy (Wali)

Micronutrient programs are also one of the successful interventions on combating micronutrients malnutrition and stunting in the country, national strategy on prevention and control of micronutrients deficiencies has been developed. National Nutrition Survey 2013 shows that micronutrients deficiency, especially Iron, Iodine and zinc has been reduced considerably. Iron folic acid supplementation, salt iodization and supplementation of zinc during treatment of diarrhea have been the programs, with wide coverage in Afghanistan.
However, high level of vitamin D and vitamin A deficiency among children and women was discovered in the NNS 2013. Still the level of iron deficiency, iodine deficiency, folate deficiency are very high, according to WHO cut off point. Therefore, there is need for more clear strategies on food fortification, food diversification as well as improving the quality of current supplementation programs for addressing

micronutrient deficiency.

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

To strengthen the treatment and follow up of acute malnutrition cases, the Community-based Management of Acute Malnutrition (CMAM) was integrated to Basic Package of Health Services (BPHS) in 2009 and subsequently the CMAM guideline has been revised and integrated (outpatient and inpatient) as Integrated Management of Acute Malnutrition (IMAM) in 2014. Currently there are more than 500 Out-patient Department for SAM (OPD-SAM) and Out-patient Department for MAM (OPD-MAM) sites under the IMAM program is functioning in 28 provinces.

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

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

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

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

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

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

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

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

Nutrition cluster coordinated efforts in resource mobilization and management of acute malnutrition in the country with support from humanitarian fund. All achievements in treatment of SAM and MAM in the country is mainly due to efforts of the nutrition cluster.

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

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

A national Infant and Young Child Feeding Policy and Strategy have been developed in 2009 to strengthen the IYCF program. Breastfeeding counseling tools development and training of more than 100 breastfeeding master trainers and 5000 counselors at health facilities and community level, the Code of Marketing of Breast Milk Substitutes by the government endorsed of in 2009 and national board on implementation and enactment of the Cod has been established which is responsible to monitoring the violation from the Cod. The Baby-Friendly Hospital Initiative (BFHI) established in 65 tertiary, regional, provincial and district hospitals of the country, IYCF communication campaigns through mass media and print materials, world breastfeeding week has been celebrating each year since long time to promote and support exclusive breastfeeding and timely introducing of complementary feeding practices to families and mothers, according to National nutrition survey 2013 report the exclusive breastfeeding rate is around 58.4% and initiation of breastfeeding within one hour of birth is 69.4%. Based on World Breastfeeding Trend Initiative (WBTi) assessment , Afghanistan is ranking 12th out of 81 assessed countries, due to having IYCF policy, regulation, training package, counseling, exclusive breastfeeding and initiation of breastfeeding within one hour of birth high rate.
However, low complementary feeding rate was re-emphasized in the NNS 2013. Community food demonstration, IYCF counseling and monitoring of Code of BMS requires clear strategies and guidelines to be strengthen and improve the nutrition status of infants and young children.

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

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

However, the great need of the country considering the nutrition situation of the population requires further attention and allocation of more resources to this important public domain. The department with the current capacity within the organizational chart of the MoPH is not able to address all these needs, especially when there is a lot of focus by development partners and allocation of resources from international aid agencies in nutrition, the MoPH also should think of upgrading the administrative level of the department within the organizational chart and allocate more resources.

In the training part, there is also need to shift from knowledge transfer methods to more competency based training of health personnel to enable them provide quality services. These trainings cannot be done at once, and there should be a system of continuous education to make sure personnel keep their knowledge and skills updated and be able to answer to the growing needs of their clients. To achieve

this there is great need for academically qualified staff in nutrition with bachelor or master degrees. There is need for creating positions within the health system for these nutrition cadres to create demand for education in the field of nutrition.

D. Summary of the situation (Problems Statements)

A. Continued high prevalence of malnutrition among young children and women of childbearing age, exhibited by essentially the entire population of children not achieving their growth potential, and very high prevalence of vitamin and mineral deficiencies among the children and women.

B. Inadequate understanding among the general population about malnutrition, its causes and consequences, as well as about age-appropriate feeding, stimulation and caring for young children.

C. Insufficient understanding by the high level national policy makers about the role of malnutrition in impeding national economic development, and the high benefit-to-cost ratio of sustained evidence-based nutrition interventions. Thus, there is inadequate investment of national funds in public nutrition programs and substantial dependence of the MoPH on support from international donor agencies, which have earmarked most of the fundsfor humanitarian and emergency related nutrition interventions rather than development nutrition programs. Furthermore, there has been insufficient coordination among different sectors engaged in nutrition-specific and nutrition-sensitive programs.

D. Continued high rates of infectious diseases and parasitic infestation due to the use of unsafe water, exposure to an unsanitary environment and inappropriate hygiene practices that are direct causes of malnutrition among women and children, as well as cultural practices of early marriages, multiple gestations, and low status of women within society that are underlying determinants of maternal and child malnutrition.

E. Inadequate human resource capacity in planning, implementation and evaluation of public nutrition programs, as well as delivery of preventive and therapeutic nutrition services by BPHS and EPHS providers. Furthermore, the PND has limited human resources, infrastructure, and budgetary and administrative capacity to carry out its responsibilities as the nation's lead public nutrition agency.

F. Limited national capacity for regulatory quality control to assure the fortification and sanitary quality and safety of food products (fortified and otherwise) at the production and retail levels.

G. Lack of data to track the quality, coverage and impact ofpopulation-based nutrition interventions(e.g. food fortification and nutrition promotion efforts),and thedelivery ofnutrition services through the BPHS and EPHS, as well as an inadequate capacity to carryout applied

research in public nutrition within the Afghanistan context or to fully evaluate the overall effectiveness of nutrition programs so as to guide related policy decisions.

PART II

National Nutrition Policy & Strategy 2015-2020

Policy statements:

- **Enhancement of nutritional status is an investment in economic development:** The highest levels of leadership within national and local governments, industry and business, and public and private health care and academic sectors must understand about the essential role of good nutrition in the economic development of the nation and take action accordingly.

- **Implement evidence-based interventions:** All PN interventions should be evidence-based, with special focus on maternal and child nutrition – from conception until the child's is 24 months old in order to:
  - Break the cycle of intergenerational malnutrition where a small and stunted mother delivers a small and stunted child, who in turn grows up to be a small and stunted mother, and so on.
  - Enable the young generation to achieve optimal physical growth and cognitive capacity.

- **Increased focus on prevention**: Orient nutrition interventions to promote optimal growth in young children, especially those <24 months old (i.e. infants and toddlers), and micronutrient deficiencies in preconception and pregnant women and infants and toddlers.

- **Promotion of appropriate food and nutrition choices**: The role of the national and local authorities is to implement strategies that inform, encourage and enable the population to make appropriate choices regarding their own and their families' dietary practices and choices of nutrient-rich foods that are hygienically prepared and consumed.

- **Transparent public-private sector partnership:** The public sector must acknowledge the critical role of private sector food producers, importers and retailers as protectors of the nutritional health and cognitive development of the population, and engage and enable them, through relevantinter-sectoral incentives and promulgation and transparent enforcement of appropriate laws and regulations tomarket nutrient-rich foods.

- **Ownership, partnership and responsibilities:** Goals, objectives and strategies are jointly agreed upon and pursued by the relevant government sectors and its private sector partners, and

supported by the international community through coordinated actions and funding allocation determined by the national plans.

- **Quality and high coverage interventions:** To be effective, evidence-based maternal and child nutrition interventions should be implemented with high standards of quality, be accessible to essentially all women and children, and sustained over time. Interventions would range from enabling the population to have access to sufficient nutrient-rich foods, to promotion of appropriate dietary and feeding practices, to delivery of preventive and therapeutic maternal and child nutrition services.

- **Integrated approach:** Public nutrition interventions are integrated with reproductive health and family planning, child and adolescent health, immunization, water and sanitation, agriculture, rural development, education, and commerce, industry and labor programs, as well as through a collaborative and transparent partnership with the private food production, importation and retail sectors.

