Urgent Action Needed in Afghanistan: Funding gaps in nutrition response place thousands of lives at risk

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EXECUTIVE SUMMARY

The nutrition situation in Afghanistan is worsening, and the nutrition response in Afghanistan is struggling to meet the needs of an estimated 2.9 million acutely malnourished children due to a combination of funding gaps and access issues. The data in this paper shows that almost 580,000 children in need of life-saving nutrition care in Afghanistan risk being missed in 2024. Around half of these children (almost 228,000) are suffering from severe acute malnutrition (SAM) – without care they are 12 times more likely to die than healthy children. The highest prevalence of malnutrition has been reported in Helmand (22.3% of children are malnourished) and Daykundi (17.5% of children are malnourished). Action Against Hunger (ACF) is active in both Helmand and Daykundi, and can use the data collected from its operations to underline the needs of the population, and the challenges faced by the country-wide nutrition response.

The key drivers of malnutrition are disease outbreak which exacerbate malnutrition, insufficient food diversity and frequency, high food insecurity and poor access to health and nutrition services. Increasing restrictions on women have contributed to issues in access. Poor access has further been highlighted in this paper by analyzing admission trends: while rates of acutely malnourished children have not significantly changed since last year, admission rates between January and July 2024 have dropped by 16% compared to the same period in 2023. This reduction in admission is largely attributed to the widespread closure of Mobile Health and Nutrition Teams (MHNTs), 52% of which have been closed since last year. The closures are down to decrees from the de-facto authorities (DfA) recommending fixed facilities over mobile teams, and a lack of funding. Finally, geographic coverage of Therapeutic Feeding Units (TFU) remains low. Data from ACF-run units shows that 60% of people travel over the recommended distance to reach services.

URGENT ACTION NEEDED TO SAVE LIVES

- Increase funding and coordinated engagement with the DfA to ensure the continuation and expansion of Mobile Health and Nutrition Teams (MHNT), especially in underserved areas.
- Screening and referrals should be increased: Targeted Supplementary Feeding program (TSFP) assistants should engage in nutrition screening at Basic Health Centers (BHC) and Sub Health Centers (SHC), and additional nutrition screeners should be recruited for crowded health facilities. Mass Mid-Upper Arm Circumference (MUAC) screening campaigns are needed including within Polio campaigns and within Community-Based Vaccination Centers (CBVC). Family MUAC initiatives, whereby caregivers are trained to identify early signs of malnutrition, should be reactivated.
- To improve the quality of services at TFUs, it is recommended to strengthen the capacity of health workers through training, support overcrowded centers with additional staff, scale up existing TFUs by expanding to new units and establish more TFUs in underserved provinces.
- Coordinated engagement with the Minister for Public Health to advocate for the approval of cash assistance for transport to help caretakers and patients access TFUs.
- Meet the critical funding gap of the Nutrition Cluster ($52.5 million) for the remainder of 2024.

The data in this paper was provided by the Afghanistan Nutrition Cluster, WHO and UNICEF, and is complemented with data from ACF operations in country.

TERMINOLOGY GUIDE

ACF	Action Against Hunger
ARI	Acute Respiratory Infection
AWD	Acute Watery Diarrhea
BHC	Basic Health Center
CBVC	Community-Based Vaccination Center
DfA	De-facto Authorities
HNRP	Humanitarian Needs and Response Plan
IPD	In-Patient Department
MUAC	Mid-Upper Arm Circumference
MAD	Minimum Acceptable Diet
MDD	Minimum Dietary Diversity
MMF	Minimum Meal Frequency
MHNT	Mobile Health and Nutrition Teams
MAM	Moderate Acute Malnutrition
OPD	Out-Patient Department
PBW	Pregnant and Breastfeeding Women
SAM	Severe Acute Malnutrition
SHC	Sub-Health Center
TSFP	Targeted Supplementary Feeding Program
TFU	Therapeutic Feeding Units

1. OVERVIEW OF THE NUTRITION SITUATION IN AFGHANISTAN

As shown in figure 1, Afghanistan continues to face persistently high level of acute malnutrition. [1]

