

Afghanistan



Nutrition Cluster



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Acronyms

BSFP	Blanket Supplementary Feeding Program
BPHS	Basic Package of Health Services
CBNP	Community Based Nutrition Package
CHW	Community Health Worker
CHF	Common Humanitarian Fund
CSO	The Central Statistics Office
DFID	Department for International Development
EPHS	Essential Package of Health Services
HNO	Humanitarian Needs Overview
HRP	Humanitarian Response Plan
IPD	Inpatient Department
IMAM	Integrated Management of Acute Malnutrition
IDP	Internally Displaced person
IOM	International Office of Migration
IYCF	Infant and young child feeding Practices
MAM	Moderate Acute Malnutrition
MoPH	Ministry of Public Health
OPD	Outpatient Department
PLW	Pregnant and Lactating women
PND	Public Nutrition Department
PPHD	Provincial Public Health Department
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SEHAT	System Enhancement for Health Action in Transition
USAID	United States Agency for International Development

Acknowledgement

The lifesaving nutrition assistance provided to about 850,000 children under five and women was made possible by the generous support of Common Humanitarian Fund (CHF), ECHO, Government of Canada, Italian Agency for Development Cooperation, DFID, and the American people through United States Agency for International Development (USAID).



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Afghanistan Nutrition Situation Overview

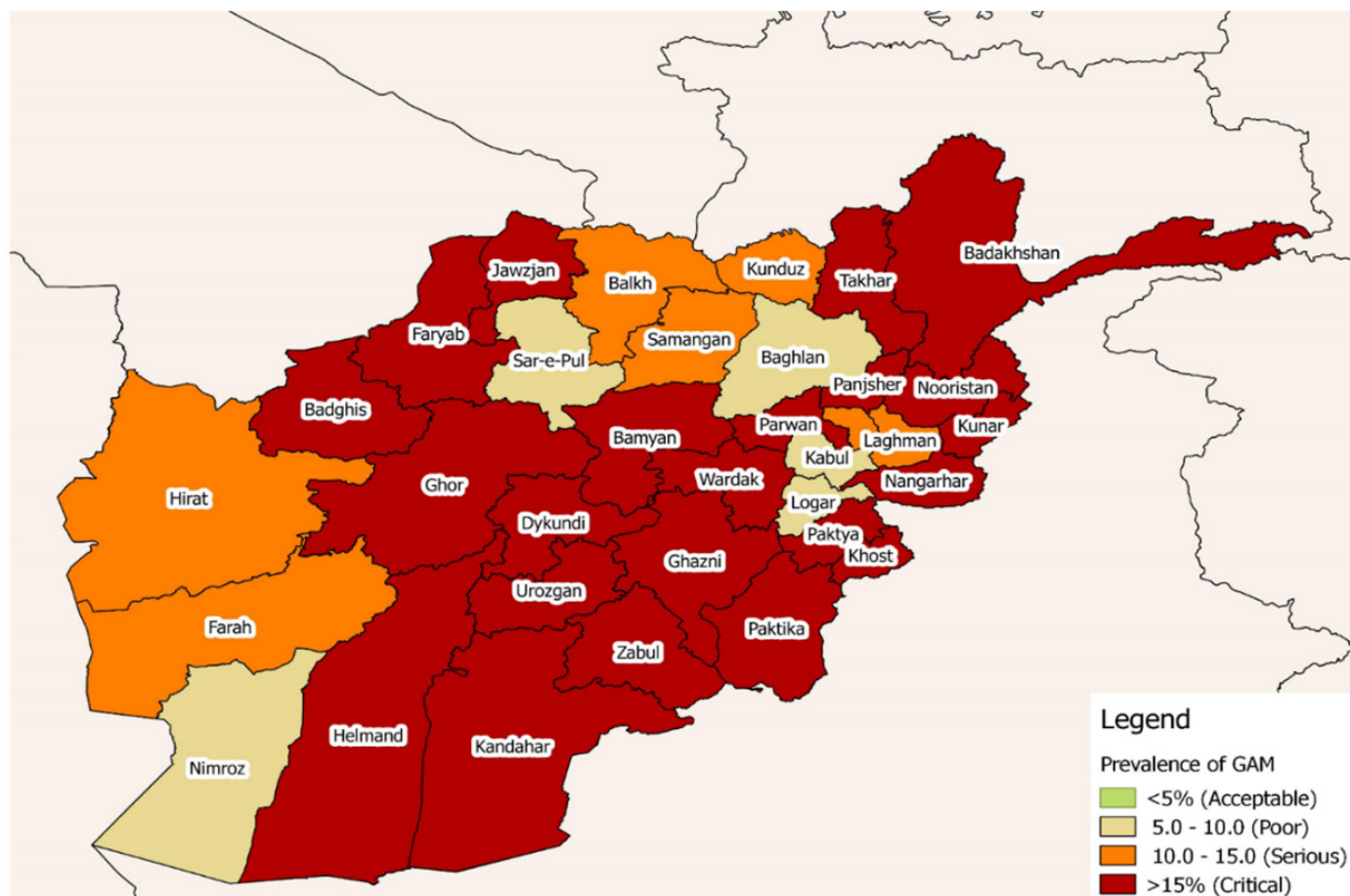
Humanitarian Context

A chaotic and unpredictable security situation, combined with a severe drought, have prompted an almost doubling in the number of people in need in 2019 compared to last year. By end of 2018 more than 550,000 civilians had been displaced and the number of people in need of emergency food assistance reached 3.6 million. In 2019, a total 6.3 million people require some form of humanitarian and protection assistance including 3.7 million in severe and major need due to a convergence of factors arising from exposure to escalating violence, forced displacement, the loss of essential livelihoods and limited access to basic services (OCHA Afghanistan, 2019 HNO).

Nutrition Situation Analysis

The nutritional situation in Afghanistan continues to be alarming. Ongoing conflict, low access to basic services, and impact of natural disasters have exacerbated the existing vulnerabilities of communities, contributing towards high rates of acute malnutrition, which are reflected in severity of acute malnutrition map below.

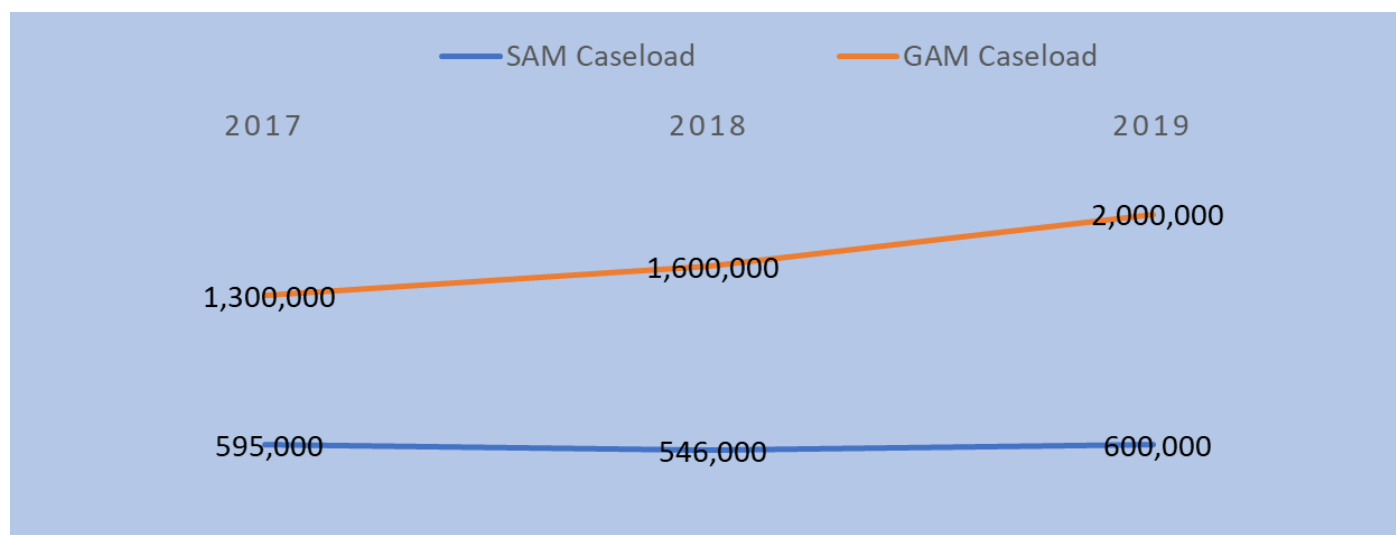
SEVERITY OF ACUTE MALNUTRITION IN AFGHANISTAN ,DECEMBER,2018



The findings of most recent nutrition surveys across Afghanistan show that 22 out of 34¹ provinces are currently above the emergency level threshold of acute malnutrition based on WHO classification of wasting rates for children under the age of five (global acute malnutrition (GAM) ≥ 10 per cent with aggravating factors)². The impact of drought in 2018 is likely to extend through mid-2019 (next harvest period), further aggravating the poor nutritional situation. Annually, an estimated 2 million children under the age of five and 485,000 pregnant and lactating women (PLW) are affected by acute malnutrition. About 75 percent of acute malnourished children under five are in twenty-two high priority provinces.

Children under the age of five and pregnant & lactating women (PLW) are the most vulnerable population groups to acute malnutrition. Among the 2 million children under the age of five years who are suffering from acute malnutrition in Afghanistan, a staggering 600,000 children (29 percent) are suffering from severe acute malnutrition (SAM), which is the most dangerous form of undernutrition in children. Children suffering from SAM are nine times more likely to die than their healthy peers³ and those suffering from prolonged undernutrition who survive may become locked in a cycle of recurring illness and faltering growth, with irreversible damage to their development and cognitive abilities. Women of reproductive age and adolescent girls affected by undernutrition have adverse effects on their own health as well as later on the birth outcome of infants, such as low birth weight (LBW) infants, causing inter-generational cycle of undernutrition.

NUMBER OF ACUTE MALNOURISHED AND SEVERELY ACUTE MALNOURISHED CHILDREN, 2017-2019



Despite scale up of treatment of acute malnutrition services over the last years, a significant proportion of children with acute malnutrition continue to have no access to treatment. With the scale-up of services by Nutrition Cluster partners, the number of children receiving SAM treatment increased by 18 percent in 2018 compared to 2017. However, in 2018 only about 50 percent of SAM children and 30 percent of moderately acutely malnourished (MAM) children had access to treatment services. To date about 1 million acutely malnourished children under the age of five do not have access to treatment services. This is mainly due to lack of adequate resources and capacity to provide services through decentralized facilities, closer to communities.