- **Break the infection-malnutrition cycle**: Continued efforts to reduce the public health burden of infections and communicable diseases are essential toward the reduction of malnutrition among Afghan children. Thus, sustained efforts are necessary to ensure measles immunization, vitamin A supplementation, and rapid identification and treatment of diarrhea (including zinc supplementation) and pneumonia.

- **Good governance, peace and security:** These factors are vital to a sustained effort to improve the nutritional status of the population, especially women and children.

- **Sustainability through technical and financial capacity building:** Technical and financial self-reliance is essential to development and implementation of sustainable evidence-based public nutrition interventions. Technical capacity is of particular importance as currently there are no academically trained Afghan public nutrition or dietetics professionals or certified allied health professionals to advise on, lead, implement, and track the quality, coverage and impact of preventive and therapeutic nutrition interventions.

- **Polices and strategies are revised based on evidence:** Decisions on public nutrition policies, strategies and actions are informed by data and information from systematic program monitoring and surveillance, public nutrition studies, economic analysis, sharing of lessons learned, and adaptation of international experience and recommendations to the Afghanistan context.

Guiding Principles of the Public Nutrition Strategy

This Public Nutrition (PN) Strategy is based on the following core values and operational principles, which are in line with the Ministry of Public Health's mission and vision, and with the Afghanistan National Development Strategy (ANDS).

E. Core Values

Human Rights: Based on a human rights approach, the PN strategy promotes the rights of all people, especially women and children, to life and highest attainable standard of nutrition and health.

Gender: The strategy aims at promoting gender equality as the basis of PN programs, especially maternal and young child nutrition programs, by addressing the lower status of women and discrimination against women.

Equity: The actions promoted within the strategy aspire to contribute toward decreasing the inequities in nutritional status in the country.

Culture: The strategy aims at improving the nutritional status of the population, with special emphasis on women of childbearing age and young children, through engagement of families, communities and national and local leaders and implementation of culturally sensitive interventions.

F. Vision, Mission and Goal of the Public Nutrition Strategy

Vision

Optimal nutritional status for all Afghans

Goal

To reduce nutrition related mortality and morbidity and contribute to economic development of the nation through reduction in all forms of malnutrition particularly stunting, micronutrients deficiency and acute malnutrition, with focus on the first 1000 days of life.

Mission

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

G. Targets and Indicators

The following indicators would be used to assess the progress toward improved nutrition status of the population, especially among women and children and targets for the next five years are summarized in table 6, bellow.

Table 6. Key Nutrition Indicators and targets for year 2020

Indicator	Baseline NNS 2013 (%)	Target 2020
Chronic malnutrition (HAZ <-2) in children 6-59 months	40.9	35%
Underweight (WAZ <-2) in children 0-59 months	24.6	15%
Global acute malnutrition (WHZ <-2 in children 6-59 months	9.5	4%
Severe acute malnutrition (WHZ <-3) in children 6-59 months	4	2.5%
Initiation of breastfeeding within one hour after birth	69.4	80%
Exclusive breastfeeding, in children 0-6 months	58.4	70%
Minimum acceptable diet in children 6-23 months	16.3	40%
Iron deficiency (low ferritin <12ng/ml) in children 6-59 months	26.1	15%
Iron deficiency (low ferritin <12ng/ml) in women 15-49 years	24	15%
Iodine deficiency (UIE <100 µg/L) in children 7-12 years	29.5	20%
Iodine deficiency (UIE <100 µg/L) in women 15-49 years	40.7	30%

STRATEGIC COMPONENTS

Component 1: Implement evidence-based nutrition-specific interventions of high quality and coverage with more emphasis on preventive nutrition programs and services that target females of childbearing age and young children, especially those <24 months old.

Strategies through 2020:

Strategy	Strategic Approaches
1.1 Improve Infant and young child feeding and caring practices	- Promote and expand the Baby Friendly Hospital Initiative - Promote and support early and exclusive breastfeeding until 6 months, including among working mothers - Develop national standards to regulate the sale of breast milk substitutes and enforce of the code of marketing of breast-milk substitutes. - Strengthen coordination with the Ministry of Labor, Social Affairs, Martyrs & Disabled (MoLSAMD) to encourage "breast-feeding friendly" worksites, maternity leave for lactating mothers in first few months post-partum, and to ensure that young age children are appropriately fed and cared for within day care facilities. - Promote timely introduction of nutrient-rich complementary foods for infants, and provision of age-appropriate home-made complementary foods fortified with multi-micronutrient powders, or commercially produced fortified complementary foods that meet national standards. - Develop and enforce regulations for the sale of industrially produced fortified complementary foods through the retail sector. -
1.2 Improve maternal nutrition	- Require multi-micronutrient supplementation of pregnant and lactating women through public and private health care providers. - Promote appropriate weight gain during pregnancy. - Food supplementation for pregnant and lactating women with undernutrition in food insecure area - Promotion of balanced and micronutrients rich diet for pregnant and lactating women -
1.3 Micronutrient deficiency prevention and treatment	a. Micronutrients supplementation - Develop and implement guidance on multi-micronutrient supplementation for non-pregnant adolescent girls and adult women - Develop and implement protocols to screen and treat 6-24 month old for anemia. - Standardize the implementation of iron/folic acid supplementation for pregnant and lactating women among BPHS implementers and private health care providers. - - Develop and implement national clinical guidelines for preventive micronutrient supplementation of all low birth-weight and preterm infants (per WHO recommendations) through BPHS and private sector physicians. - Continue semi-annual vitamin A supplementation for children 6-59

	months old - Require zinc supplementation as adjunct to diarrheal disease treatment in children <59 months old through BPHS and promote such practice among private health care providers. b. Food fortification - Strengthen the existing mandatory of salt iodization program and explore feasible approaches to increase availability of iodized salt in low coverage areas of the country. - Promulgate and enforce mandatory law on fortification of industrially milled domestic and imported flour with iron, zinc, folic acid and vitamin B12 (per WHO recommendation) in a collaborative manner with domestic industrial flour mills and flour importers. - Promulgate and enforce mandatory law on fortification of industrially produced domestic and imported vegetable oil and ghee with vitamins A and D in a collaborative manner with domestic producers and importers. Establish an on-going legal QA/QC monitoring system to help ensure that domestically produced and imported fortified foods meet national standards. c. Food diversification Promoting use of national food based dietary guideline among families as well as other social institutions
1.4 Prevention and treatment of acute malnutrition	- Early identification and supplementary feeding of <5 year old children (with a special focus on <2 year olds)with Moderate Acute Malnutrition (MAM) (including use of domestically produced lipid-based nutritional supplements,and appropriate recipesusing local ingredients and products for home-based hygienic preparation of energy-dense and nutrient-rich foods). - Integrated management of <5 year old children (especially those <24 months old) with Severe Acute Malnutrition (SAM) through in-patient and out-patient treatment. - Promotion of locally prepared food recipes for treatment of MAM and prevention of SAM based on local feasibility studies.
1.5 Nutrition interventions during emergencies	- Promote appropriate infant and young child feeding, especially breastfeeding among infants and feeding of hygienically prepared complementary foods, in the light of national BMS code. - Blanket and targeted food distribution and micronutrient supplementation, as appropriate. - Enable the affected population to have access to safe water and soap. - Establish protocols for screening and rapid identification and appropriate treatment of <5 year old children, especially those <24 months old, with various degrees of acute malnutrition. -
1.6 Strengthening implementation of public nutrition component in the BPHS and EPHS	- Encouraging and supporting innovations in provision of nutrition specific services - Developing necessary guidelines, standard operation procedures and job aids to BPHS and EPHS staff - Technical support, regular assessments, monitoring, supportive supervision, mentoring and follow up with health staff

Component2: 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<24 months old.