In 2024, an estimated 2.9 million children aged under five are acutely malnourished including around 857,000 children suffering from severe acute malnutrition (SAM). In addition, nearly 1.1 million pregnant and breastfeeding women in Afghanistan are estimated to suffer from acute malnutrition in 2024. [2] The recent UNICEF Community Nutrition Sentinel Sites and Nutrition Cluster/ PND Mass Mid-Upper Arm Circumference (MUAC) screening, a simple measurement of the upper arm used to identify children with malnutrition, reported malnutrition rates among children above 10% in more than half of provinces. The three worst affected provinces are Helmand (22.3%), Daykundi (17.5%) and Sar-e-Pul (17.2%).

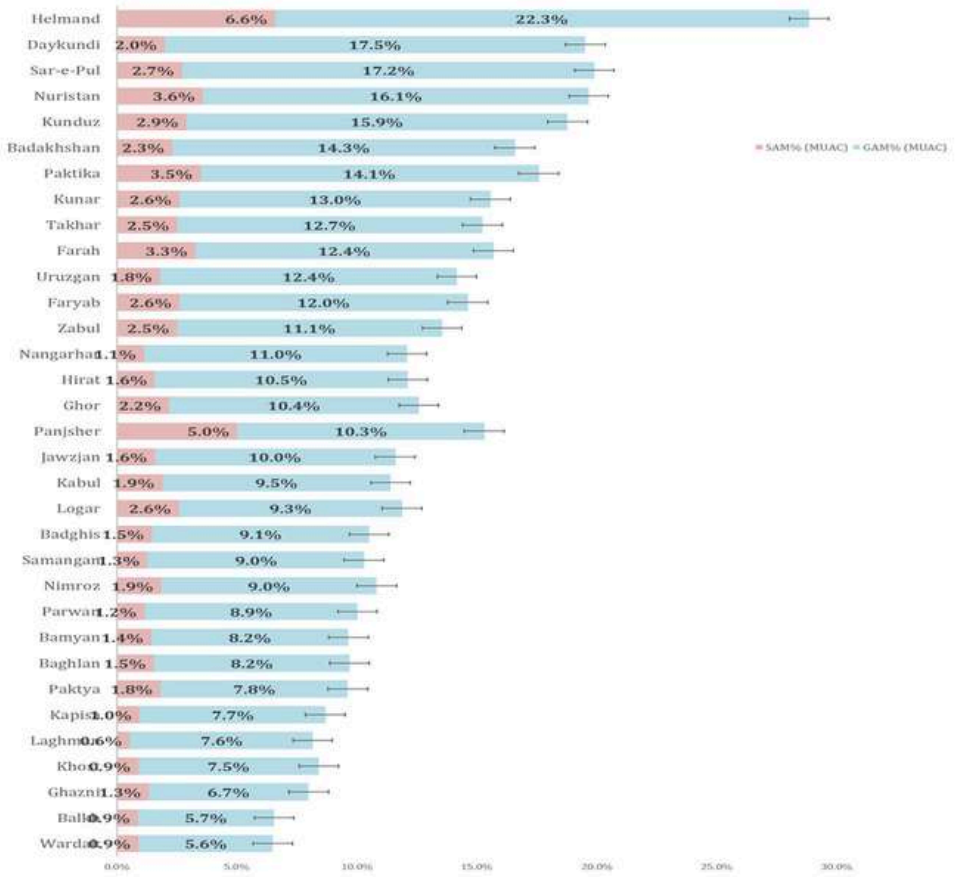

Figure 1: Acute Malnutrition prevalence by Province

[1] UNICEF Community Nutrition Sentinel Sites Results, July 2024; Nutrition Cluster Mass MUAC Screening Results, August-September 2024
[2] Nutrition Cluster, 2024

2. FUNDING GAP

Key message: The funding gap for the nutrition cluster for 2024 affects nutrition services for 2.6 million people.

The Nutrition Cluster in Afghanistan faces a total funding gap of $108.2 million for the remainder of 2024, based on the 2024 Humanitarian Needs and Response Plan (HNRP).