1 million acutely malnourished children under the age of five do not have access to treatment services.

1 Badakhshan, Badghis, Bamyan, Dykundi, Farah, Faryab, Ghazni, Ghor, Helmand, Jawzjan, Kandahar, Khost, Kunar, Nangarhar, Nuristan, Paktika, Paktya, Parwan, Takhar, Urozgan, Wardak, Zabul

2 http://www.who.int/diseasecontrol_emergencies/publications/idhe_2009_london_malnutrition_fenn.pdf

3 https://www.unicef.org/nutrition/index_sam.html

CHILDREN AFFECTED BY SEVERE ACUTE MALNUTRITION ACCESSING TREATMENT SERVICES IN AFGHANISTAN, 2016-2018



In Afghanistan, chronic vulnerability and undernutrition significantly overlap. Emergency needs must be addressed while building resilience and sustaining gains achieved by development interventions. A significant proportion of children suffer from various forms of undernutrition - 41 percent of children under the age of five years are chronically malnourished and 45 percent are anaemic (Afghanistan National Nutrition Survey, 2013). While humanitarian response primarily focuses on life saving, services also contribute towards mitigating the risk of undernutrition globally. Longer term development is essential to improve and sustain the nutritional status of families and communities affected by undernutrition. Strengthening community and health systems is key to building the resilience and ability of households to absorb sudden shocks and recover. The fight against undernutrition can only be won through concurrent investment in prevention activities that ensure proper nutrition, health services, safe drinking water and sanitation, livelihood and income opportunities, education, and other social services. Achieving a sustained reduction in undernutrition rates is an important indicator of improvement in equitable access and quality of basic social services. The complementarity of the humanitarian and development initiatives is vital to ensure that basic needs of women and children are met in the short and longer term.

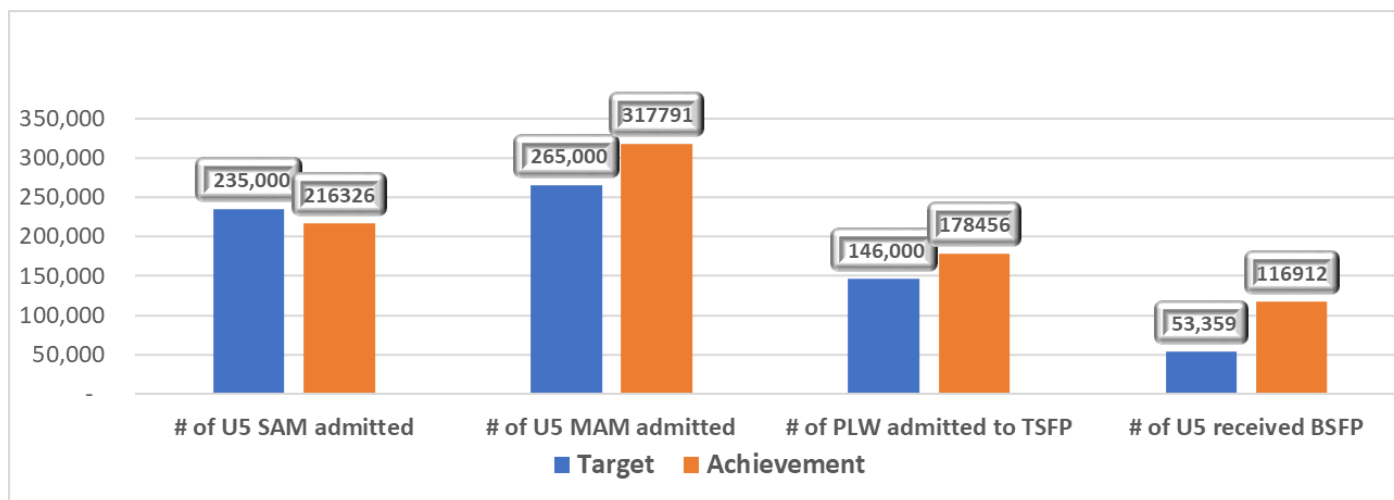
Nutrition Cluster 2018 Humanitarian Response Plan (HRP) Achievements

In 2018 Afghanistan Nutrition Cluster partners targeted to reach 708,818 children under the age of five and pregnant and lactating women (PLW) through life saving and preventive services in high priority districts across the country. The Ministry of Public Health (MoPH) and over 40 partners including UN agencies, national and international NGOs have been engaged in the provision of emergency nutrition services. The nutrition interventions included treatment of severe and moderate acute malnutrition, blanket supplementary feeding program (BSFP), micronutrient supplementation and deworming to children under five and PLW affected by rapid onset emergencies.

From January to December 2018, 216,326 (97,347 male boys and 118,979 girls) children 0-59 months of age affected by SAM were identified and admitted to treatment program through OPD-SAM (1308) and IPD-SAM(145) facilities. The coverage of SAM children reached with treatment was

92 percent of the HRP 2018 target for SAM treatment services. Through the targeted supplementary feeding program (TSFP) 317,791 (141,417 boys and 176,374 girls) MAM children under the age of five and 178,456 undernourished pregnant and lactating women (PLW) have received treatment services between January and December 2018. The number of MAM children treated during 2018 reached 119 percent of the annual HRP target while the number of PLW reached through TSFP was 112 % of the HRP target. From mid- 2018 nutrition interventions were scaled up in response to the drought which affected 22 out of 34 provinces across the country. Blanket supplementary food was provided to 116,912 children 6-23 months old in the drought affected provinces. Nutrition Cluster partners have also been responding to needs of population affected by rapid onset emergencies such as Afghan returnees from neighboring countries. During 2018, 14,603 returnee children aged 6-59 months received Vitamin A supplements and 4,890 returnee children 24-59 months received deworming tablets.

AFGHANISTAN NUTRITION CLUSTER HRP 2018 ACHIEVEMENT AGAINST TARGET JANUARY TO DECEMBER 2018



Overall the Nutrition Cluster reached a total of 844,088 people through lifesaving nutrition services. This achievement represents 119 percent of the Nutrition Cluster HRP 2018 target. The overachievement this year is attributed to significantly scale up of nutrition response in drought affected provinces. By end of 2018, Nutrition Cluster partners received funding amounting US\$34.4 Million for life saving nutrition services out of US\$62.3 Million required for 2018 response.

Major Challenges and solutions sought

The main challenges faced during implementation included insecurity and access difficulties, unavailability of well staffed health facilities to deliver acute malnutrition treatment services in remote villages in drought affected provinces, and inadequate response from nutrition sensitive sectors.

Insecurity and access difficulties: The insecurity situation limits the continuous provision of life saving emergency nutrition services, frequent program monitoring and supportive supervision activities. Emergency nutrition services at times have been interrupted due to insecurity and lack of access to deliver essential supplies to health facilities providing SAM treatment in remote villages. Among the most notable access difficulty faced by cluster partners was in Badghis province, where delivery of essential nutrition supplies to districts was not possible for about three months. This had resulted in a two-month interruption of nutrition services in 29 health facilities. Through continuous engagement with local communities, the access issue was resolved, and all nutrition facilities were able to receive supplies and resume provision of nutrition services.

Low coverage of health services: The scale up of life saving nutrition services in drought affected provinces was difficult due to limited availability of acute malnutrition treatment services in health

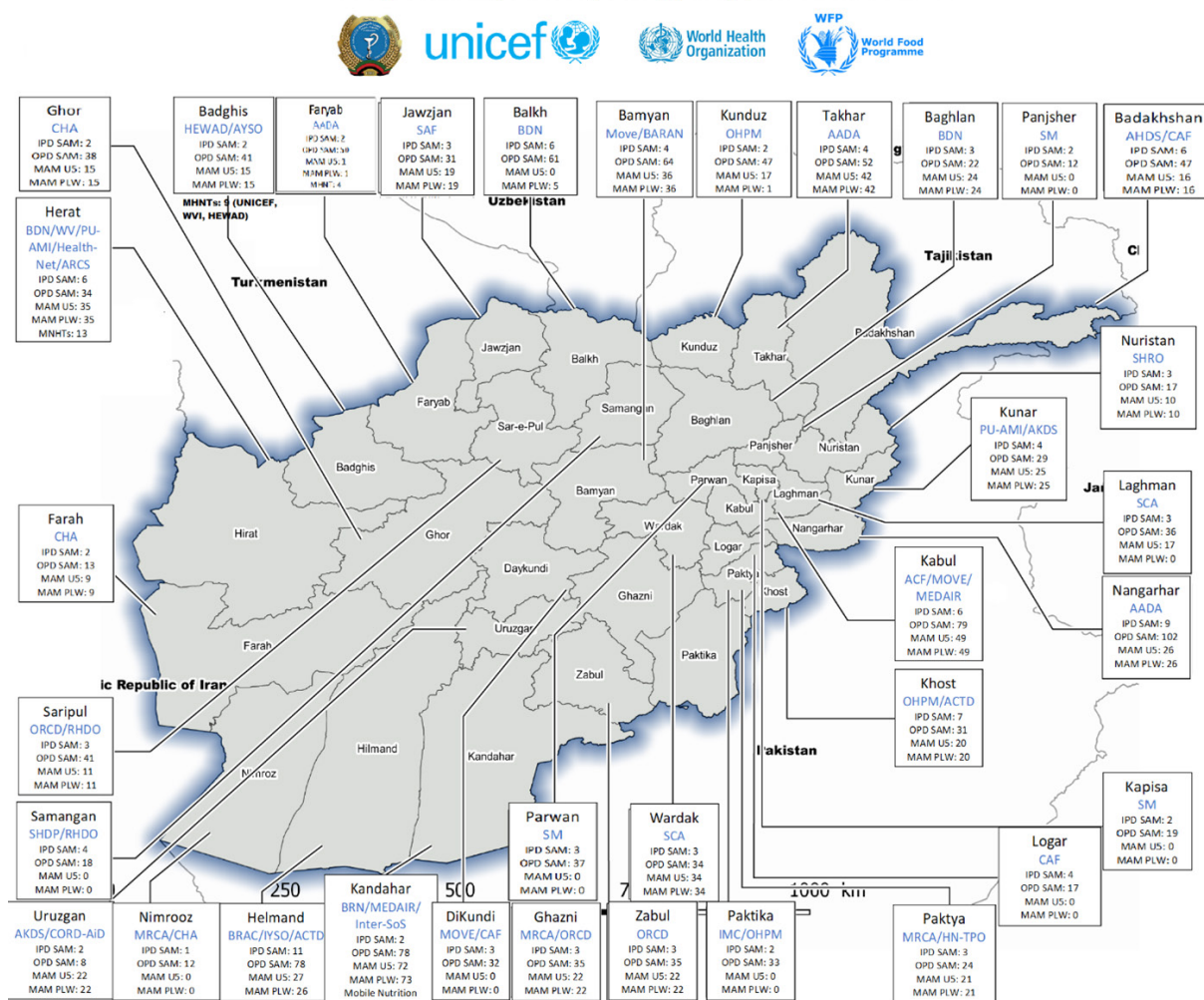
facilities covering remote villages in drought affected provinces. Acute malnutrition outpatient treatment services are primarily provided through Basic Health Centers(BHCs). The BHCs in most cases are far away from remote villages which limits the timely access to treatment services. To address this issues, Nutrition Cluster partners in coordination with MoPH-PND established Integrated Management of Acute Malnutrition (IMAM) treatment services to be delivered through Sub Health Centers (SHC) in the drought affected districts of Badghis, Helmand and Kandahar provinces. SHCs are decentralized health facilities which are closer to communities and are meant to cover a population of about 7,000 people. Provision of IMAM services at SHCs has improved access to SAM treatment services to affected children in remote villages.