Strategies through 2020:

Strategy	Strategic Approaches
2.1 Ongoing and strategic promotion of appropriate food and nutrition practices, with a special focus on improving the nutritional status of adolescent girls, mothers and infants and toddlers.	- Inform the population about appropriate growth of children <5 years old, especially those <24 months old, and support monitoring and promotion of children's growth, accompanied with appropriate counseling, through primary health facilities and communities. - Develop and implement nutrition and dietary behavior change and social marketing messages related to improving the growth and development of children, based on population-specific formative studies - Strengthen the ability of maternal and child health care providers to deliver appropriate preventive and therapeutic food and nutrition messages to their patients. - Promote the use of the Food Based Dietary Guidelines among the population. - Development and promote healthy recipes for special groups of population - Engage relevant national and local civic organizations and the mass media to regularly deliver nutrition information and promotion messages as a component of social responsibility of their businesses. - Develop nutrition topics for elementary and secondary school teachers to incorporate into subject-specific curricula, - Implement nutrition communication and social marketing, based on appropriate formative studies, to promote the national Food Based Dietary Guidelines. - Inclusion of nutrition education in different social programs, such as literacy for life, Life skill education, cash transfer, community development, and other development activities - Promote proper nutrition and care during the first 1000 days of life, through mass communication and campaigns

Component3:Advocate for public nutrition policies and adequate resources to support quality and high coverage interventions as essential components of the national development agenda.

Strategy	Strategic Approaches
3.1 Advocacy and awareness building among high level government and private sector leaders	- Develop an estimate of benefit-to-cost ratio of feasible large-scale public nutrition interventions (as awareness building and advocacy tool for national policy makers). - Regularly advocate to cabinet of ministers regarding public

	nutrition programs and successes in Afghanistan, especially from a perspective of national development. - Advocate for establishment of high level steering committee in the office of president with involvement of key sectoral ministers supported by a technical committee - Convene periodic multi-sectoral high level political advocacy (and periodic re-advocacy) events at national and sub-national levels.
3.2 Mobilization of national resources for public nutrition	- Establish an annual public nutrition budget line within the MoPH budget
3.3 Seek international support for preventive and curative nutrition interventions	- Engage the international donor agencies so as to help align their support with the Public Nutrition Strategies of the MoPH.

Component 4: Improve multi-sectoral coordination to help increase coverage of quality nutrition-specific and nutrition-sensitive interventions.

Strategic approaches through 2020:

Strategy	Strategic Approaches
4.1 Operationalize the Nutrition Action Framework (NAF)	- Renew collaboration with the already involved ministries and also engage the Ministry of Economy and Ministry of Women's Affairs to finalize the NAF and start its implementation under the auspices of the Office of the Vice-President - Closely collaborate with relevant units of MoPH and other ministries toward the implementation of their nutrition-sensitive strategies and interventions. - In collaboration with the relevant ministries, implement a feasible system to track the implementation and impact of the NAF strategies on an on-going basis. - Regularly inform the Cabinet of Ministers on the NAF related programs and interventions.
4.2 Design, implement, monitor and evaluate Nutrition-sensitive interventions in coordination and collaboration with other sectors	- Strengthen coordination with MAIL toward the implementation of AFSANA. - Design, implement and monitor "conditional cash transfer" approaches to enable very low income families to access fortified foods, micronutrient powders, vitamin/mineral supplements,safe water, and preventive nutrition services especially for pregnant women and children <24 months old. - Improve coordination and collaboration with the WASH program of MoPH and relevant units of MRRD such that their water and sanitation interventions include promotion of appropriate dietary practices (based on the Food Based Dietary Guidelines and cost of a nutritious diet in Afghanistan). - Implement sustained health communication strategies to promote appropriate hygiene practices and seeking deworming services per MoPH guidance. - Sustain high coverage of pediatric measles vaccinations and vitamin A supplementation and consistently promote such practices among the general population. - Implement sustained health communication strategies to inform the population of symptoms of pediatric pneumonia and

	encourage them to seek appropriate health care services for their affected children. - Strengthen collaboration with the MoE to ensure that all school feeding programs require the use of hygienically prepared and distributed foods made with fortified ingredients. - Collaborate with national and regional religious leaders, the Ministry of Justice (MoJ) and Ministry of Women's Affaires (MoWA) to promote the role of women in establishing a stronger family and society, and the importance of good nutrition in ensuring the well-being of women, and thus, families and communities. - Work with the appropriate entities within MoPH, MAIL (especially, the Food and Drug Administration, when it is established) and city and provincial municipal governments, international donor agencies, to develop enforceable laws and regulations, as well as quality control monitoring capacity and operational protocols at central and provincial levels related to the safety and quality of foods at each level of food chain (production, process, transport, storing, preparation and consumption). - Actively engage relevant medical and allied health professional associations and organizations to incorporate appropriate preventive and therapeutic nutrition services as a component of their health services provision.

Component 5: Develop human resource capacities in planning, implementation and evaluation of nutrition interventions and strengthening the role and capacity of the PND.

Strategic approaches through 2020:

Strategy	Strategic Approaches
5.1 All allied health personnel responsible for delivery of nutrition services through health system provision must successfully complete a competency-based training program.	- Develop and implement MoPH-accredited competency-based certification programs in preventive and therapeutic nutrition service delivery for allied health professionals to be administered by relevant public and private academic and professional training institutions. - Establish continuing education requirements to maintain "certification" as a nutrition services provider.
5.2 Strengthen the capacity and role of PND within MoPH	- Upgrade the administrative level of PND to Directorate level within MoPH. - Establish a dedicated annual budget line for PND. - Increase the number of Nutrition Officer posts at the central and provincial levels based on a review of the required workload, and explore the need for, and feasibility of, sub-provincial posts in some parts of the country. - Establish a competency-based in-service training approach for National and Provincial Nutrition Officers, with mandatory continuing education requirements.
5.3 Improve the nutrition component of the pre-service curriculum for medical, nursing and other relevant	- In collaboration with the Ministry of Higher Education (MoHE), assistpublic and private medical universities and allied health institutes to update and improve their nutrition curricula.

health personnel training institutions.	
5.4 Develop and advocate for academically trained nutrition professionals	In the short term: - Encourage and support scholarship applicants to obtain graduate degrees in nutrition. - Support qualified candidates to undertake accredited degree education in public nutrition i.e. online or in-campus - In collaboration with a foreign institution, establish Associate Degree program in nutrition that could lead to certification as a "Dietetic Technician" following a clinical internship. - establish positions within the PND at the central and provincial levels that require a nutrition certificate, and require BPHS and EPHS implementers to do the same. In the medium term: - In collaboration with one or more foreign institutions, establish a bachelor degree program in nutrition that could also lead toward certification as "Registered Dietitian" following a 1-year clinical internship program. - establish positions within the health system which require academic degrees in nutrition, and encourage other public entities (e.g. MAIL, MoE, MoWA, etc.) to do the same. In the long-term: - Support the establishment of in-country graduate nutrition degree programs.

Component 6: Strengthen the national capacity to track the quality, coverage and impact of public nutrition interventions and services to guide future policies and strategies.