This gap affects services for an estimated 2.6 million children under five and pregnant and breasfeeding women (PBW) including almost 228,000 severe acutely malnourished children who are at risk of not receiving critical lifesaving care. Within this $108.2 million total, the Nutrition Cluster has estimated the critical funding gap to be $52.5 million, which is required for essential, life-saving nutrition treatment services for severe acute malnutrition (SAM) and outpatient department for moderate acute malnutrition (MAM) care. Without treatment, SAM children are twelve times more likely to die than healthy children, underlining how critical the needs are of the almost 228,000 SAM children who risk not receiving care this year.[1]

[1] Nutrition Cluster Funding Gap Analysis, September 2024

3. THE KEY DRIVERS OF MALNUTRITION IN AFGHANISTAN

Key message: Disease outbreak, suboptimal infant and young children care feeding practices, acute food insecurity levels and poor access to nutrition and health services in Afghanistan are amongst the key drivers of malnutrition in Afghanistan.

Morbidity: As shown in figure 2, the Nutrition Cluster analysis highlights a strong correlation between elevated rates of acute watery diarrhea (AWD) and acute respiratory infection (ARI) and the increase in SAM and MAM cases, particularly evident from June 2024 onward. This suggests that periods of high AWD and ARI prevalence exacerbate malnutrition issues in Afghanistan.[1] Elevated rates of AWD and ARI can be attributed to limited access to clean drinking water, poor sanitation and hygiene, and inadequate healthcare and immunization.

[1] Nutrition Cluster, July 2024

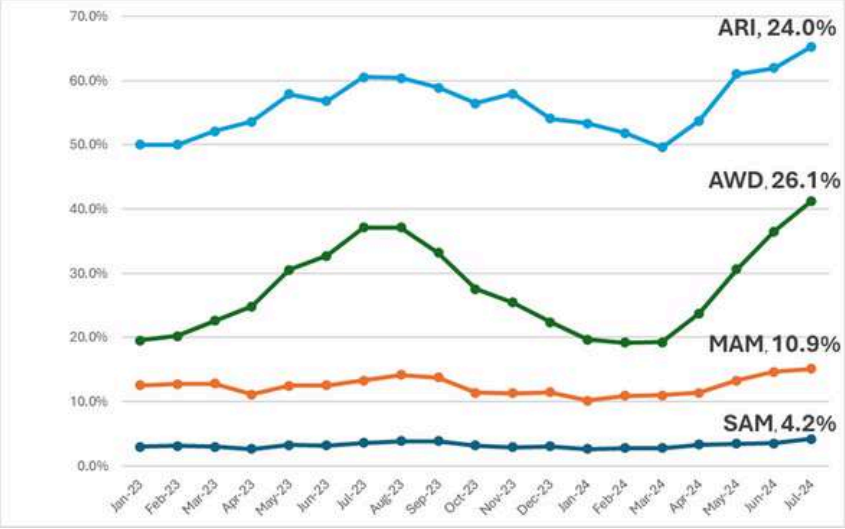

Figure 2: Trends in disease prevalence related to SAM and MAM

Suboptimal Infant and Young Child Feeding Practices: In Afghanistan, suboptimal infant and young child feeding practices contribute to the poor nutritional status of children under two years of age. The exclusive breastfeeding rate for infants under six months is 63.3%, but continued breastfeeding drops sharply with only 52.3% of mothers continuing breastfeeding up to two years. Complementary feeding practices are also very low with only 14.8% of children aged 6 to 23 months meeting the Minimum Dietary Diversity (MDD) by consuming at least five food groups. Furthermore, only 34.2% meet the Minimum Meal Frequency (MMF) and just 6.8% achieve the Minimum Acceptable Diet (MAD), reflecting a concerning gap in proper complementary feeding practices. [1]

Elevated levels of acute food insecurity: Over a third of Afghanistan's population (14.2 million people) are experiencing high levels of acute food insecurity (IPC Phase 3 or above), driven primarily by climatic shocks and high food prices. [2]

[1] UNICEF, Afghanistan Multiple Indicator Cluster Survey (MICS), 2022-2023
[2] IPC Analysis Projection for November 2023 to March 2024