Inadequate response from nutrition sensitive sectors: The nutrition situation can only be improved through multi-sectoral response with adequate coverage. Due to capacity and resource limitations the response from coverage of response from health, WASH and food security clusters hasn't been adequate enough to improve the nutrition status of vulnerable groups.

Operational Presence Of Nutrition Cluster Partners

Emergency Nutrition Services in Afghanistan are provided through SEHAT project contracted Basic Package of Health Services (BPHS) and Essential Package of Health Services (EPHS) partners as well as Non-SEHAT program contracted organizations. UNICEF ,WHO and WFP support the components of continuum of care of acute malnutrition across the country.

NUTRITION CLUSTER 3W (WHO,WHAT,WHERE) MAP,DECEMBER,2018



Sources : Nutrition Cluster Afghanistan, OCHA, UNICEF, WHO & UNICEF, OPD SAM : supported by UNICEF, MAM treatment : supported by WFP

MoPH/PND oversees the planning implementation monitoring and coordination of nutrition services

The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

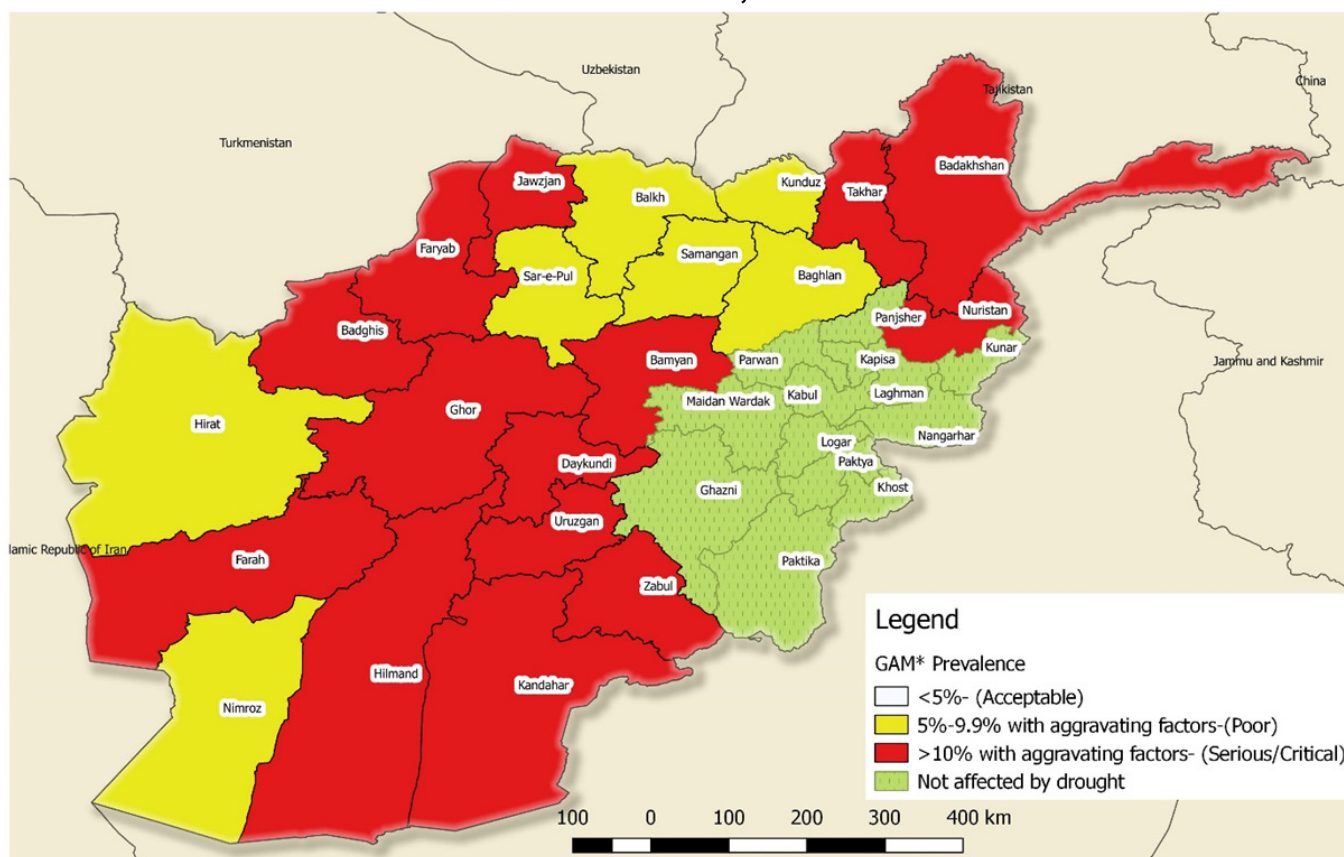
Drought Situation and Response

Drought Situation

Nutrition situation continued to be alarming in Afghanistan especially in the drought affected areas. Drought has affected 22 out of 34 provinces across the country. By September 2018 the results of the IPC (integrated phase classification) of food insecurity analysis indicated that most of the country was in IPC classification 3 (Crisis) or worse, IPC classification 4 (People in emergency). Over 10.6 million were found to be in IPC 3+ as of November 2018 through February 2019 (Afghanistan Food Security and Agriculture Cluster, HNO 2019)

Drought has resulted in displacement of an estimated about 223,000 people, of which 148,000 are in Herat, 70,000 in Badghis and 5,000 in Ghor province⁴. Overall an estimated over 45,000 children under five and about 20,500 PLW are currently displaced in Herat and Badghis as a result of mainly drought induced factors. Recent nutrition assessments conducted during June to December 2018 by nutrition cluster partners in drought affected locations have revealed emergency level acute malnutrition in Badakhshan, Badghis, Jawzjan and Kandahar provinces. Global acute malnutrition (GAM) rate of 20.7% in Badakhshan, 19.7% in Badghis, 27.4% in Jawzjan and 22.3% in Kandahar province was observed.

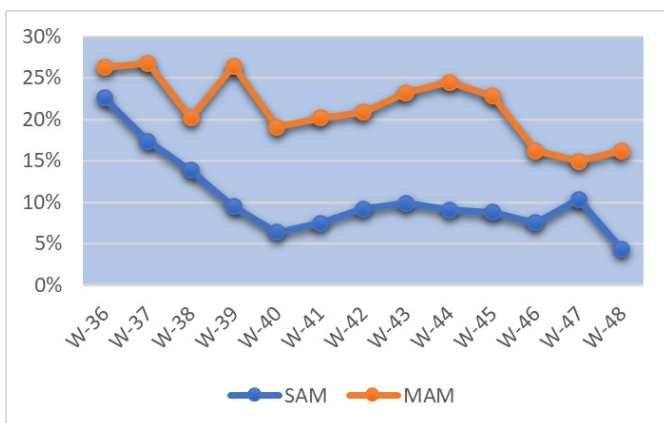
SEVERITY OF ACUTE MALNUTRITION IN DROUGHT AFFECTED PROVINCES, DECEMBER, 2018



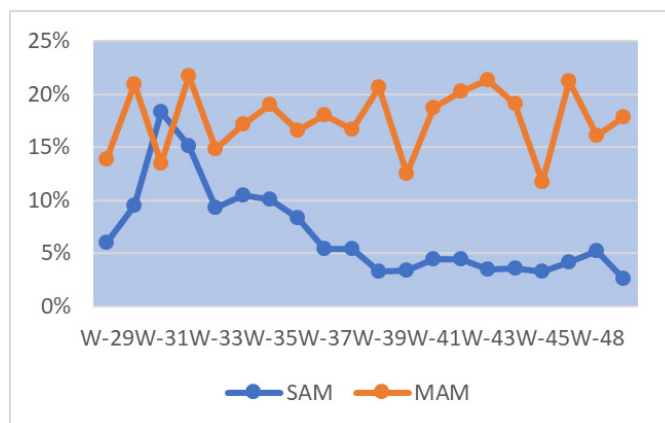
Overall, there is a decreasing trend has been seen in the proportion of acutely malnourished children among MUAC screened IDP children in Herat and Badghis provinces which can be attributed to increasing admission to treatment programs. However, the proportion of acutely malnourished children still remains high. MUAC screening among IDP children showed about a quarter of children 6-59 months are acutely malnourished in Herat city while in Badghis almost a third of children under five were found to be acutely malnourished.