Strategic approaches through 2020:

Strategy	Strategic Approaches
6.1 Establish a national Nutrition Monitoring and Surveillance System (NMSS)	- Improve the quality of the nutrition program related data through the HMIS - Establish/ strengthen Nutrition Monitoring and Surveillance System to track and assess the quality, coverage and impact of public nutrition interventions in the long-term through an appropriate combination of non-probabilistic (e.g. sentinel site approach and convenience sampling approach) and probabilistic (i.e. statistical survey approach) data collection methods. - Improve the data management capacity of the PND
6.2 Improve administrative monitoring of nutrition service delivery through BPHS and EPHS	- Strengthen coordination with relevant units of the MoPH toward routine monitoring and supportive supervision of nutrition services in by BPHS and EPHS facilities(including appropriate use of the Basic Score Card and Nutrition Program Monitoring Checklists).
6.3 Establish a National Institute of Nutrition to serve as a "center of excellence" in public nutrition science, research and evidence-based policy development	- Establish collaborative partnerships and academic exchange programs with similar institutions in other countries - Strengthen capacity in applied public nutrition research and in evaluation of on-going interventions as well as pilot projects before their scale-up, and formative researches

INVOLVEMENT OF OTHERS

A. Partnerships within the MoPH

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

Table 7. Coordination with other departments of MOPH

Departments of MoPH	Nutrition Related Responsibilities	Key Nutrition Related Roles	Related Role of PND	Coordination Mechanism
Child and Adolescent Health (CAH)	Integrated Management of Childhood Illness (IMCI)	Overall leadership, guidelines development, and implementation monitoring	Technical support, oversight and review of nutrition components of IMCI	General Directorate (GD) of Preventive Medicine, Child Health Taskforce, and ad hoc meetings
Community-Based Health Care (CBHC)	Nutrition services provided by Community Health Workers (CHWs)	Overall leadership, guidelines development, and implementation monitoring	Technical support, oversight and review of nutrition components of CBHC	GD of Preventive Medicine, CBHC Taskforce
Immunization	High dose vit. A supplementation and deworming	Vitamin A supplementation and deworming during National Immunization Days (NID)	Technical support and monitoring of intervention coverage	GD of Preventive Medicine, EPITaskforce
Reproductive Health	Iron/folic acid supplementation for pregnant and lactating women, and IYCF promotion	Monitoring and capacity building	Technical support, development of strategies guidelines, and IEC materials, and monitoring coverage of nutrition interventions	RH Taskforce
Health Promotion	Behavior change communication (BCC)	Developing BCC messages, fund raising for BCC, relationship with media and production companies, and	Technical support related to development of nutrition messages, and monitoring	Health Promotion Taskforce

Departments of MoPH	Nutrition Related Responsibilities	Key Nutrition Related Roles	Related Role of PND	Coordination Mechanism
		monitoring delivery of BCC messages	coverage of BCC efforts	
Food and Drug Quality Control Laboratory	Quality control ofhygienic safety and micronutrient composition of foods (e.g. fortified foods, therapeutic foods, infant formulas)	Laboratory-based Quality Control monitoring of food products	Technical support, providing food samples for testing,interpreting results and coordination with fortified food production and importing firms	Food Safety and Quality Working Group
GCMU	Coordination with BPHS implementing NGOs	Managing contracts, monitoring and coordination	Technical support to NGOs in implementation of nutrition components of BPHS and monitoring quality and coverage of nutrition services	EPHS/BPHS coordination workshops and ad hoc meetings
Curative Medicine	EPHS and in-patient treatment of SAM, implementation of Baby Friendly Hospital Initiative	Overall leadership in hospital care services	Technical support, ensure availability of therapeutic food items, and monitoring service delivery	Ad hoc meetings and workshops
Policy and Planning	Strategic planning, developing procedures and ToRs based on regulations	Processing reports, follow up of MoPH plan, processing approval of procedures and ToRs based on national regulations	Provide annual implementation plans, reports, draft procedures and ToRs related to nutrition	Ad hoc meetings and workshops
Afghanistan National Public Health Institute (ANPHI)	Nutrition surveillance, surveys, and research	Leading implementation of Disease Early Warning Surveillance(DEWS), and Institutional Review Board (IRB)	Implementation and sharing findings ofNutrition Monitoring and Surveillance System, and seeking IRB approval for research/surveys and studies IRB	Nutrition Surveillance Taskforce, ad hoc meetings and workshops
Environmental Health	Food safety and quality	Monitoring and inspection of markets for safety and quality of food (other than special foods[23])	Monitoring and inspection of special foodsat the production and market level; Certification and authorization of use of fortification logo for special foods	Food Safety and Quality Working Group
Health Law &Regulations	Enforcement of regulations (fortified food	Legal monitoring of private and public institutions and enforcement of	Technical support, coordinating and providing evidence toward	Need based meetings

[23] Special foods are fortified foods, infant formula and therapeutic foods.

Departments of MoPH	Nutrition Related Responsibilities	Key Nutrition Related Roles	Related Role of PND	Coordination Mechanism
Enforcement Dept.	and code of BMS)	relevant nationallaws and regulations	disciplinary measures	
Human Resource	Employment services, and capacity building	Employment and management of civil service employees, and regulating capacity building programs	Developing ToRs for relevant PND positions, supporting HR management in recruitment process, and PND staff capacity building	Capacity Building Committee and ad hoc meetings and workshops
Pharmacy	Micronutrient supplements and therapeutic foods	Developing national lists of licensed and essential nutrition products	Technical support and development ofpharmacy related guidelines for nutrition items	National Food and Drug Board

B. Other Ministries and Government Agencies

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

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

Ministry/ Government Agency	Nutrition Related Responsibilities	Key Nutrition Related Roles	Related Role of PND	Recommendations
MoF	Taxation and customs control of imported foods budget allocation	Represented on the National USI Board, and the National Committee on Code of BMS	Engagement with Customs Department regarding enforcement of fortification laws to imported foods, and providing information on PND budgetary requirements	Current level of coordination is not satisfactory and should be improved
MoEc	Strategic planning and advocacy for the role of nutrition in national economic development	To be developed; could be engaged in NAF	To be developed	Need to clarify roles and responsibilities
MoE	Incorporation of nutrition into subject-specific curriculum;	NAF	To be developed	Implement NAF

Ministry/ Government Agency	Nutrition Related Responsibilities	Key Nutrition Related Roles	Related Role of PND	Recommendations
	provision of nutritious foods through school meals			
MAIL	Food security and food safety(of unprocessed food)	NAF and AFSANA	Coordination and collaboration with strategies and activities of Home Economics Department	Implement NAF and renew existing MoU on food safety
MoCI	Regulation and control of domestic and imported fortified foods and fortified food industry related materials and equipment	NAF, National Board on Iodized Salt, National Committee on Code of BMS	To be developed	Implement NAF and specify roles and responsibilities
MRRD	Water, sanitation and hygiene in rural communities	NAF	To be developed	Implement NAF and specify roles and responsibilities
MoRA	Public awareness building through religious leaders and facilities	National Committee on Code of BMS	To be developed	Strengthen the follow up of existing TOR
MoWA	Women's empowerment and nutrition education	To be developed	To be developed	Clarify roles, responsibilities and need for technical support
MoLSAMD	Safety net and nutrition education through targeted programs; maternity protection	To be developed; could be involved in NAF	To be developed	Clarify roles, responsibilities and need for technical support
MoJ	Developing national laws and regulations	Based on need	Provision of information as needed	Strengthen coordination
MoI	Enforcement of food laws and regulations	National Board onIodized Salt; National Committee on Code of BMS	Collaborate with Health Department of MoI	Strengthen coordination andfollow up of existing TORs

Ministry/ Government Agency	Nutrition Related Responsibilities	Key Nutrition Related Roles	Related Role of PND	Recommendations
ANSA	Development of fortified food standards	National Board onIodized Salt; National Committee on Code of BMS; Food and Drug Board	Collaborate with Standards Development Department	Strengthen coordination
Municipalities	Monitoring of national regulations (e.g. Code of Marketing of BMS, USI) at the market level	National Board onIodized Salt; National Committee on Code of BMS	Collaborate with Environmental Health Unit	Strengthen coordination, especially at the provincial level

C. Non-Government Partners

Table as above;

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

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

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

Stakeholders	Organizations	Key Nutrition Related Activities	Coordination mechanisms	Recommendations
United Nation Organizations	Unicef	IYCF, treatment of SAM, maternal and adolescent nutrition, Community based surveillance, technical support to PND	Annual plan, nutrition cluster, several other mechanisms	Involvement of PND as co-lead of nutrition cluster
	WHO	Inpatient treatment of SAM, facility based surveillance, food safety and quality, IYCF	Annual plan, nutrition cluster, several other mechanisms	Involvement of PND in the health cluster coordinate the two mechanisms
	WFP	Treatment of MAM, maternal nutrition, promotion of fortified food	Annual plan, nutrition cluster, several other mechanisms	Develop comprehensive annual plan
	FAO	Food based dietary guideline, food diversification	National committee on FBDG	Develop comprehensive annual plan
	UNOCHA	Supporting nutrition in emergency	Nutrition Cluster	Involvement of PND in the decision process
Development Partners	World Bank	BPHS/EPHS, system strengthening, nutrition communication/ advocacy	Nutrition Program Coordination Committee	Appreciation of stewardship role of PND in the sector