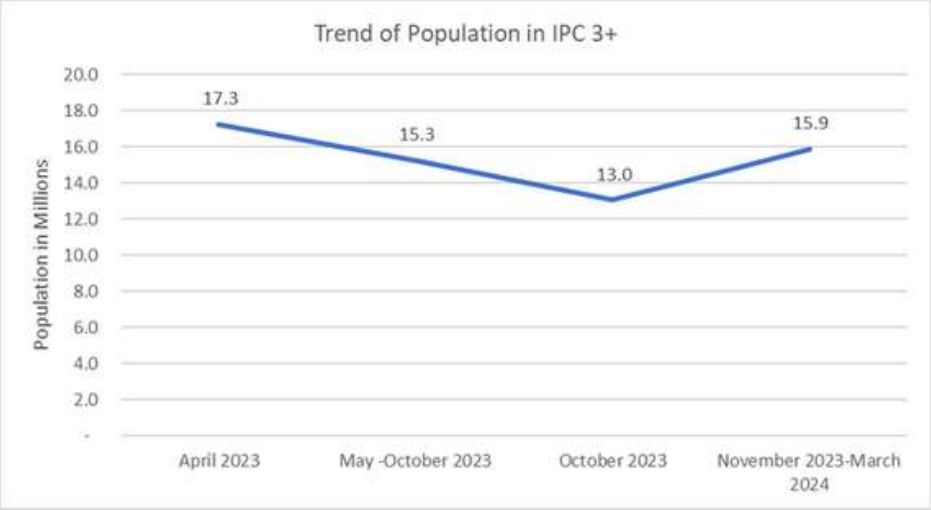

Figure 3: IPC trends April 2023 - March 2024

Poor access to nutrition and health services: The mahram requirement, imposed by de facto authorities (DfA) in December 2021, severely restricts women's and girls' access to essential health and nutrition services by making their mobility largely dependent on having a mahram available to escort them. [1] This restriction not only limits their ability to seek timely and critical nutrition and healthcare but also creates additional barriers in accessing other humanitarian aid. As a result, women who cannot "secure" a mahram face delays or completely unmet health and nutrition needs and increasing the risk of malnutrition and preventable illnesses. The mahram requirement further deepens gender inequalities in accessing sustained essential nutrition and healthcare.

[1] GEEWG Strategy Afghanistan, September 2024

4. DECREASE IN SAM AND MAM ADMISSIONS

Key message: The closure of MHNTs and TSFPs, the phasing out of the UNICEF-supported urban strategy, as well as poor screening at health facilities for nutrition services is causing a decrease in admission rates for MAM and SAM patients nationally.

As shown in Table 1, the first seven months of 2024 saw an overall decline of 19% in SAM admissions and a 16% decline in MAM admissions across Afghanistan compared to the same period in 2023.

	SAM admission	MAM admission	Total admision
2023 (Jan -Jul)	392930	855784	1248714
2024 (Jan - Jul)	319908	723222	1043130
Difference	-19%	-15%	-16%

Table 1: Total admissions across Afghanistan Jan - July 2024 (source: Nutrition Cluster)

4.1. CONTRIBUTING FACTORS FOR SAM AND MAM ADMISSIONS DECLINE IN 2024

4.1.1 MHNTs Closure

Mobile Health and Nutrition Teams (MHNT) are small teams of healthcare workers who travel to hard-to-reach areas of Afghanistan to provide basic health services, as well as nutrition screening and services to children under 5. [1] The number of mobile health and nutrition teams (MHNTs) services decreased by 52% in 2024 compared to 2023. Two factors have contributed to the closure of over 317 MHNTs in 2024: funding shortages and decrees from the DfA recommending fixed health services over mobile services. This sharp decrease in MHNTs has not been matched by an increase in fixed health facilities, thus coverage of health and nutrition services is reduced. [2]

[1] UNICEF, Healthcare on Wheels, 2024
[2] Nutrition Cluster, 2024

Figure 4: Trends of the # of MHNTs over the last 3 years (source: Nutrition Cluster)

4.1.2. Impact of MHNT closures on SAM and MAM admissions at MHNTs

Due to the widespread closure of MHNTs, admissions of SAM and MAM cases through MHNTs have dropped drastically. Compared to the same period in 2023, the first six months of 2024 saw an overall decline in SAM admissions through MHNTs of 58% (36,490) and a decline in MAM admissions through MHNTs of 79% (64,985). These closures severely impact the reach and effectiveness of nutrition services, particularly in hard-to-reach areas, resulting in more than 100,000 children in need of treatment being missed.