4 OCHA, 2018 – Humanitarian Snapshot (30 Oct – 05 Nov)

Trend of Acute Malnutrition among MUAC screened IDP children in Badghis Province, September -December 2018



Trend of Acute Malnutrition among MUAC screened IDP children in Herat Province, August - December 2018



Through collaborative efforts of Nutrition Cluster partners, a full package of emergency nutrition services to drought affected IDPs have been scaled up in Herat city. A total of 13 integrated mobile health and nutrition teams (MHNT) have been providing emergency health and nutrition services to IDPs in Herat city since beginning of August 2018. Overall, the expected caseload of acute malnourished children (7000 cases of acute malnutrition) have been reached through SAM and MAM treatment services. To avert deterioration of nutritional status of children and women, preventive services such as blanket supplementary food, Vitamin A supplementation, and infant and young child feeding counselling services have been provided.

Drought Response at Area of Displacement

Herat IDP response

Through collaborative efforts of nutrition cluster partners, full package of emergency nutrition services to drought affected IDPs have been scaled up in Herat city. A total of 13 integrated mobile health and nutrition teams (MHNT) have been providing emergency nutrition services to IDPs in Herat city since beginning of August 2018. Overall, the expected caseload of acute malnourished children (7000 cases of acute malnutrition) have fully been reached through SAM and MAM treatment services. To avert deterioration of nutrition status of children and women, preventive services such as provision of blanket supplementary food, micronutrient Supplementation, and infant and young child feeding counselling services have been provided.

By end of December 2018 :

- A total of 32,908 children 6-59 months old have been screened for acute malnutrition
- A total of 9,668 children 6-59 months have been provided with Vitamin A supplementation
- 1,926 severe acute malnourished (SAM) and 5519 moderate acute malnourished (MAM) children have been admitted to treatment program provided through thirteen MHNTs in Herat IDP settlement areas
- A total of 8,956 IDP children under two years were provided with blanket supplementary feeding programs (BSFP).
- A total of 22,311 mothers have been reached through at least one counselling session on infant and young child feeding (IYCF)



Mother in mobile clinic in Herat demonstrating appetite test for enrolment in the program. @ unicef/Afghanistan/2018/ Afzal



Nutrition nurse collecting empty sachets of RUTF from caretaker ensuring RUTF consumed but not sold. @ Unicef/Afghanistan/ 2018/Afzal

Badghis IDP response

A total of eight integrated mobile health and nutrition teams (MHNT) have been providing emergency nutrition services to IDPs in Badghis since beginning of September 2018. Overall, the expected caseload of acutely malnourished children (about 2,000 cases) have been fully reached through SAM and MAM treatment services. To avert deterioration of nutrition status of children and women , preventive services such as blanket supplementary food, micronutrient supplementation, and infant and young child feeding counselling services have been provided.

By end of December 2018 :

- A total of 12,286 children 6-59 months were screened for acute malnutrition.
- A total of 1,310 severe acute malnutrition (SAM) and 3,716 moderate acute malnutrition (MAM) were admitted for treatment by 8 integrated mobile health and nutrition teams.
- 5,953 children 6-23 months received Supplementary food through Blanket supplementary feeding program (BSFP).
- 1,788 undernourished IDP pregnant and Lactating women (PLW) received supplementary food
- 9,617 mothers/ care takers have been reached through at least one session of infant and young child feeding (IYCF) counselling services.

About **12,500** acute malnourished drought affected IDP children received treatment in Herat and Badghis



Mobile Health and Nutrition Clinic at IDP settlement in Badghis Province @Unicef/ Afghanistan/2018/Ahmad



Social Mobilizer giving key nutrition awareness messages at mobile nutrition clinic in Badghis. UNICEF/Afghanistan/2018/Ahmed

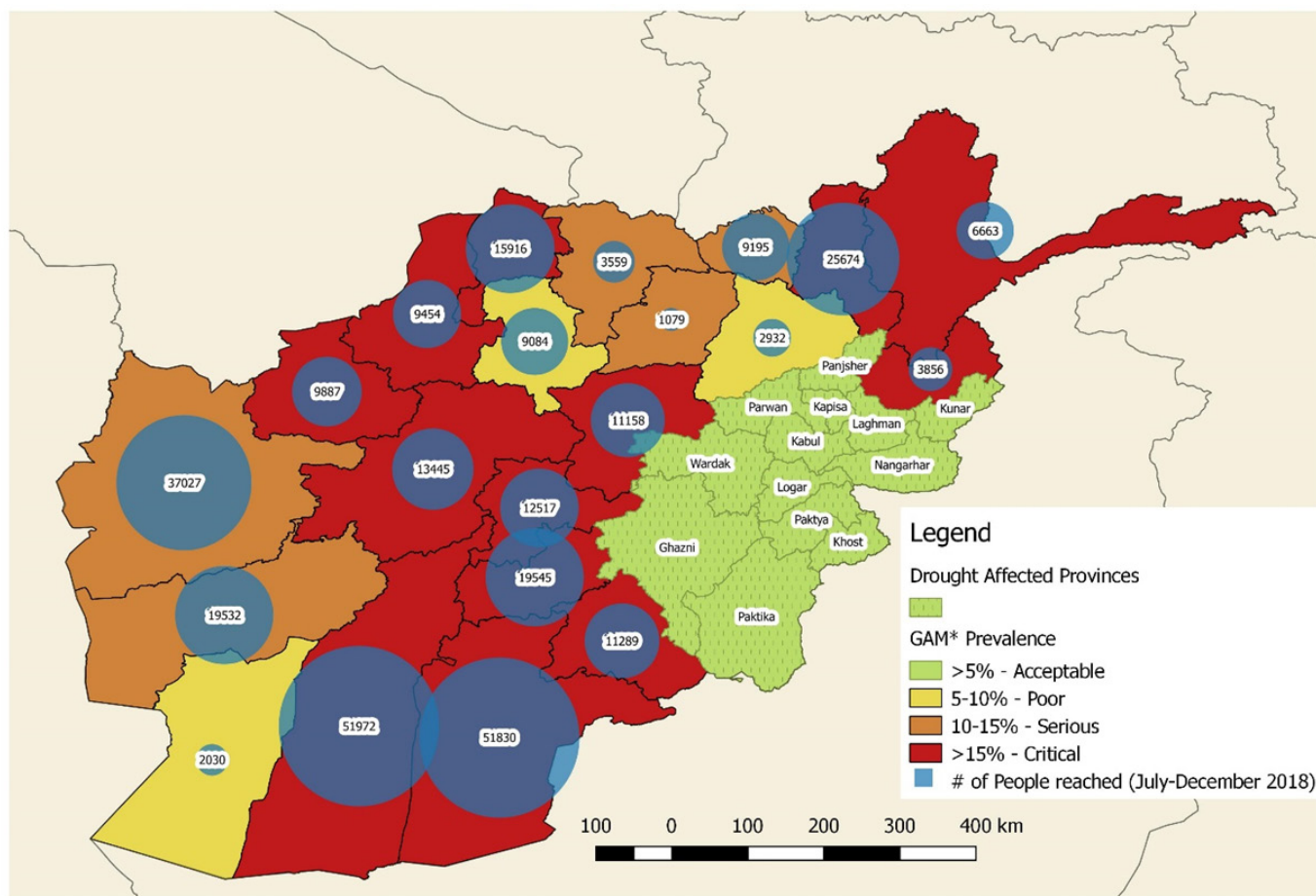
Response at areas of Origin

Since the beginning of July nutrition services have been scaled up across 22 drought affected provinces. The nutrition services have been provided through mainly fixed BPHS facilities. The number of Basic Health Centers providing acute malnutrition treatment increased from 551 to 712 health facilities. In severely drought affected provinces such as Badghis nutrition services have been provided through Sub Health centers -decentralized facilities which usually cater for about 7000 people. In addition a total of 59 Mobile Health and Nutrition teams have been deployed in hard to reach and low coverage communities.

- 88,967 SAM and 37,639 MAM children received treatment services at place of origin across drought affected provinces.
- 23,523 undernourished IDP pregnant and Lactating women (PLW)received supplementary food
- 116,912 Children 6-23 months received supplementary food through the Blanket Supplementary feeding Program

A total of **126,000** acute malnourished children treated
in **22** drought affected provinces

PEOPLE REACHED THROUGH DROUGHT RESPONSE, DECEMBER, 2018



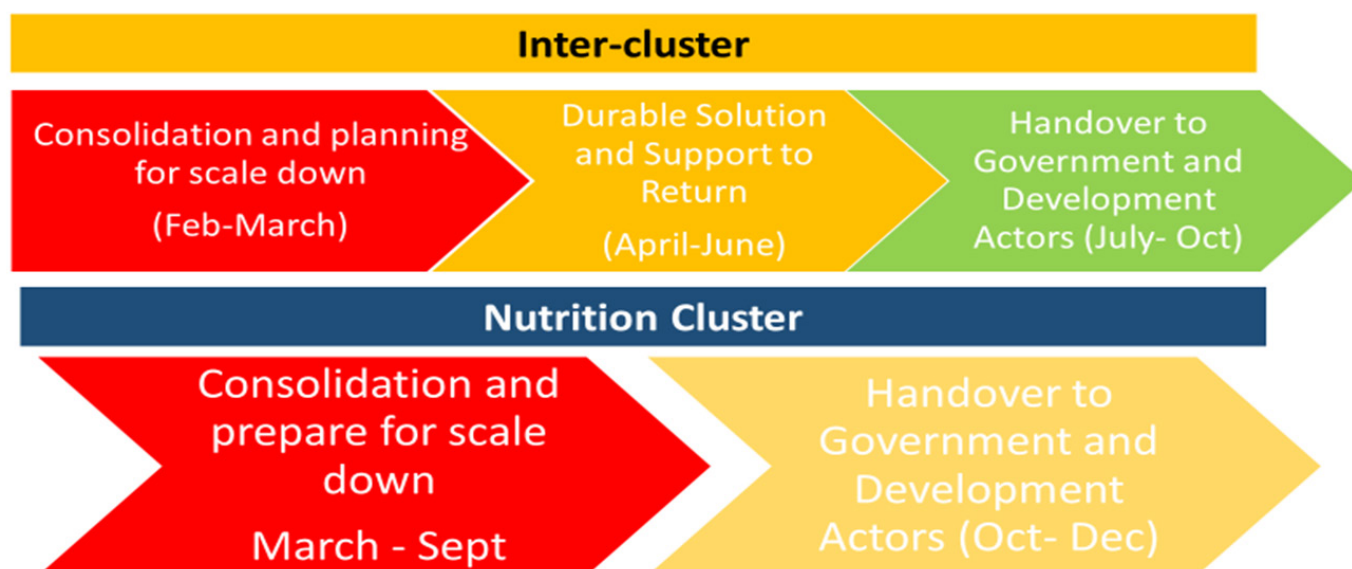
Nutrition Cluster Drought Response Timeframe and Strategy

The Nutrition Cluster plans to continue the drought response to IDPs till end of the year and at places of origin (rural population) till end of October 2019. The following considerations were taken into account in deciding the timeframe of the nutrition response.