	USAID	In-service training, multi-sectoral approach to improve nutrition, nutrition in emergency, strengthening nutrition in BPHS	NPCC	Involvement of PND in the management of projects
	European Union	Pre-service training, strengthening nutrition in BPHS, community based nutrition	NPCC	Involvement of PND in the management of projects
	Canada – DFATD	Nutrition surveillance, strengthening nutrition in BPHS through Save the Children and World Vision	NPCC, Project Steering Committee meetings	Appreciation of stewardship role of PND in the sector
	DFID	Nutrition in emergency, agriculture	No mechanism	Need to establish mechanism
	GAIN	Supporting private sector in producing fortified food	NPCC, annual plan, MOU	Comprehensive annual plan and MoU
International NGOs	MI	Provision of Vitamin A supplies, supporting food fortification, zinc supplementation and IYCN	NPCC, MOU	Comprehensive annual plan and MoU
	AKDN	Multisectoral approach to nutrition, diploma course in nutrition	Project Steering Committee, technical sub committee	Comprehensive annual plan and MoU
	NEI	Production and promotion of Soy products	Ad hoc	Comprehensive annual plan and MoU
	IBFAN	Supporting IYCF	Annual breastfeeding forum	Comprehensive annual plan and MoU
BPHS/EPHS implementers		Public nutrition component of BPHS and EPHS, implementation of nutrition in emergency	BPHS/EPHS coordination meeting, GCMU	Strengthen through GCMU
Food industry	Iodized Salt Production companies	Producing Iodized salt	National Board on USI, quarterly meetings	Strengthening it by more involvement of other sectors

	Fortified flour producers/ importers	Producing/ importing fortified flour	Ad hoc	Need to establish national board of food fortification
	Fortified Oil Producers/ importers	Production/ importing fortified vegetable oil	Ad hoc	Need to establish national board of food fortification
	Special food producers/ importers	Production of Micronutrients powder, LNS, fortified supplementary food	Not clear	Need to establish a working mechanism
Others	Academia	Training, education and research	Not established	Need to establish a working mechanism
	Mass Media	Broadcasting nutrition communication messages	Ad hoc	Need to establish a working mechanism

COORDINATION MECHANISM

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

Table 10. Coordination mechanisms

Coordination Mechanism	Chaired by/ secretariat	Key participants*	Meeting Frequency	Main Areas of Work	Recommendation
High level committee on nutrition	2nd Vice-President	Ministers of health, economy, agriculture, rural rehabilitation and development, education, commerce and industry	Semi-annually	Multi-sectoral NAF	Support of the Minister of Public Health is need to help activate the NAF
National Board	Minister or	Representatives of MoF,	Semi-annually	Mandatory salt	Already active, based on

on Universal Salt Iodization	deputy minister of public health/PND	MoMP, ANSA, MoCI, MoI, MoICY, MAIL, technical agencies (UNICEF, GAIN, MI) and Afghanistan Iodized Salt Producers' Association (AISPA)		iodization	national regulation on salt iodization To be changed to National Board on Food Fortification once the food fortification law is promulgated, and representatives of additional Food Fortification Alliance members can be added
National Committee for Promotion and Protection of Child Nutrition With Breast milk	Minister or deputy minister of public health/ PND	MoCI, MoF, MoI, Municipality, MoWA, MoRA, MoICY, tehnical agencies (Unicef)	Semi-annually	Regulating the marketing of BMS	Already active, based on national regulation on promotion and protection of child nutrition with breast milk (Cod of Marketing of BMS)
Nutrition Program Coordination Committee	PND Director/PND	Donor agencies, UN agencies, technical agencies (MI, GAIN)	Monthly	Strategic directions on nutrition programs	To be appreciated and supported by the leadership of the MoPH
Nutrition Cluster	UNICEF	Bi-lateral donor agencies, UN agencies, NGOs, PND	Monthly	Nutrition in emergency	PND to gradually take the lead
NAF technical meetings	PND Director/PND	Technical representatives of ministries involved in NAF	Quarterly	Multi sectoral NAF	Needs support from the highest levels of related Ministries
Technical Working Groups	PND Director/PND	NGOs, UN agencies, private sector, donors, other technical departments of MoPH	Quarterly and as needed	Separate groups for: IYCF, IMAM, Micronutrients, Assessment, Surveillance, Trainings	Strengthening involvement of relevant partners

*In addition to MoPH and PND.

IMPLEMENTATION

A. Annual Action Plans

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

B. Nutrition Program Monitoring, Surveillance and Evaluation

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

- Improve its system for administrative monitoring of the implementation of nutrition services through BPHS and EPHS implementing facilities.
- Implement the Nutrition Monitoring and Surveillance System (NMSS) that is being developed with funding support of CIDA and technical support of WHO and UNICEF, and is expected to track the quality, coverage and impact of large-scale nutrition interventions in the country.

The indicators to be tracked are presented in the Targets and Indicators section above.

C. Costed Implementation Plan

A costed plan for the implementation and monitoring and evaluation of this Public Nutrition Strategy in 2015 is developed as follow: .

Table 11. Implementation Plan 2015-2020

No	ACTIVITIES	KEY PARTNERS	TARGET	DELIVERABLES	MEANS OF VERIFICATION	TIMELINE						BUDGET 1000 USD
						2015	2016	2017	2018	2019	2020	
1	**STRATEGIC COMPONENT 1: Implement evidence-based nutrition-specific interventions**											
1.1	**Strategy 1: Improve Infant and Young Child Feeding and caring Practices**											
1.1.1	Expanding the Baby Friendly Hospital Initiative	**Unicef, BPHS/EPHS implementers**	**128**	**Certificate**	**assessment**	28	20	20	20	20	20	
1.1.2	Promoting and supporting early and exclusive breastfeeding until 6 months, including among working mothers	**Unicef, BPHS/EPHS implementers**	**EIBF: >70% EBF: >60%**		**Household survey**							
1.1.3	Developing national standards to regulate the sale of breast milk substitutes and enforce of the code of marketing of breast-milk substitutes.	**Unicef, WHO**	**National Regulation revised, enforced**									

1.1.4	Strengthening coordination with the Ministry of Labor, Social Affairs, Martyrs & Disabled (MoLSAMD) to encourage "breast-feeding friendly" worksites, maternity leave for lactating mothers in first few months post-partum, and to ensure that young age children are appropriately fed and cared for within day care facilities	**MoLSAM, Unicef**	**>80 % respected**									
1.1.5	Promoting timely introduction of nutrient-rich complementary foods for infants, and provision of age-appropriate home-made complementary foods fortified with multi-micronutrient powders, or commercially produced fortified complementary foods that meet national standards.	**Unicef, GAIN, MI, WHO, BPHS Implementers**	**>40%**									
1.1.6	Developing and enforcing regulations for the sale of industrially produced fortified complementary foods through the retail sector	**BMS National committee**	**Included in the revised Regulation**									
1.2	**Strategy 2: Improve maternal nutrition**											
1.2.1	supplementing multi-micronutrient supplements for pregnant and lactating women through public and private health care providers	**RH, BPHS/EPHS implementers**	**>40%**		**household survey**							
1.2.2	Promoting appropriate weight gain during pregnancy.	**RH, BPHS/EPHS implementers**	**?**									
1.2.3	Supplementing food for pregnant and lactating women with undernutrition in food insecure area	**WFP/ BPHS Implemnters**	**>70%**									