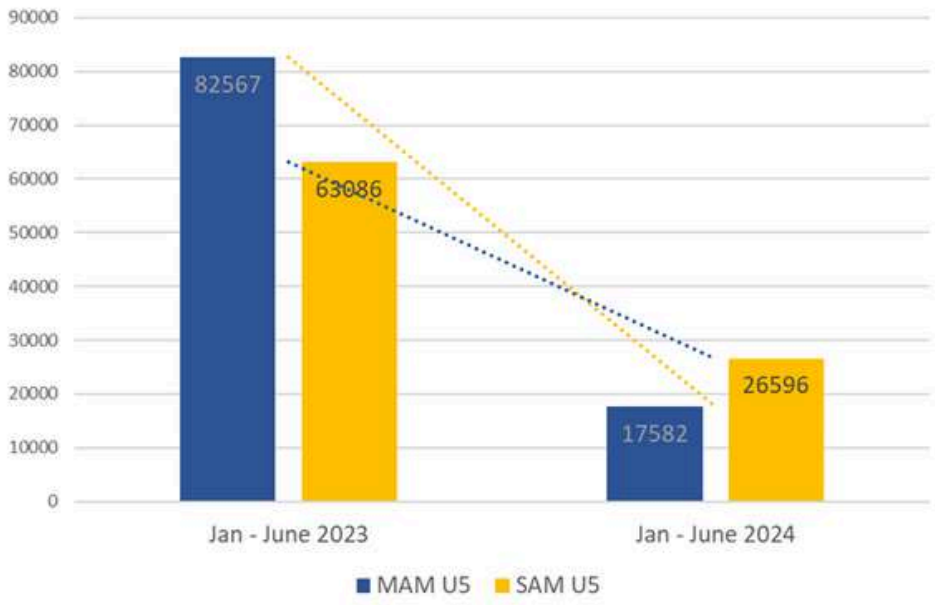

Figure 5: MAM and SAM admission through MHNTs, Jan-June 2023 and Jan-June 2024 (source: Nutrition Cluster, 2024)

4.1.3 Closure of TSFP sites

More than 450 targeted supplementary feeding program (TSFP) sites closed in 2024, affecting MAM admissions for over 67,000 children and reducing geographic coverage for nutrition services. TSFPs are designed to provide nutritional support to children under five and pregnant and breastfeeding women (PBW) who are identified as being moderately malnourished.

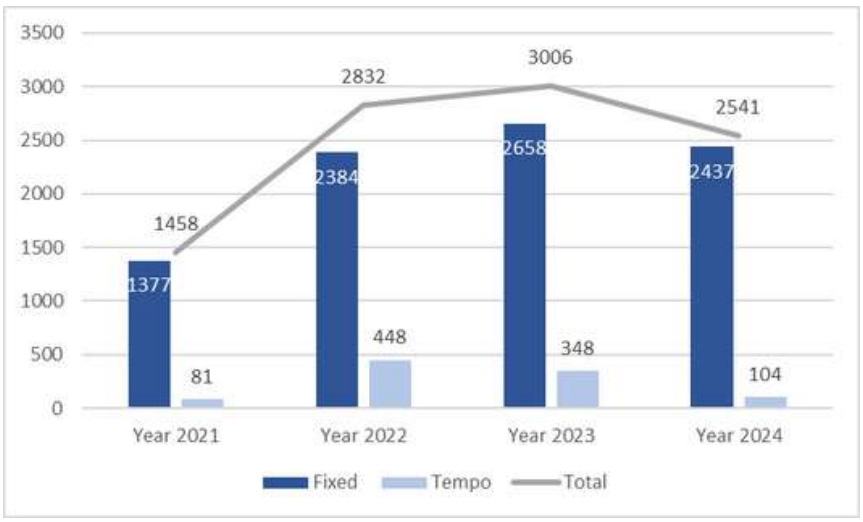

Figure 6: Trends in the number of MAM sites. Fixed = permanent, Tempo = temporary (source: Nutrition Cluster)