- **The prospect of Nutrition Situation:** Impact of drought on acute malnutrition is expected to continue through 2019. The trend analysis of nutrition situation over the last years shows overall the acute malnutrition admissions and incidence peaks during May- October period.
- **IDP Intention Survey Findings:** According to IOM Intention survey , IDPs in Herat and Badghis are unlikely to return
 - In Herat: 70% of IDPs in Herat indicated they are unwilling to consider the idea of voluntary return
 - In Herat: The vast majority (97%) remain undecided about what they intend to do.
 - In Badghis: 27% of IDPs in Badghis indicated they are unwilling to consider the idea of voluntary return
 - In Badghis: Most (68%) are still undecided though about what they intend to do according to IOM intention survey in January 2019.

The inter-cluster coordination team (ICCT) came up with scaling down and phaseout time frame and package of assistance for drought response. For most clusters first quarter of 2019 will be a period of preparation for scaling down. During April-June, scaling down and transition to livelihood (humanitarian plus) support, will take place followed by phasing out by end of October 2019. Given the seasonal spike of acute malnutrition during June -October, there won't be scaling down and phasing out of nutrition services during this period.

Nutrition cluster proposed timeframe and response strategy



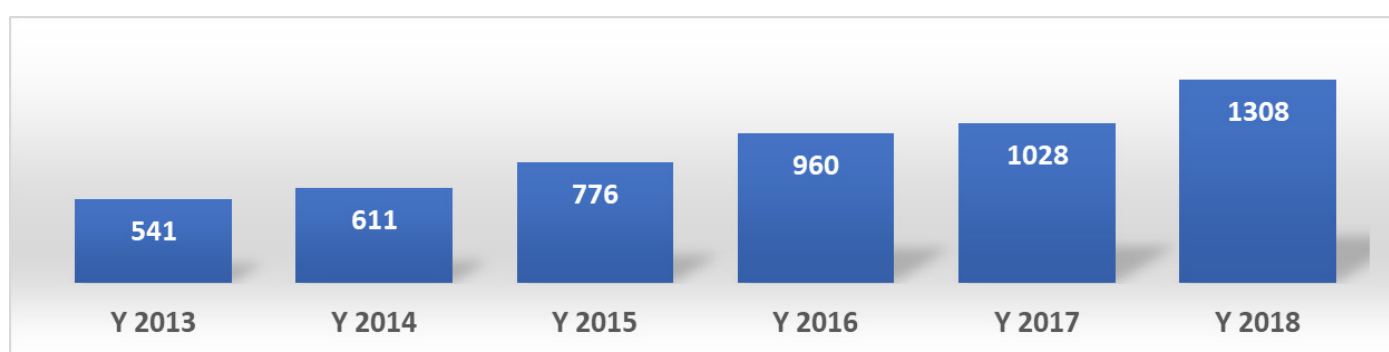
Inter-cluster Time frame	Nutrition Cluster Strategy	Areas of Origin (Rural) response
February –March 2019: Prepare for Scale down	Maintain and scale up Response	All drought affected provinces
April –June 2019 : Scaling up transitional livelihoods/ 'humanitarian plus' support	Maintain services in low coverage provinces	16 Provinces: Badakhshan, Badghis, Baghlan, Balkh, Bamyán, Dykundi, Farah, Ghor, Hirat, Jawzjan, Kandahar, Nooristan, Samangan, Sar-e-Pul, Takhar, Urozgan
July to October :Phase Out	Maintain services till end of October	16 Provinces

Inter-cluster Time frame	Nutrition Cluster Strategy	Areas of Displacement response
February –March 2019: Planning for scale- down of emergency response	Maintain and scale up Response	Herat and Badghis
April –June 2019: Encouragement to return	Maintain and scale up Response	Herat and Badghis
July to October: Phase Out	Continue services till end of the year	Herat and Badghis

Performance of Integrated Management of Acute Malnutrition (IMAM) Program

By end of 2018, 277,660 children with severe acute malnutrition (SAM) have been admitted to outpatient therapeutic program (OTP) across the country⁵. An increase of 14.4 % and 17.6 %, 36.8% in the rates of admission have been recorded in 2018 as compared to SAM admissions during 2017(243,550), 2016 (209,523) and 2015 (164,475) respectively. The number of children who had access to treatment services for severe acute malnutrition in 2018 is more than double as compared to 2014. The increase in admission is mainly due to the expansion of treatment to health facilities as a result of the scale up of IMAM services across the country. As shown in the barograph below ,the number of SAM treatment facilities has increased from 1,028 in 2017 to 1,308 by end of 2018. In addition, the scale up of SAM treatment services through Sub Health Centers and Mobile Health and Nutrition teams in hard-to-reach areas contributed to increased admission to treatment services.

NUMBER OF SAM TREATMENT FACILITIES, 2013-2018



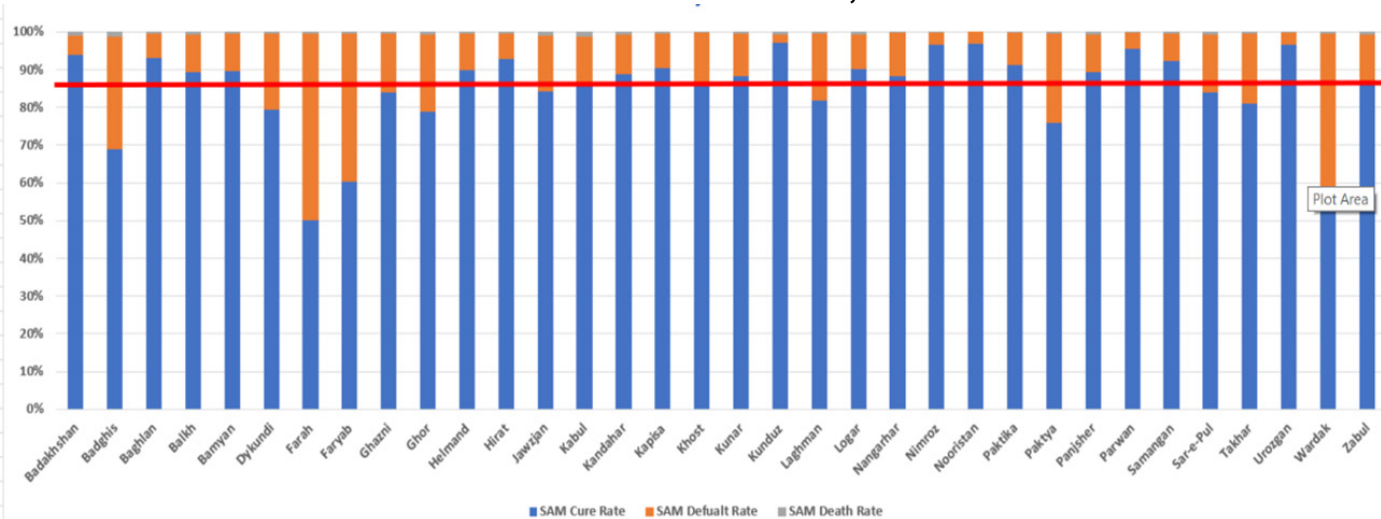
The performance of SAM treatment services has been maintained within SPHERE standards parameters across most of nutrition (health) facilities. According to SPHERE standard, a cure rate greater than 75%, a death rate greater than 10% and a defaulter rate less than 15% of all children discharged from treatment are considered acceptable levels of performance. In 2018, the average national level cure rates among OPD-SAM admitted children was 83 per cent; the death rate was 0.04 per cent and defaulter rate was 12.5 per cent. For IPD-SAM admitted children the average cure rate was 85 per cent; with a death rate and defaulter rate being 4 per cent and 11 per cent respectively. Nationally the performance parameters of SAM treatment met SPHERE minimum standards. The better performance on SAM treatment services in Afghanistan can be attributed to the IMAM trainings provided to health workers and relative improvement in the IMAM reporting and follow up system. In addition, monitoring and supportive supervision on the implementation of standard guidelines has contributed to maintaining acceptable level of performance of SAM treatment services.

About **70% increase** in the number of SAM children treated since 2016

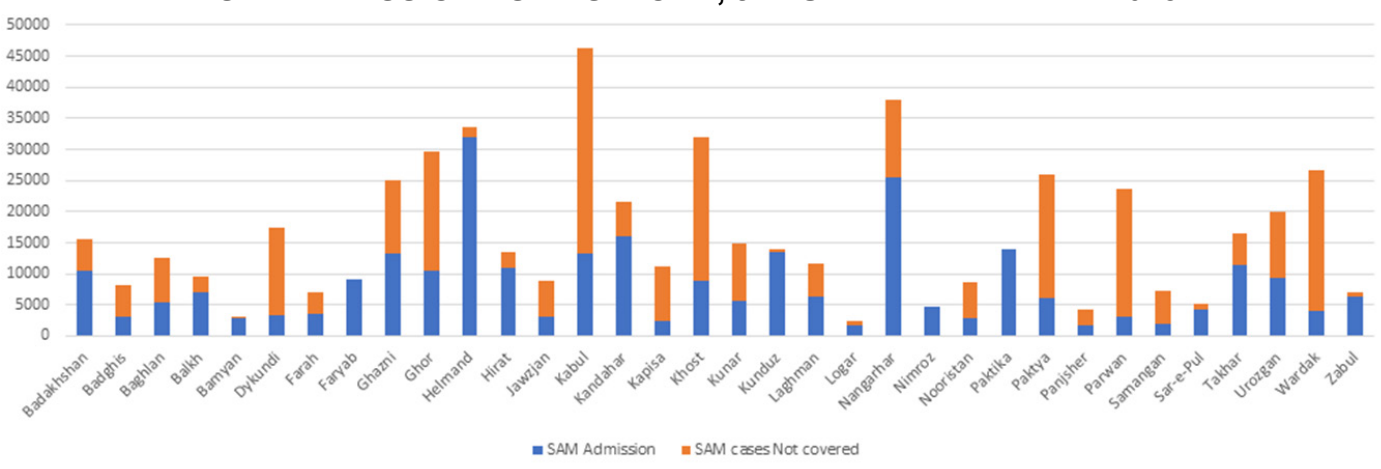
Over **100% increase** in the number of IMAM facilities since 2014