1.2.4	Promoting balanced and micronutrients rich diet for pregnant and lactating women	**FAO, BPHS Implementers**	**>40%**									
1.3	**Strategy 3: Micronutrient and dietary supplementation of adolescent females and women of childbearing agedeficiency prevention and treatment**											
1.3.1	Developing and implementing guidance on multi-micronutrient supplementation for non-pregnant adolescent girls and adult women	**Unicef, MoE**	**> 60%**									
1.3.2	Developing and implementing protocols to screen and treat 6-24 month old for anemia	**Unicef, CAH,**	**> 20% treated**									
1.3.3	Standardizing the implementation of iron/folic acid supplementation for pregnant and lactating women among BPHS implementers and private health care providers.	**BPHS Implementers , Private sector**										
1.3.4	Developing and implementing national clinical guidelines for preventive micronutrient supplementation of all low birth-weight and preterm infants (per WHO recommendations) through BPHS and private sector physicians	**Unicef, CAH, RH, WHO**	**?**									
1.3.5	Improving semi-annual vitamin A supplementation for children 6-59 months old	**EPI, MI, Unicef**	**> 95% coverage**									

1.3.6	Promoting zinc supplementation as adjunct to diarrheal disease treatment in children <59 months old through BPHS and promote such practice among private health care providers	**CAH, BPHS Implementers**	**>60% coverage**									
1.3.7	Strengthening the existing mandatory of salt iodization program and explore feasible approaches to increase availability of iodized salt in low coverage areas of the country.	**GAIN, MI, Unicef, Private sector**	**> 90% coverage**									
1.3.8	Promulgating and enforcing mandatory law on fortification of industrially milled domestic and imported flour with iron, zinc, folic acid and vitamin B12 (per WHO recommendation) in a collaborative manner with domestic industrial flour mills and flour importers.	**GAIN, MoJ, ANSA, Private secgtor**	**> 80% coverage**									
1.3.9	Promulgating and enforcing mandatory law on fortification of industrially produced domestic and imported vegetable oil and ghee with vitamins A and D in a collaborative manner with domestic producers and importers.	**GAIN, MoJ, ANSA, Private secgtor**	**> 80% coverage**									
1.3.10	Promoting use of national food based dietary guideline among families as well as other social institutions	**FAO,**	**> 50% knowledge**		**KAP survey**							
1.3.11	Establishing an on-going legal QA/QC monitoring system to help ensure that domestically produced and imported fortified foods meet national standards.	**FDQD, WFP, GAIN**										
1.4	**Strategy 4: Prevention and treatment of acute malnutrition**											

1.4.1	Early identification and supplementary feeding of <5 year old children (with a special focus on <2 year olds)with Moderate Acute Malnutrition (MAM) (including use of domestically produced lipid-based nutritional supplements,and appropriate recipesusing local ingredients and products for home-based hygienic preparation of energy-dense and nutrient-rich foods).		**> 70% coverage**										
1.4.2	Integrated management of <5 year old children (especially those <24 months old) with Severe Acute Malnutrition (SAM) through in-patient and out-patient treatment.		**> 70% coverage**										
1.4.3	Promoting locally prepared food recipes for treatment of MAM and prevention of SAM based on local feasibility studies.												
1.5	**Strategy 5: Nutrition interventions during emergencies**												
1.5.1	Promoting appropriate infant and young child feeding, especially breastfeeding among infants and feeding of hygienically prepared complementary foods, in the light of national BMS code	**Nutrition Cluster**	**> 90% coverage**										
1.5.2	Conducting blanket and targeted food distribution and micronutrient supplementation, as appropriate.	**Nutrition Cluster**	**> 40%**										
1.5.3	Enabling the affected population to have access to safe water and soap.	**Nutrition Cluster**	**> 70%**										

1.5.4	Establishing protocols for screening and rapid identification and appropriate treatment of <5 year old children, especially those <24 months old, with various degrees of acute malnutrition.	**PND**	**> 90%**										
1.6	**Strategy1.6: Strengthening implementation of public nutrition component in the BPHS and EPHS**												
1.6.1	Developing necessary guidelines, standard operation procedures and job aids to BPHS and EPHS staff	**BPHS Implementers , GCMU**	**for all components**										
1.6.2	Technical support, monitoring, supportive supervision, mentoring and follow up with health staff		**80% staff**										
1.6.3	Encouraging and supporting innovations in provision of nutrition specific services		**all provinces**										
2	**STRATEGIC COMPONENT 2: Inform the public about the role of nutrition in physical health and cognitive development, and promote dietary practices to prevent malnutrition**												
2.1	**Strategy 2.1: Ongoing and strategic promotion of appropriate food and nutrition practices, with a special focus on improving the nutritional status of adolescent girls, mothers and infants and toddlers.**												

2.1.1	Monitoring growth of children <5 years old, especially those <24 months old, accompanied with appropriate counseling, through primary health facilities and communities.		**> 70% for U2 > 50% for U5**									
2.1.2	Developing and broadcasting nutrition and dietary behavior change and social marketing messages related to improving the growth and development of children, based on population-specific formative studies		**> 70% knowledge/Practic e**		**KAP survey**							
2.1.3	Strengthening the ability of maternal and child health care providers to deliver appropriate preventive and therapeutic food and nutrition messages to their patients.		**> 80% staff**									
2.1.4	Developing and promoting healthy recipes for special groups of population		**based on need**									
2.1.5	Engaging relevant national and local civic organizations and the mass media to regularly deliver nutrition information and promotion messages as a component of social responsibility of their businesses.											
2.1.6	Developing nutrition topics for elementary and secondary school teachers to incorporate into subject-specific curricula,		**1-12 grade**									
2.1.7	Implementing nutrition communication and social marketing, based on appropriate formative studies, to promote th enational Food Based Dietary											

	Guidelines.											
2.1.8	Inclusion of nutrition education in different social programs, such as literacy for life, Life skill education, cash transfer, community development, and other development activities		**> 80% programs**									
2.1.9	Promoting proper nutrition and care during the first 1000 days of life, through mass communication and campaigns		**2 rounds/ year**									
3	**STRATEGIC COMPONENT 3: Advocate for public nutrition policies and adequate resources**											
3.1	**Strategy 3.1Advocacy and awareness building among high level government and private sector leaders**											
3.1.1	Developing an estimate of benefit-to-cost ratio of feasible large-scale public nutrition interventions (as awareness building and advocacy tool for national policy makers).		**1 study**									
3.1.2	Regularly advocating to cabinet of ministers regarding public nutrition programs and successes in Afghanistan, especially from a perspective of national development.											
3.1.3	Convening periodic multi-sectoral high level political advocacy (and periodic re-advocacy) events at national and sub-national levels.		**2 meeting/ year**									

3.2	**Strategy 3.2: Mobilization of national resources for public nutrition**											
3.2.1	Establishing an annual public nutrition budget line within the MoPH budget		**annual budget**									
3.3	**Strateg 3.3: Seek international support for preventive and curative nutrition interventions**											
3.3.1	Engaging the international donor agencies so as to help align their support with the Public Nutrition Strategies of the MoPH.		**100%**									
4	**STRATEGIC COMPONENT 4: Improve multi-sectoral coordination to help increase coverage of quality nutrition-specific and nutrition-sensitive interventions**											
4.1	**Strategy 4.1: Operationalize the Nutrition Action Framework (NAF)**											
4.1.1	Renewing collaboration with the already involved ministries and also engage the Ministry of Economy and Ministry of Women's Affairs to finalize the NAF and start its implementation under the auspices of the Office of the Vice-President		**2 meeting/ year**									
4.1.2	Closely collaborating with relevant units of MoPH and other ministries toward the implementation of their nutrition-sensitive strategies and interventions											

4.1.3	In collaboration with the relevant ministries, implementing a feasible system to track the implementation and impact of the NAF strategies on an on-going basis.		**semi annual monitoring**									
4.1.4	Regularly informing the Cabinet of Ministers on the NAF related programs and interventions.		**semi annual meetings**									
4.2	**Strategy 4.2: Implement, monitor and evaluate Nutrition-sensitive agriculture and food security interventions in coordination and collaboration with other sectors**											
4.2.1	Strengthening coordination with MAIL toward the implementation of AFANSA.											
4.2.2	Designing, implementing and monitoring "conditional cash transfer" approaches to enable very low income families to access fortified foods, micronutrient powders, vitamin/mineral supplements,safe water, and preventive nutrition services especially for pregnant women and children <24 months old.											
4.2.3	Improving coordination and collaboration with the WASH program of MoPH and relevant units of MRRD such that their water and sanitation interventions include promotion of appropriate dietary practices (based on the Food Based Dietary Guidelines and cost of a nutritious diet in Afghanistan).											

