Afghanistan in transition: call for investment in nutrition

Although much attention centres on Afghanistan's political and security transitions, malnutrition is a foremost concern. Because an absence of adequate nutrition has crucial long-term effects on individuals and on social and economic development, nutrition rates in Afghanistan deserve attention and action, especially during this time of transition. A national survey from Afghanistan's Ministry of Public Health, UNICEF, and Aga Khan University provides the first update in 10 years on the nutritional status of women, children, adolescents, and elderly people in Afghanistan.[1]

Nutritional status has well-established, profound effects on health throughout the lifecycle and is closely associated with cognitive and social development, particularly in early childhood.[2] Despite investments in the social sector in the past decade, Afghanistan has been shown to have very low commitment to tackle hunger and undernutrition, according to the Hunger and Nutrition Commitment Index.[3]

Compared with a 2004 nutrition survey, the latest cross-sectional household survey from 2013[1] shows a fall in estimates of stunting and underweight prevalence, but an almost stagnant level of wasting in children younger than 5 years. It also reports moderate improvement in malnutrition in women of reproductive age, although maternal wasting and micronutrient deficiencies remain widespread.

Despite some progress, reported rates of stunting in Afghanistan are still some of the highest in the world, ranging by province from 24·3% in Ghazni to 70·8% in Farah. Afghanistan's latest reported rates of stunting in children younger than 5 years are high compared with nearby countries.[1] For example, national estimates are lower for stunting in Uzbekistan at 19·6% and Tajikistan at 26·8% than India at 47·9% and Pakistan at 45·0%.[4] Alarmingly, almost half of figures for stunting (low height for age) and wasting (low weight for height) for children younger than 5 years in Afghanistan are severe

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Panel: **Selected indicators showing determinants of child undernutrition in Afghanistan**

Immediate

Health status

- 26·4% of children had diarrhoea (in the preceding 2 weeks)[1]
- 44·9% of children had anaemia[1]
- 45·8% of children had vitamin A deficiency[1]

Dietary intake

- 14·2% of children received the minimum acceptable diet (aged 6–23 months)[1]
- 6·3% of households had poor food consumption score and 17·9% had borderline[1]

Underlying

Food availability

- 30·1% of population had calorie deficiency[6]
- 19·4% of population had protein deficiency[6]
- 42·0% of households who experienced a shock (eg, shocks related to food or farm prices, or drinking water supply, agricultural problems, or natural disasters) resorted to food intake reduction[6]

Care of mothers and children

- 48·1% of mothers of young children had at least one antenatal care visit[1]
- 45·5% of mothers of young children had a skilled attendant at birth[1]
- 58·4% of children were exclusively breastfed (aged 0–5 months)[1]
- 12·2% of children received the minimum acceptable diet (aged 6–23 months)[1]

Health environment and services

- 62·9% of the population used improved drinking water sources[1]
- 40·4% of the population used improved sanitation facilities[1]
- 44·6% of children younger than 5 years of age received vitamin A supplementation[1]

Basic

Socioeconomic

- 40·9% of the working-age population participated in the labour force[6]
- 36·5% of the population was below the poverty line[6]
- 31·4% of the population aged 15–24 years were literate[6]

Public policy and laws

- 8·0% of total health expenditure as a percentage of gross domestic product (GDP)[7]
- 1·8% of public expenditure on the health sector as a percentage of GDP[8]
- 3·7% of public expenditure on agriculture as a percentage of GDP[3]
- National Nutrition Strategy (under development: 2015–19)
- Regulation on iodized salt (2011)[9]
- Regulation on protection and strengthening of child feeding by breast milk (2009)[10]

The three levels come from UNICEF's conceptual framework.[11]

(minus three SDs from the median measurement for the reference population). Provinces with high numbers of conflict incidents[5] also show poor indicators of nutrition. Food insecurity is another important factor.