⁵The 277,660 SAM admission includes non HRP priority provinces

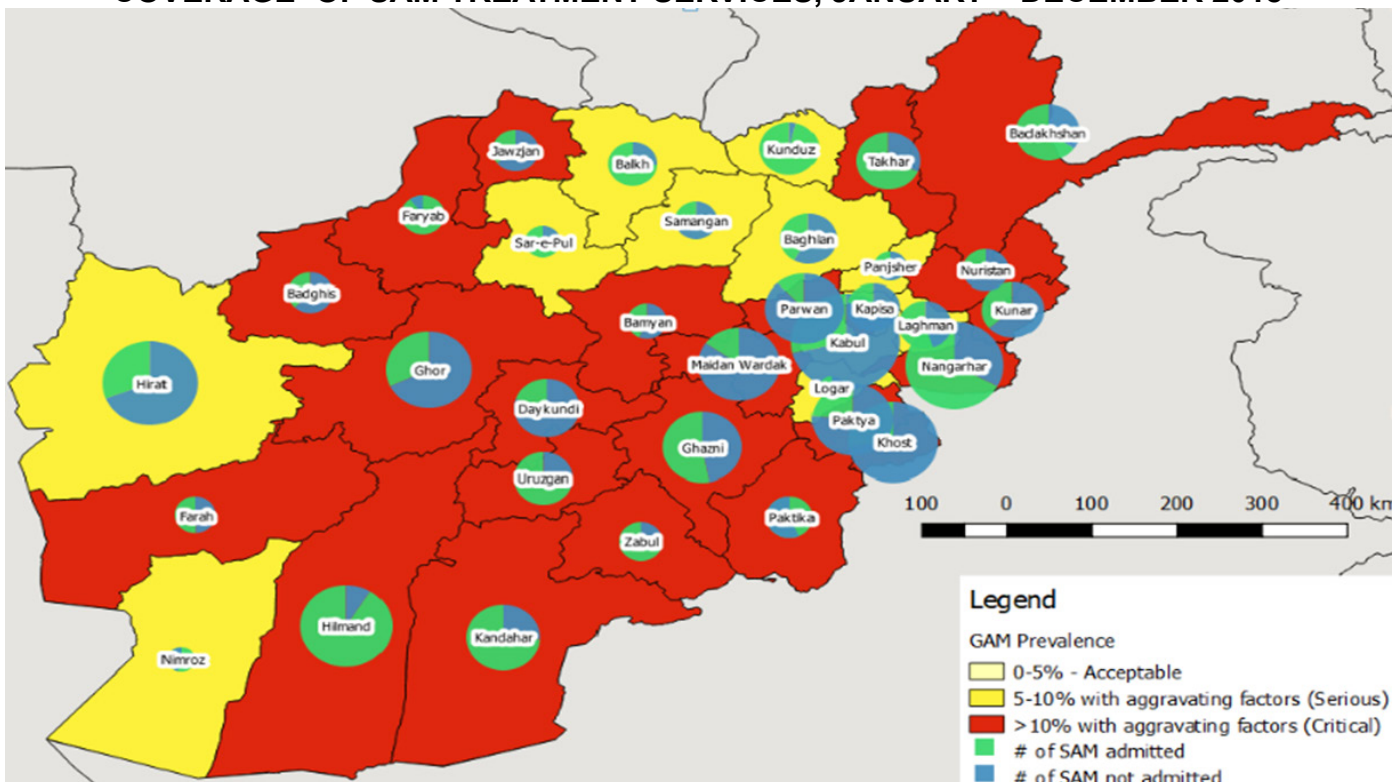
PERFORMANCE OF SAM TREATMENT PROGRAM, JANUARY - DECEMBER 2018



SAM ADMISSION VS CASELOAD, JANUARY - DECEMBER 2018



COVERAGE⁶ OF SAM TREATMENT SERVICES, JANUARY – DECEMBER 2018



⁶The treatment 'Coverage' is the proportion of children with SAM admitted to IMAM services among total SAM children estimated to be affected by SAM during the 12 months of the year.



The State of Afghanistan Nutrition Cluster Coordination

The Nutrition Cluster coordinates all nutrition in emergency activities in Afghanistan. Currently emergency nutrition coordination is jointly lead by UNICEF and Ministry of Public Health (MoPH) – Public Nutrition department (PND) at National and Sub National Level. Action Against Hunger (AAH) is an NGO co-lead. The cluster coordination core functions entail: 1) supporting service delivery; 2) informing strategic decision making of the Humanitarian Country Team (HCT) through ongoing situation monitoring and needs' analysis; 3) planning and strategy development including resource mobilization for critical priorities; 4) advocacy; 5) monitoring and reporting of emergency nutrition activities 6) contingency planning, preparedness, and capacity building; and 7) ensuring accountability to affected populations (AAP). UNICEF plays a leading role in coordinating cluster and providing technical support on emergency nutrition response. During 2018, the Nutrition Cluster coordination mechanism was maintained, delivering capacity development of MoPH staff on coordination and establishing emergency preparedness and response mechanisms. The cluster also conducted cluster coordination performance monitoring (CCPM) survey and validation workshop.

Maintaining Functional Coordination

The cluster coordination team comprising of a cluster coordinator, deputy cluster coordinator (NGO co-lead) and information management specialist based in the UNICEF country office; and five cluster focal persons based in the UNICEF zonal offices were able to dedicate sufficient time for interagency emergency nutrition coordination. Currently, the Nutrition Cluster comprises of five (5) UN agencies, MoPH/PND, 21 INGOs, 17 LNGOs, 1 observer, five (5) donors and MoPH-PND. Through collective efforts of its partners in 2018 the Nutrition Cluster reached about 850,000 people through lifesaving nutrition services. This achievement represents 118 percent of the Nutrition Cluster HRP 2018 target. The cluster partners were able to reach a higher number of people in need in 2018 partly because of a functioning coordination which was able to put in place a harmonized responses strategy, an early warning and preparedness mechanism, continuously monitor nutrition situation and identify critical gaps as well as avoid duplication among partners. A total of 12 national and 20 regional (zonal) level cluster coordination meetings were held on a monthly and quarterly basis respectively. In addition, monthly technical working groups' meetings were conducted at national level. The Nutrition Cluster coordinated periodic needs' analysis and response plan development exercises in a harmonized manner. The Nutrition Cluster, in coordination with Ministry of Public Health, Public Nutrition Directorate (MoPH-PND), ACF, and BPHS implementers conducted three

(3) Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) assessments, 10 SMART surveys and four (4) rapid nutrition assessments (RNA) across priority provinces and IDP sites. Based on the ongoing analysis of the nutritional need and gaps, a mid-year review of the 2018 humanitarian response plan (HRP) and development of the 2019 annual HRP was done.

The Nutrition Cluster also continuously monitored the 3W (who, what, where) information matrix which helped identify gaps and avoided overlaps among partners. The 3W maps were produced and disseminated on quarterly basis. The cluster progress against its annual target was monitored on an ongoing basis and quarterly HRP dashboards were produced and disseminated. All situation and response related publications as well as technical guidelines are made accessible through online repository and cluster web page accessible at <https://www.humanitarianresponse.info/en/operations/afghanistan/nutrition>.

Capacity Development On Coordination

The Nutrition Cluster works closely with five technical working groups of the Ministry of Public Health, Public Nutrition Directorate (MoPH-PND) and provincial nutrition officers. In order to enhance the coordination capacity of MoPH staff, the Nutrition Cluster provided humanitarian coordination training to a total of 27 MoPH nutrition staff.

Establishing Preparedness Mechanism

The cluster has also continued its efforts to ensure that key minimum preparedness measures and response capacities are in place at national and sub national level. A total of 24 participants from government, BPHS and EPHS implementing partners were provided with emergency preparedness mechanism training. To effectively and timely respond to the rapid onset of emergencies, UNICEF signed standby Program Cooperation Agreements (PCAs) with three partners.

The establishment of emergency preparedness mechanism involved national level risk analysis, capacity development of partners, strengthening strategic partnerships between UNICEF and NGO partners and improving supply chain management.

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- **Risk analysis and preparedness plan:** In coordination with MoPH-PND and partners, a national and subnational level risk analysis based on the last 5-10 years incidence of rapid onset emergencies was carried out. Based on the risk analysis all five UNICEF coordination zones developed a preparedness plan through consultative process with cluster partners.
- **Training on Emergency Preparedness:** Training on emergency preparedness was given to a total of 27 staff of Nutrition Cluster partners, MoPH nutrition officers and UNICEF zonal cluster focal persons.
- **Strengthening supply chain management:** a well-functioning supply management system is an important backbone of emergency response. This grant supported the roll out of supply chain management training at province level. A total of 253 participants comprising of nurses, pharmacists, and heads of health facilities were trained on supply chain management system.
- **Strengthening strategic partnership with NGO partners:** UNICEF team across all five coordination zones have identified NGO partners which are willing and capable of responding to small scale rapid onset emergencies. So far UNICEF signed three contingency Project Cooperation Agreements (PCAs).



EPP workshop participants in Kabul

Cluster Coordination Performance Monitoring

Afghanistan Nutrition Cluster with support from the Global Nutrition Cluster conducted a cluster coordination performance monitoring (CCPM) online survey by mid of 2018. A total of 32 partners (68 percent response rate) responded to the online survey. The preliminary report of the survey was shared with the cluster partners in August 2018. Subsequently a validation workshop was conducted to reflect on the findings and come up with an improvements plan. The Nutrition Cluster has performed well in most of the core cluster functions. The accountability to affected population(AAP) is one of the function area cluster did not perform satisfactorily. The improvement action plan was developed which constituted specific activities that should be carried out in 2019 in order to make the cluster more effective in preparing and responding to the need of population.