4.2.4	Implementing sustained health communication strategies to promote appropriate hygiene practices and seeking deworming services per MoPH guidance.											
4.2.5	Sustaining high coverage of pediatric measles vaccinations and vitamin A supplementation and consistently promote such practices among the general population											
4.2.6	Implementing sustained health communication strategies to inform the population of symptoms of pediatric pneumonia and encourage them to seek appropriate health care services for their affected children.											
4.2.7	Strengthening collaboration with the MoE to ensure that all school feeding programs require the use of hygienically prepared and distributed foods made with fortified ingredients.											
4.2.8	Collaborating with national and regional religious leaders, the Ministry of Justice (MoJ) and Ministry of Women's Affaires (MoWA) to promote the role of women in establishing a stronger family and society, and the importance of good nutrition in ensuring the well-being of women, and thus, families and communities.											

4.2.9	Working with the appropriate entities within MoPH, MAIL (especially, the Food and Drug Administration, when it is established) and city and provincial municipal governments, international donor agencies, to develop enforceable laws and regulations on food safety and quality, as well as quality control monitoring capacity and operational protocols at central and provincial levelsrelated to the safety and quality of foods											
4.2.10	Actively engaging relevant private medical and allied health professional associations and organizations to incorporate appropriate preventive and therapeutic nutrition services as a component of their health services provision.		**> 50% private health care**									
5	**STRATEGIC COMPONENT 5: Develop human resource capacities in planning, implementation and evaluation of nutrition interventions and strengthening the role and capacity of the PND.**											
5.1	**Strategy 5.1: All allied health personnel responsible for delivery of nutrition services through BPHS and EPHShealth system provision must successfully complete a competency-based training program.**											

5.1.1	Developing and implementing MoPH-accredited competency-based certification programs in preventive and therapeutic nutrition service delivery for allied health professionals to be administered by relevant public and private academic and professional training institutions.		**> 70% Public** **> 50% private**									
5.1.2	Establishing continuing education requirements to maintain "certification" as a nutrition services provider.											
5.2	**Strategy 5.2: Strengthen the capacity and role of PND within MoPH**											
5.2.1	Upgrading the administrative level of PND to Directorate level within MoPH.											
5.2.2	Establishing a dedicated annual budget line for PND.											
5.2.3	Increasing the number of Nutrition Officer posts at the central and provincial levels based on a review of the required workload, and explore the need for, and feasibility of, sub-provincial posts in some parts of the country.		**> 100 employees in**									
5.2.4	Establishing a competency-based in-service training approach for National and Provincial Nutrition Officers, with mandatory continuing education requirements.											

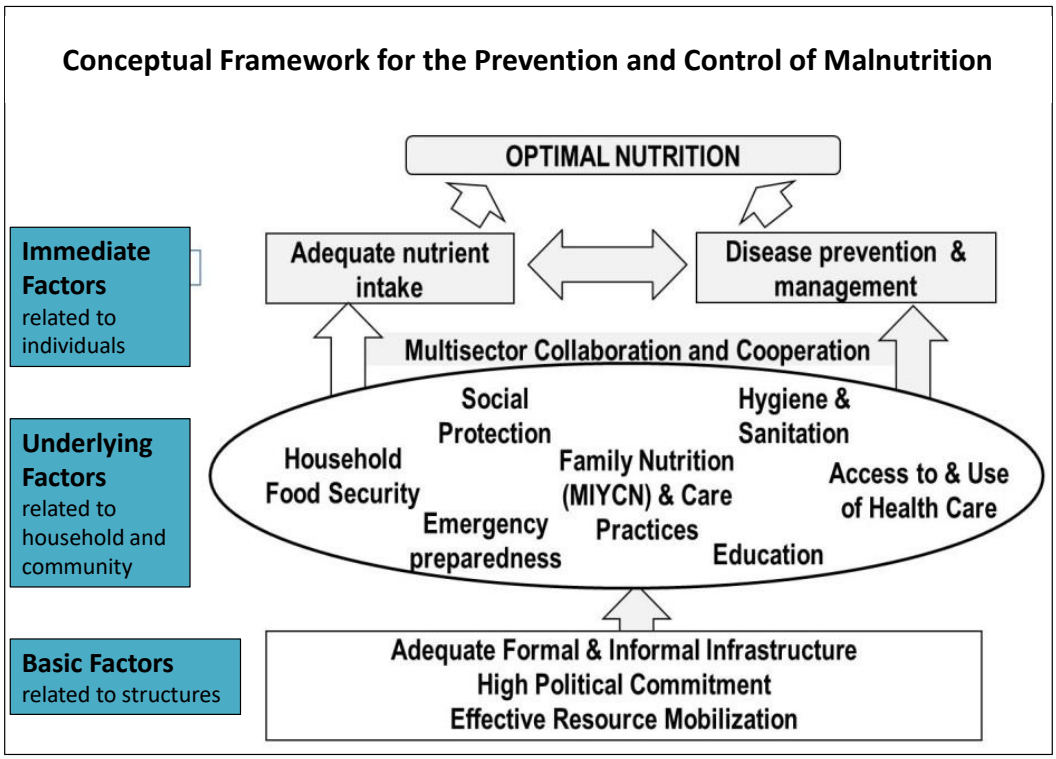
5.3	**Strategy 5.3: Improve the nutrition component of the pre-service curriculum for medical, nursing and other relevant health personnel training institutions.**											
5.3.1	In collaboration with the Ministry of Higher Education (MoHE), assist public and private medical universities and allied health institutes to update and improve their nutrition curricula.											
5.4	**Strategy 5.5: Develop and advocate for academically trained nutrition professionals**											
5.4.1	Encouraging and supporting scholarship applicants to obtain graduate degrees in nutrition.		**10 applicants**									
5.4.2	Supporting qualified candidates to undertake accredited degree education in public nutrition i.e. online or in-campus		**10 applicants**									
5.4.3	In collaboration with a foreign institution, establishing Associate Degree program in nutrition that could lead to certification as a "Dietetic Technician" following a clinical internship.		**1**									
5.4.4	establishing positions within the PND at the central and provincial levels that require a nutrition certificate, and require BPHS and EPHS implementers to do the same.		**1 post/ Health Facility**									

5.4.5	In collaboration with one or more foreign institutions, establishing a bachelor degree program in nutrition that could also lead toward certification as "Registered Dietitian" following a 1-year clinical internship program.		**1 program**									
5.4.6	establishing positions within the health system which require academic degrees in nutrition, and encourage other public entities (e.g. MAIL, MoE, MoWA, etc.) to do the same											
5.4.7	Supporting the establishment of in-country graduate nutrition degree programs		**1 program**									
6	**STRATEGIC COMPONENT 6: Strengthen the national capacity to track the quality, coverage and impact of public nutrition interventions and services to guide future policies and strategies.**											
6.1	**Strategy 6.1: Establish a national Nutrition Monitoring and Surveillance System (NMSS)**											
6.1.1	Improving the quality of the nutrition program related data through the HMIS		**100% reporting**									
6.1.2	Establishing a Nurtion Monitoring and Surveillance System to track and assessthe quality, coverage and impact of public nutrition interventions		**34 provinces reporting**									

6.2	**Strategy 6.2: Improve administrative monitoring of nutrition service delivery through BPHS and EPHS**											
6.2.1	Strengthening coordination with relevant units of the MoPH toward routine monitoring and supportive supervision of nutrition services in by BPHS and EPHS facilities (including appropriate use of the Basic Score Card and Nutrition Program Monitoring Checklists).		**1 joint monitoring/quarter**									
6.3	**Strategy 6.3:Establish a National Institute of Nutrition to serve as a "center of excellence" in public nutrition science, research and evidence-based policy development**											
6.3.1	Establishing collaborative partnerships and academic exchange programs with similar institutions in other countries		**1/year**									
6.3.2	Strengthening capacity in applied public nutrition research and in evaluation of on-going interventions as well as pilot projects before their scale-up		**2/ year**									