The panel provides an overview of the determinants of child undernutrition in Afghanistan. These data represent the three levels of cause of undernutrition from UNICEF's conceptual framework,[11] which the nutrition community has been using for programming for more than two decades. From selected indicators, action is evidently needed in Afghanistan to address causes at all three levels—ie immediate (operating at the individual level), underlying (affecting households and communities), and basic (relating to the structure and processes of societies).

Measures should be institutionalised with a national strategy focused on multisectoral action with clear targets.[12] A range of actions is needed to address immediate and underlying causes of hunger and malnutrition.[13] Priority nutrition programmes should be identified, such as promotion of healthy growth, improvement of breastfeeding practices, and addressing of micronutrient deficiencies. Although multisectoral support and coordination is imminently needed, the role of national institutions should be strengthened in promotion of nutrition awareness, technical support, food safety, and regulatory mechanisms; food fortification; and behaviour change communication. Central coordination and oversight mechanisms are needed to support provinces, especially those with a small capacity and serving remote and insecure catchment areas.

An urgent need exists for public awareness at national and international levels of the importance and effect of nutrition in social and economic development of the Afghan society. Newly available evidence is a first step towards advocacy for better nutrition funding as a share of the national budget and policies to improve the nutrition status of the population, especially women and children. Further research to identify and address root causes of poor nutrition status and bottlenecks to improved service delivery for cases of malnutrition will support national and subnational surveillance, planning, and monitoring efforts.

Afghanistan is going through a crucial transition, the outcome of which will have profound effects on the health of its population. Although gains in nutrition might be deemed marginal, these gains are nevertheless important in the Afghan context and provide reason for hope—resources invested in the past decade are slowly, yet steadily, beginning to bear fruit. The new government can serve as a catalyst to accelerate progress, with continued support necessary from donors and development partners specialised in nutrition and food security. The Afghan people will look on with expectation, as the path the country will take unveils itself during the coming months.

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1 Afghanistan Ministry of Public Health, UNICEF. National nutrition survey Afghanistan (2013): survey report. Kabul: Afghanistan Ministry of Public Health, 2013.

2 Black RE, Victora CG, Walker SP, et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. *Lancet* 2013; **382:** 427–51.

3 Hunger and Nutrition Commitment Index. Key data for Afghanistan. http://www.hancindex.org/countries/afghanistan (accessed Dec 3, 2014).

4 WHO. 2013 joint child malnutrition estimates—levels and trends. UNICEF–WHO–World Bank project. http://www.who.int/entity/nutgrowthdb/jme_master2013.xlsx?ua=1 (accessed Dec 3, 2014).

5 UN Office for the Coordination of Humanitarian Affairs. 2014 humanitarian needs overview: Afghanistan. Kabul: UN Office for the Coordination of Humanitarian Affairs, 2013.

6 Central Statistics Organization. National risk and vulnerability assessment 2011–2012 (Afghanistan living condition survey). Kabul: Central Statistics Organisation, 2014.

7 Afghanistan Ministry of Public Health. Afghanistan national health accounts with subaccounts for reproductive health 2011–2012. Kabul: Afghanistan Ministry of Public Health, 2013.

8 World Bank. Health expenditure, public (% of GDP). http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS (accessed Dec 3, 2014).

9 Dodd N, Hamid BA, Shams MQ, Nasiri S. Awareness and household coverage of iodised salt in Afghanistan. Iodine Deficiency Disorders Newsletter. May 2013. http://www.iccidd.org/newsletter/idd_may13_afghanistan.pdf (accessed Dec 3, 2014).

10 International Baby Food Action Network. State of the code by country. Penang: International Baby Food Action Network, 2011.

11 UNICEF. The state of the world's children 1998. New York: UNICEF, 1998.

12 de Onis M, Dewey KG, Borghi E, et al. The World Health Organization's global target for reducing childhood stunting by 2025: rationale and proposed actions. *Matern Child Nutr* 2013; **9:** 6–26.

13 Food and Agricultural Organization of the UN, International Fund for Agricultural Development, World Food Programme. The state of food insecurity in the world 2014. Strengthening the enabling environment for food security and nutrition. Rome: Food and Agricultural Organization of the UN, 2014.