2018 CCPM validation workshop participants , Kabul ,Afghanistan

Synthesis of Nutrition Assessments in Afghanistan:

By Action Against Hunger, Afghanistan (Manuscript submitted to Field Exchange Article)

In Afghanistan, population-representative anthropometric SMART surveys have suggested a distinct discrepancy between the prevalence of GAM by WHZ and MUAC; with the prevalence by MUAC being higher in most surveys. In order to more accurately represent the burden of acute malnutrition among children 6-59 months, Action Against Hunger with the support of local partners and the Ministry of Public Health's Public Nutrition Directorate began reporting on the prevalence of GAM combining both WHZ and MUAC in 2015. Combined GAM (cGAM) is an aggregated indicator including all cases of GAM by WHZ <-2 , MUAC <125 mm, and/or bilateral pitting edema. There are practical implications of using cGAM in the Afghan context for decision making in humanitarian programming cycle.

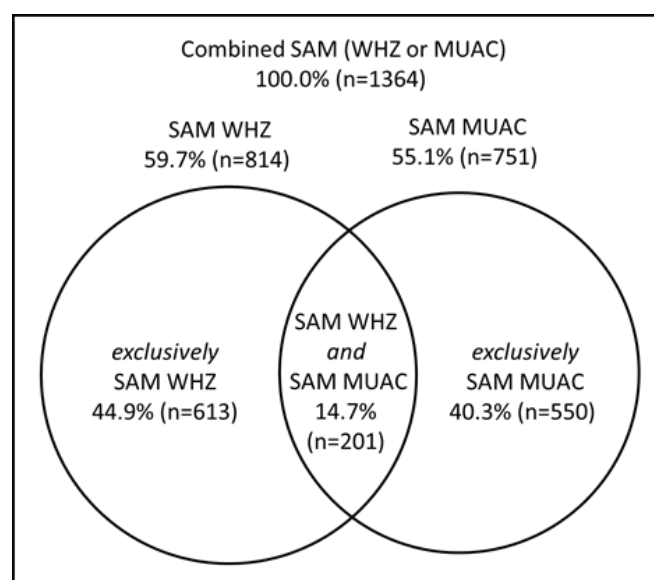
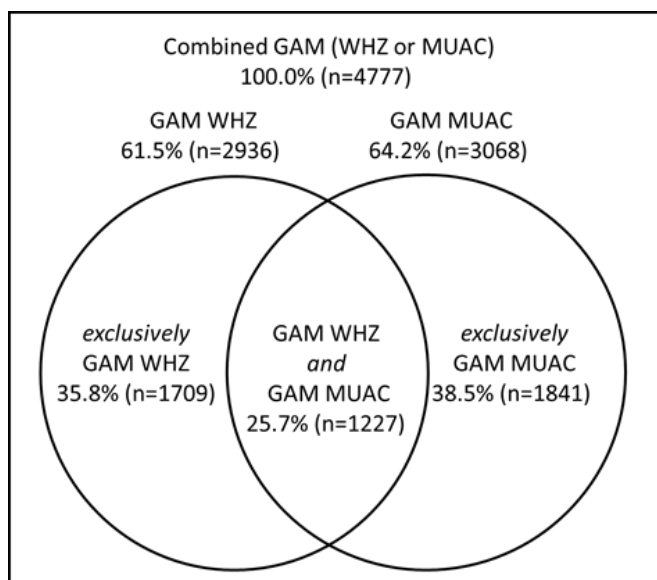
The anthropometric data were examined from 31 population-representative cross-sectional SMART Surveys conducted across 30 of the 34 (88.2%) provinces of Afghanistan from 2015 to 2018, suggesting a sample reflecting all regions of the country. The sample was 48.6% female and 51.4% male. The age ratio of children 6-29 months compared to children 30-59 months was 1.03 (higher than the expected proportion of 0.85⁷).

Overall, there were 2,936 cases of GAM per WHZ and 3,068 cases of GAM per MUAC, as presented in **Diagram (cGAM, GAM per WHZ, and GAM per MUAC)** below. Despite a similar number of cases using either indicator, there remains a large discrepancy in cases captured by both, with only 25.7% of cases identified as GAM according to both indicators. More GAM cases were identified using MUAC than WHZ, however, using MUAC alone would capture only 64.2% of cases. Alternatively, using WHZ alone would capture just 61.5% of these cases. Considering cGAM (WHZ and/or MUAC), there were a total of 4,777 GAM cases.

Overall, there were 814 cases of SAM per WHZ and 751 cases of SAM per MUAC, as presented in Diagram (cSAM, SAM per WHZ, and SAM per MUAC)

below. Despite a similar number of cases using either indicator, there remains a large discrepancy in cases captured by both, with only 14.7% of cases identified as SAM according to both indicators. More SAM cases were identified using WHZ than MUAC, however, using WHZ alone would capture only 59.7% of cases. Alternatively, using MUAC alone would capture just 55.1% of these cases. Considering cSAM (WHZ and/or MUAC), there were a total of 1,364 SAM cases.

1. Venn Diagram Visualizing Discrepancies between cGAM, GAM per WHZ, and GAM per MUAC
2. Venn Diagram Visualizing Discrepancies between cSAM, SAM per WHZ, and SAM per MUAC



⁷Per the SMART Methodology Plausibility Check

The results of the caseload calculation based on three scenarios presented in Table 1 below demonstrate the difference in caseloads based on WHZ, MUAC, and cGAM. All three scenarios examined the same twenty-two priority provinces, thereby utilizing the same total population and total population under five data, while examining a different prevalence of malnutrition per province based on the indicator. As expected, the caseload estimate by WHZ was the lowest, with an estimated 1,021,039 children under five years acutely malnourished. The caseload estimate by MUAC was higher, with an estimated 1,090,620 children under five years acutely malnourished. The caseload estimate by cGAM was the highest, with an estimated 1,578,465 children under five acutely malnourished.⁸

Table 1. Three Scenarios for Afghanistan 2019 HNO Caseload Estimation from Recent SMART Survey Data among 22 Priority Provinces

Scenario	Total Population (2018)	Total U5 population (17.3%)	GAM (range)*	SAM (range)	Total # of MAM (U5)	Total # of SAM (U5)	Total # of GAM (U5)
Scenario 1: WHZ**	17,773,741	3,074,857	(10.4% to 15.7%)	(1.4% to 4.2%)	783,201	237,838	1,021,039
Scenario 2: MUAC			(6.4% to 24.4%)	(1.3% to 7.4%)	789,370	301,250	1,090,620
Scenario 3: cGAM			(14.4% to 26.9%)	(2.7% to 8.4%)	1,122,626	455,839	1,578,465

*Range of acute malnutrition prevalence across the twenty-two priority provinces

**WHZ data was available for children 0-59 months. MUAC and cGAM data was only available for children 6-59 months (as MUAC is not a validated indicator for infants <6 months), and the results were generalized to the entire under five population.

This analysis demonstrated that in Afghanistan, there is a large discrepancy between cases of acute malnutrition identified by WHZ and MUAC, with only 1 in 4 children being captured by both.

These findings have strong implications for estimating the burden of acute malnutrition. Traditionally, most countries have relied on the prevalence of WHZ for caseload calculation, as it is standardized for age and sex and tends to generate a higher prevalence than MUAC; often perpetuating the assumption that because it is a larger prevalence, it also captures and accounts for the children which are acutely malnourished by MUAC. The poor correlation between WHZ and MUAC as demonstrated in recent literature, in addition to the results of this analysis, contribute to the discussion that cGAM should be routinely calculated and reported by countries to recognize any discrepancy between the two indicators.

Considering the known discrepancy between GAM cases per WHZ and MUAC as demonstrated in recent literature and this analysis, it is recommended that cGAM be routinely reported from population-representative nutrition surveys globally. Further, reporting cGAM should not replace but complement the reported prevalence of acute malnutrition by GAM by WHZ and GAM by MUAC, to enable nutrition stakeholders to utilize any of the three indicators for decision-making as is most appropriate for their context. cGAM should also be considered for use in calculating caseload, particularly in contexts where GAM by WHZ and GAM by MUAC are poorly correlated. Considering there exist globally validated cut-offs for GAM by WHZ as well as GAM by MUAC, global nutrition leaders should establish a globally validated cut-off for cGAM for better interpretation of findings by nutrition stakeholders and decision-makers.

2019 Nutrition Cluster Priorities and Response Strategy

(Excerpt from Afghanistan HRP 2019-2021)

2019 PEOPLE IN NEED

 2.1 M

PEOPLE TO BE ASSISTED

 1 M

REQUIREMENTS (US\$)

 57.7 M

The Nutrition Cluster aims to ensure timely access to a package of life-saving emergency services to nutritionally-vulnerable and acutely malnourished children under five, as well as pregnant and lactating women (PLW) in provinces with a critical emergency-level nutrition situation. In addition, vulnerable children and PLW with heightened risk of malnutrition and mortality among IDPs, returnees, refugees and drought-affected communities, are also priorities for the nutrition response.

Multi-year and Comprehensive Package

The nutrition sector targeted almost a million boys, girls and women in 2019 with an overall funding requirement of \$57.6 million. The priority emergency nutrition response activities for 2019 include outpatient and in-patient treatment for SAM; case management of Moderate Acute Malnutrition (MAM) for children (6-59 months); targeted supplementary feeding for under-nourished PLW; emergency blanket supplementary feeding for children (6-23 months); infant and young child feeding practices in emergency (IYCF-E) services for mothers and children; and the provision of micro-nutrient supplements to children (6-59 months). The cluster is working to strengthen referrals between the various components of emergency nutrition services and ensure a continuum of care for patients with acute malnutrition. It is important to note that children with MAM have an increased risk of mortality, infections and impaired physical and cognitive development compared to well-nourished children. Therefore, not having targeted nutrition-specific activities to address MAM in this context places children with MAM at excessive risk of adverse outcomes. Nutrition needs in 2020 and 2021 are expected to remain similar as in 2019 with just marginal increases in the number of acutely malnourished children and PLWs in line with population growth.

Although the drought situation is expected to subside, evidence suggests that the basic/ underlying causal factors of malnutrition (i.e. poverty, food insecurity, poor health infrastructure etc.) are likely to deteriorate or remain unimproved in the coming years. The nutrition program is mainly treatment-oriented and has low coverage when compared to overall need. Unless it is complemented with other multi-sector preventive programs, it will not have significant impact in reducing burden.