APPENDIXES

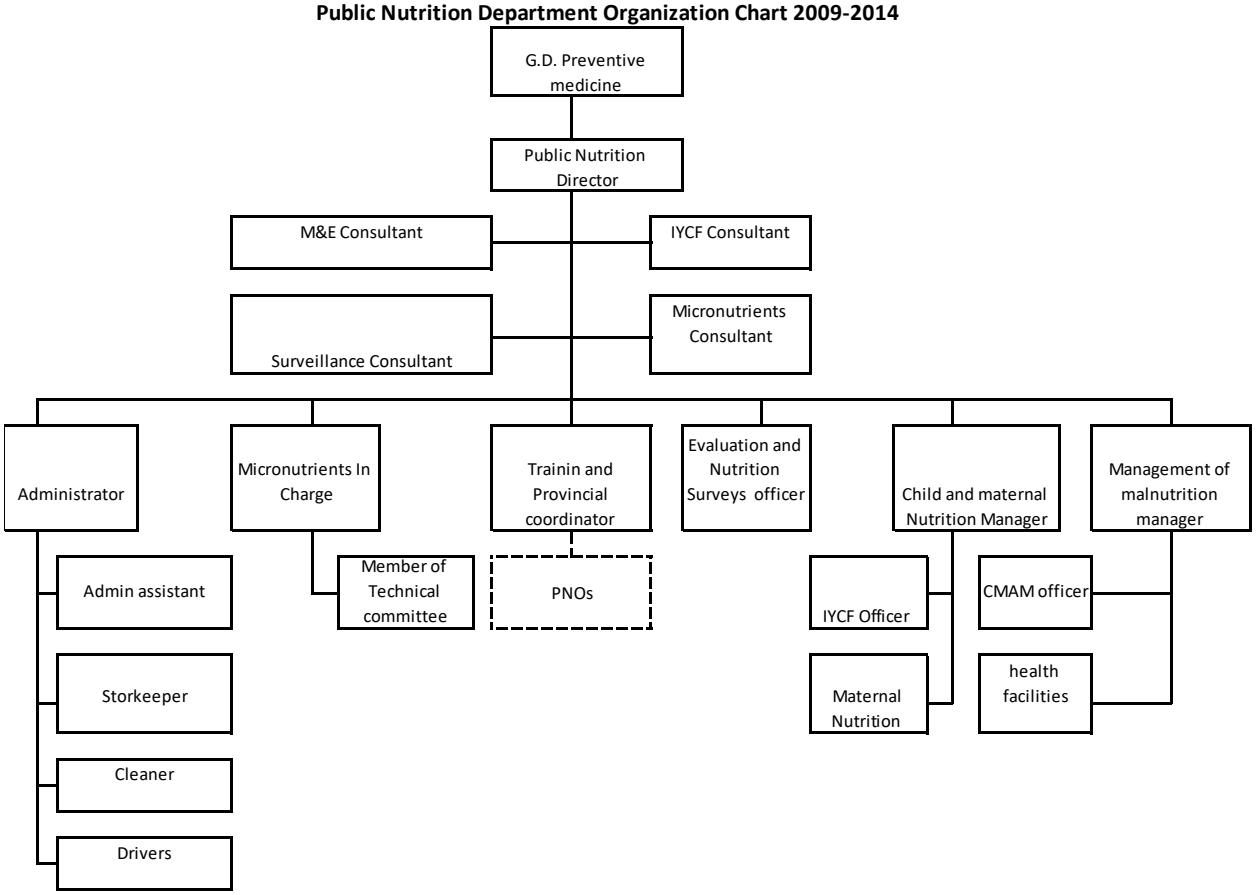
Appendix A



Adapted from: "National Food and Nutrition Policy". Republic of Rwanda; draft, 29 Oct. 2013.

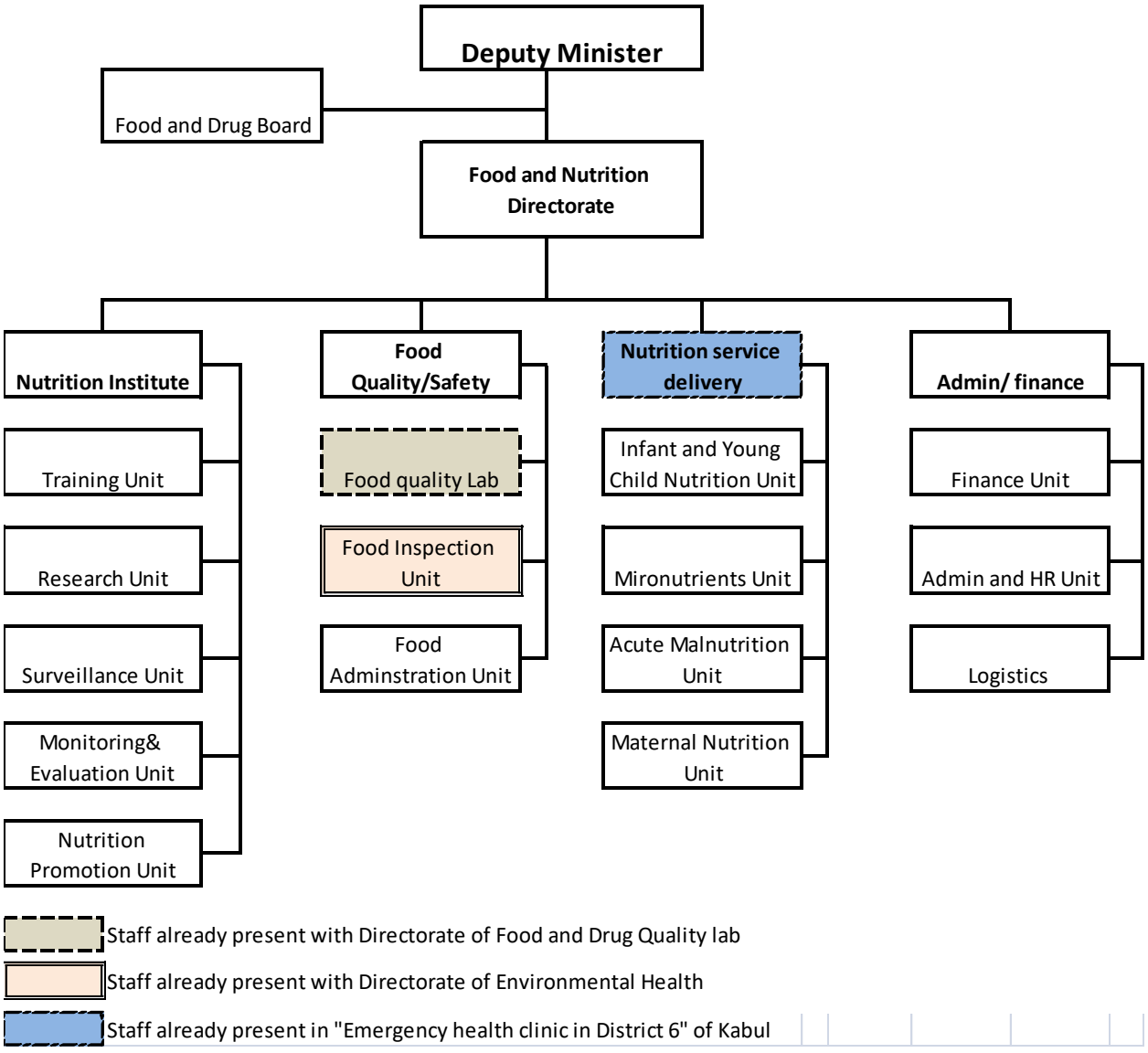
Appendix B

Public Nutrition Department Organization Chart 2009-2014



Appendix C

Proposed Organizational Chart for Food and Nutrition Directorate



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