4.1.4. Suboptimal screening performance

As shown in Figure 7, the Nutrition Cluster analysis of outpatient department (OPD) visits and nutrition screening for children under 5 in 2024 indicates that nearly 45% of these children did not receive nutrition screening services upon arriving at health facilities. This missed opportunity for nutrition screening likely also contributed to the reduction in SAM and MAM admissions.

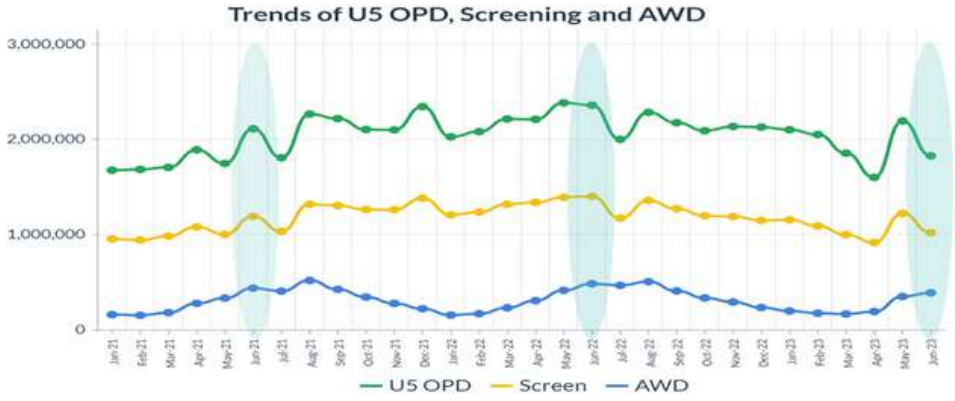

Figure 7: Trends of U5 OPD, Screening and AWD (source: Nutrition Cluster)

4.1.5. Phasing out of Urban Strategy and its impact on SAM admission

The UNICEF-supported "urban strategy" was designed to address the increasing need for nutrition care in urban areas, which may be overlooked in the nutrition response. The strategy pioneered in 2023 and consisted of four steps; scaling up of outpatient and inpatient departments, incentives for caregivers, daycare centers and community engagement.[1] Following the implementation of this strategy, the number of SAM cases admitted in Kabul city increased to nearly 92,000 in 2023, compared to just 3,000 in 2021. However, largely due to funding shortages the urbans strategy began being phased out in 2024, which led to a shortage of human resources at health facilities, resulting in a decrease in admissions.

In the first 6 months of 2024, 4600 SAM children missed treatment due to the phasing out of the urban strategy.[2]

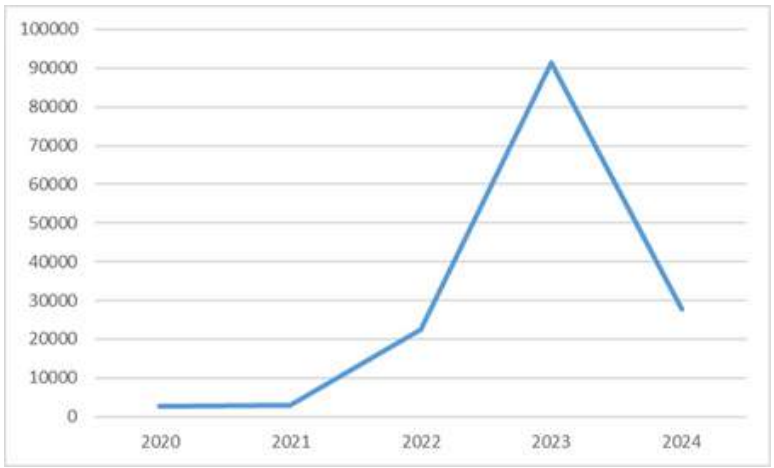

Figure 8: Trends of SAM admission in Kabul city (source: Nutrition Cluster)