It is anticipated that the same priority activities will continue to be implemented in 2020 and 2021, with an annual increase of about 15 per cent of the target. The number of nutrition facilities providing integrated management of acute malnutrition (IMAM), with both SAM and MAM treatment services, will be progressively increased, permitted resources are available to support the scale up.

Towards Improving Coverage

The Nutrition Cluster has prioritised provinces with a GAM rate of 10 per cent and above for emergency nutrition services; and over 70 per cent of nutritionally-at-risk PLW and children under five in emergency-affected population groups (returnees, refugees, disaster-affected communities and IDPs). A total of 22 provinces (Badakhshan, Badghis, Bamyán, Daykundi, Farah, Faryab, Ghazni, Ghor, Hilmand, Jawzjan, Kandahar, Khost, Kunar, Nangarhar, Nuristan, Paktika, Paktya, Parwan, Takhar, Uruzgan, Wardak, Zabul) are prioritised for emergency response with more than 1.1 million people to be assisted. The Nutrition Cluster targets are set with an aim of achieving at least 50 per cent coverage of the people in need for most nutrition in emergencies (NiE) services. This is in line with the SPHERE standard minimum coverage for most NiE services in predominantly rural populations.

Sixty per cent of children with SAM are targeted for outpatient treatment services and 10 per cent of all out-patient SAM cases are ultimately expected to need in-patient treatment in 2019. Thirty per cent of MAM children under five and 40 per cent of under-nourished PLW benefit from the targeted supplementary feeding program (TSFP). In addition, more than 70 per cent of children and PLW affected by rapid onset crises are targeted for emergency nutrition services such as IYCF-E support, micronutrient supplementation or the blanket supplementary feeding program (BSFP).

Emergency nutrition services (IYCF-E, BSFP, micronutrient supplementation) are planned for the initial phase (three to six months) of the emergency response for people affected by rapid-onset crises. Thereafter these groups will receive assistance through BPHS partners' routine preventative and treatment services.

The Nutrition Cluster aims to progressively increase the coverage of emergency nutrition services during the next three years. The ongoing scale-up of IMAM services through de-centralised delivery mechanisms such as basic health centres (BHC) and sub-health centres (SHC); the roll-out of the nutrition counsellor's package (a new cadre of nutrition workers assigned to health facilities), as well as capacity development on monitoring and reporting will enable the attainment of progressively increased coverage of treatment and preventive services in the coming years.

The Nutrition Cluster will explore the possibility of employing cash as an alternative and complementary modality of assistance in 2019. Drawing from experiences in nutrition sensitive cash programming in global humanitarian emergencies, the Nutrition Cluster will adopt a cash modality, wherever appropriate, over subsequent years of the HRP. In the meantime, the Nutrition Cluster will coordinate with the CVWG to determine the feasibility and appropriateness of cash modalities during the first phases of an emergency.

Where food assistance is substituted with cash transfers, social and behavioural change communications (SBCC) activities on appropriate feeding will be implemented to influence and encourage the expenditure preference of families towards nutritious food for young children and nursing women.

Inter-sector programming

Nutrition Cluster partners will continue to engage with other nutrition-sensitive sectors (e.g. WASH, Health, FSAC and EiE) to maximise optimal nutritional outcomes. Emergency nutrition services are typically delivered either through the existing health facility platforms and/or through emergency mobile teams. The mobile nutrition teams in hard-to-reach areas have started to evolve into nutrition-plus' mobile teams by integrating essential child healthcare services like immunisation, integrated management of childhood illnesses (IMCI) for children, maternal care services, and nutritional care. Acutely malnourished children with medical complications are referred to higher-level health facilities for better diagnosis and treatment. In coordination with the WASH cluster, emergency hygiene kits will be provided to acutely malnourished children and their care-givers wherever resources permit, while minimum handwashing facilities will also be set-up at in-patient and out-patient nutrition service centres. Health and nutrition staff and volunteers provide messages and health education sessions on appropriate nutrition and health practices both at facility and community-level. Integration with food security and livelihoods, as well as cash-based programming will further be strengthened through co-location and convergence of blanket supplementary food distributions, alongside the provision of emergency food assistance.

Efficiencies & Effective Multi-year programming

The multi-year nutrition response strategy provides an opportunity to gradually scale-up nutrition services in priority locations in order to reach the most needy and vulnerable populations. This will also enable partners to build the capacity of facility and community-based health and nutrition staff to provide quality nutrition services by progressively increasing coverage and effectiveness. Mobile teams providing emergency nutrition care for children and women will gradually hand-over these ongoing services to the nearest health facilities for greater sustainability and ownership. Joint monitoring and supervision visits will regularly be conducted together with provincial and national-level MoPH counterparts to ensure quality services, as well as on-the-job training for field staff. The multi-year response plan is also expected to ease logistics constraints and improve the supply of nutrition treatment such as ready-to-use therapeutic and supplementary food through long-term planning and prepositioning in priority provinces.

Meeting funding requirements through long-term commitments from donors may remain a potential challenge. An exit and expansion strategy for each province/ district will be made through informed decision-making processes, based on the severity of the nutrition situation and caseloads identified through nutrition surveys (Standardised Monitoring and Assessment of Relief and Transition or SMART survey, Rapid SMART surveys), surveillance (Health Management Information System or HMIS) and monthly nutrition reports.

Links to Development Programming

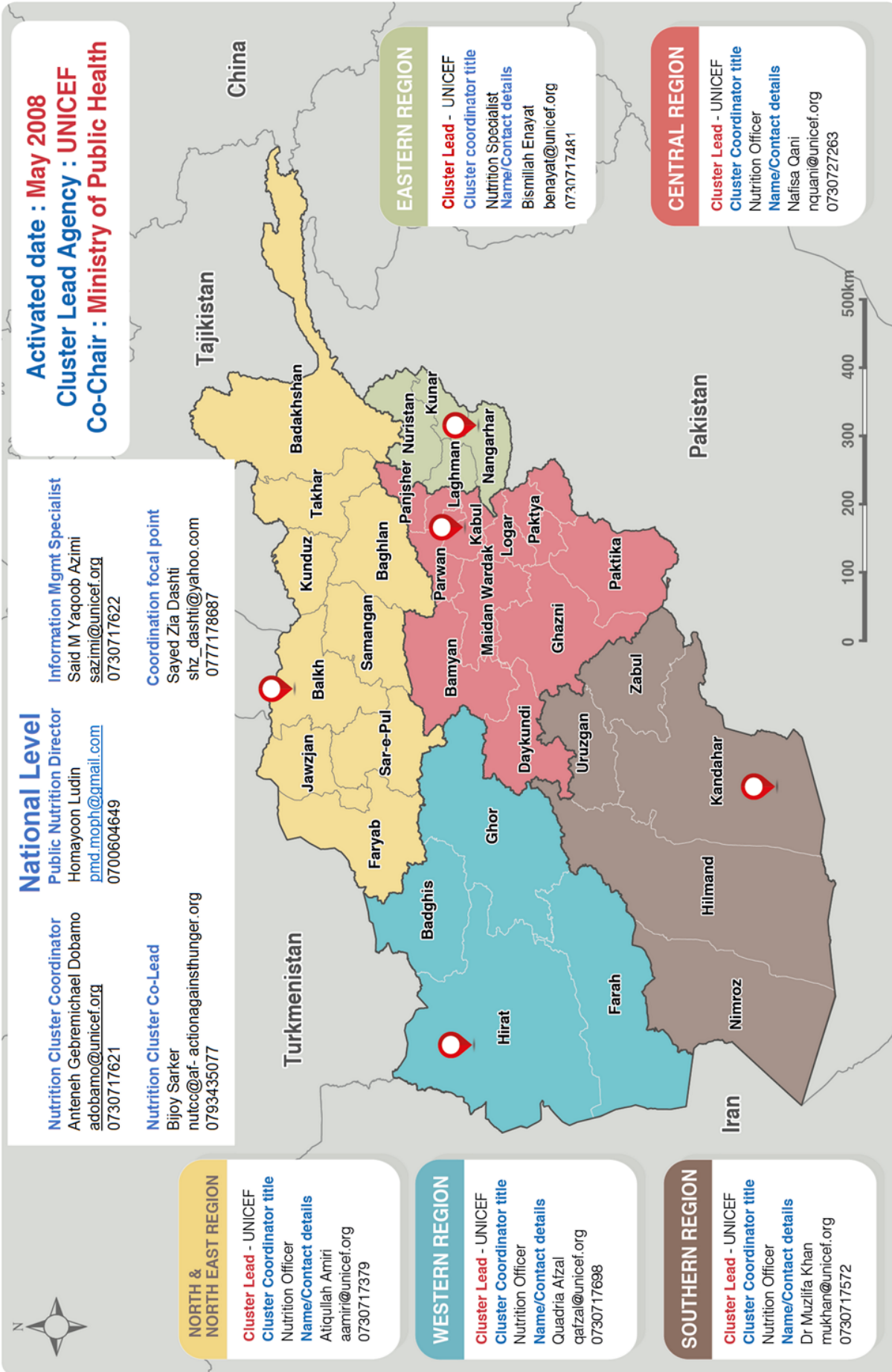
Malnutrition is a multi-causal problem which requires an integrated, holistic programming approach. Therefore, the package of emergency nutrition activities is designed in such a way that it takes advantage of and complements the ongoing, longer-term health and nutrition service delivery mechanisms such as the BPHS. Prevention-oriented One-UN framework programs complement the Nutrition Cluster's more treatment-focused emergency programs by strengthening referral linkages between prevention and treatment services, as well as contributing to enhancement of recovery, minimizing the risk of relapse for acutely malnourished children and PLW enrolled in treatment programs.

Annex 1: Afghanistan Nutrition Cluster Partners



Annex 2: Nutrition Cluster Coordination Hubs

AFGHANISTAN - Nutrition Cluster Coordination Mechanism - Focal Points - As of Jan 2019



Activated date : May 2008
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Sources : Nutrition Cluster Afghanistan, OCHA
 The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.



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About the Afghanistan Nutrition Cluster Bulletin

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Nutrition Cluster coordination information can be accessed online at:
<https://www.humanitarianresponse.info/en/operations/Afghanistan/nutrition>

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The content of this publication doesn't necessarily reflect the official position of Cluster Lead Agency (UNICEF) and PND/MoPH



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