[1] UNICEF, Four steps to deliver dramatic results for malnourished children, 2023
[2] Nutrition Cluster, 2024

5. GEOGRAPHIC COVERAGE OF NATIONAL TFUS

Key message:

Geographic coverage of TFUs remains poor, TFUs are overwhelmed and understaffed resulting in inadequate care for patients and late access to services

5.1. Current status of IPD SAM services

In Afghanistan, between January and July 2024, a total of 29,839 SAM children with complications were admitted for treatment at 142 Therapeutic Feeding Units (TFU) across Afghanistan.[1] There was a clear seasonal pattern, with admissions peaking around mid-year (June-July) likely corresponding to increased malnutrition cases during lean seasons. While OPD SAM admissions are down country-wide, IPD SAM admissions to TFUs are increased which indicates a deteriorating nutrition situation and late detection.

[1] Nutrition Cluster, 2024

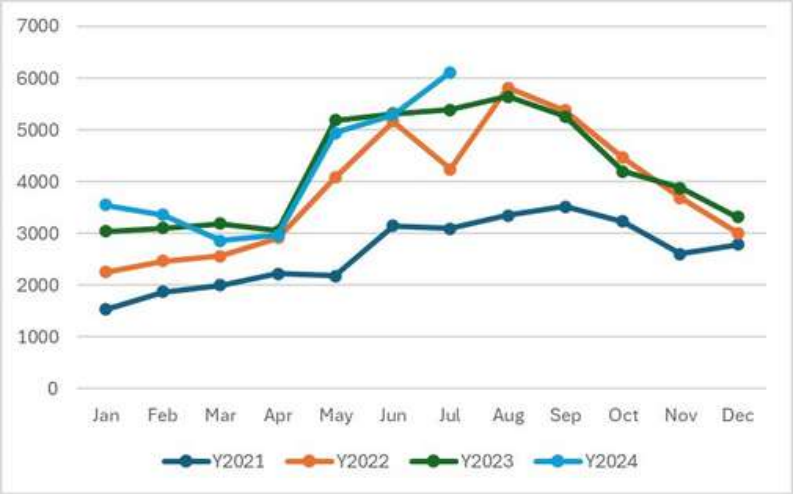

Figure 9: Trends of IPD SAM admission at TFUs (source: Nutrition Cluster)

Further, the geographic distribution of these TFUs does not adequately meet the needs of the affected populations. As shown in Figure 10, provinces with the most IPD-SAM centers include Nangarhar (8), Kabul (12) ad Ghazni (7). In contrast, the provinces with the least IPD-SAM centers are highlighted in red, including Khost (1), Nimroz (1), Farah (2), Badghis (2) and Zabul (2). The insufficient number of TFUs in these provinces has led to overcrowding in regional hospitals and inadequate care for patients.[1] Furthermore, patients are being admitted increasingly late due to access issues and a lack of awareness regarding the signs of malnutrition. This leads to complications and increases the mortality rate, particularly among children under six months.

[1] WHO, July 2024

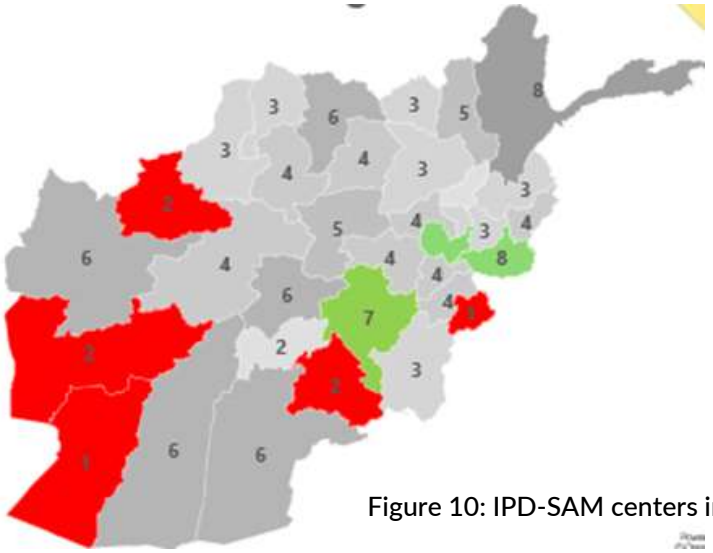

Figure 10: IPD-SAM centers in Afghanistan

5.2. IPD SAM admission trend at ACF supported TFUs

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ACF operates across three of the provinces most affected by food insecurity: Badakshan, Ghor and Helmand, making ACF key in the response to food insecurity and malnutrition in Afghanistan. 4,259 children have been admitted so far this year to ACF-supported TFUs as shown in table 2 below. As was noted in admissions across Afghanistan, peak admission occurred in June/July to coincide with the seasonal pattern. The high number of IPD SAM admissions in ACF-supported TFUs highlights the significant impact of ACF interventions. Specifically, 11.5% of all IPD SAM admissions nationwide occur in ACF-supported TFUs, further emphasizing ACF's crucial role in saving children's lives across the country.

Table 2: IPD SAM admissions in ACF-supported TFUs in 2024

Province/Base	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Total
Helmand	199	153	158	193	373	304	558	266	2,204
Daykundi	29	11	43	32	24	30	33	34	236
Ghor	109	76	44	76	83	107	261	268	1,024
Kabul	61	63	51	46	68	74	80	74	517
Badakhshan	26	19	32	22	33	49	55	42	278
Total	**424**	**322**	**328**	**369**	**581**	**564**	**987**	**684**	4,259

5.3. Distance traveled to TFU service points

According to Sphere standards, travel to access treatment should be below 5km. However, 60% of individuals accessing ACF-supported TFUs travelled more than 5km. This highlights the poor geographic coverage of TFUs in Afghanistan.

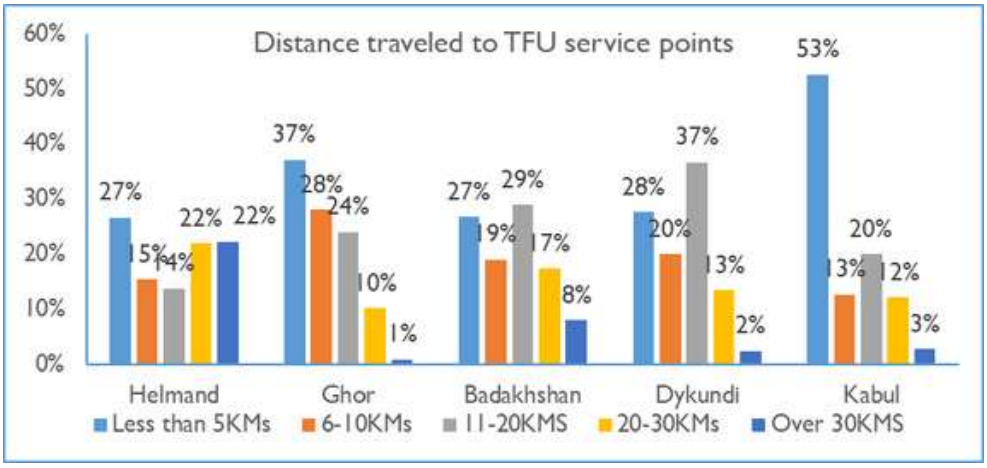

Figure 11: Distance traveled to TFU service points

Long distances, especially seen in Helmand, present a significant barrier to life-saving nutrition services increasing the likelihood of delays in treatment leading to worse malnutrition outcomes. Referral mechanisms between health facilities are also impacted by long distances. For example, referrals from Ghor Province to Herat Province require one full day of travel. Referrals between provincial and district hospitals are also poor and impacted by the ban on cash transfers [1] within hospitals is also impacting the ability to refer elsewhere.

[1] The guideline for the design, implementation and monitoring of cash transfer programs for nutrition interventions have been developed by the Nutrition Cluster and its partners but have not yet been endorsed by the the Ministry of Public Health for use by partners.

ACTION AGAINST HUNGER AFGHANISTAN

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