

Afghanistan

Demographics

Total population (2020)

38 928 341

Life expectancy at birth (years) female/male (2019)

66/63

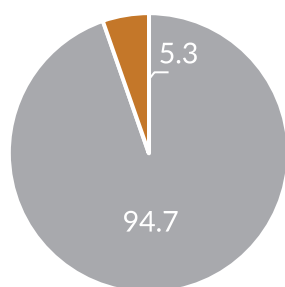
Under-5 mortality rate (per 1000 live births) (2018)¹

50

Gross domestic product per capita (current US\$) (2020)

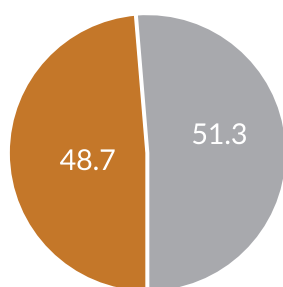
508.8

Population as percentage of regional total, 2020



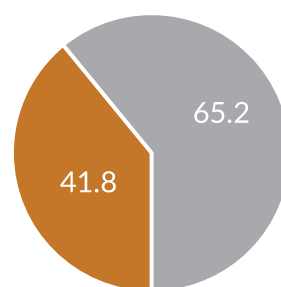
■ Region ■ Afghanistan

Percentage of female and male population, 2020



■ Female ■ Male

Population aged 0–14 of total population, 2020



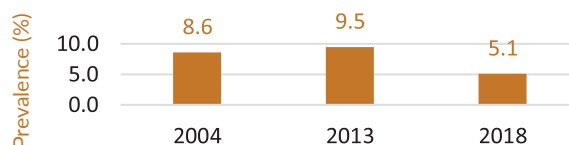
■ 0–14 ■ > 14

Source: The World Bank

Child malnutrition

According to the WHO Global Health Observatory,² the prevalence of wasting in children under 5 in Afghanistan decreased from 8.6% in 2004 to 5.1% in 2018. The prevalence of stunting has decreased from 54.6% to 35.1% over the past two decades but remains significantly higher than the regional average. During the same period, the prevalence of overweight in children under 5 decreased from 5.2% to 3.9%.

Wasting prevalence among children under 5 years of age



Stunting prevalence among children under 5 years of age



Overweight prevalence among children under 5 years of age



Source: WHO Eastern Mediterranean Regional Health Observatory; WHO Global Health Observatory.

¹ Afghanistan health survey 2018. Kabul: Ministry of Public Health; 2018 (<https://www.kit.nl/wp-content/uploads/2019/07/AHS-2018-report-FINAL-15-4-2019.pdf>, accessed 6 July 2022).

² Nutrition. In: WHO Global Health Observatory [website]. Geneva: World Health Organization; 2022 (<https://www.who.int/data/gho/data/themes/theme-details/GHO/gho-nutrition>, accessed 6 June 2022).

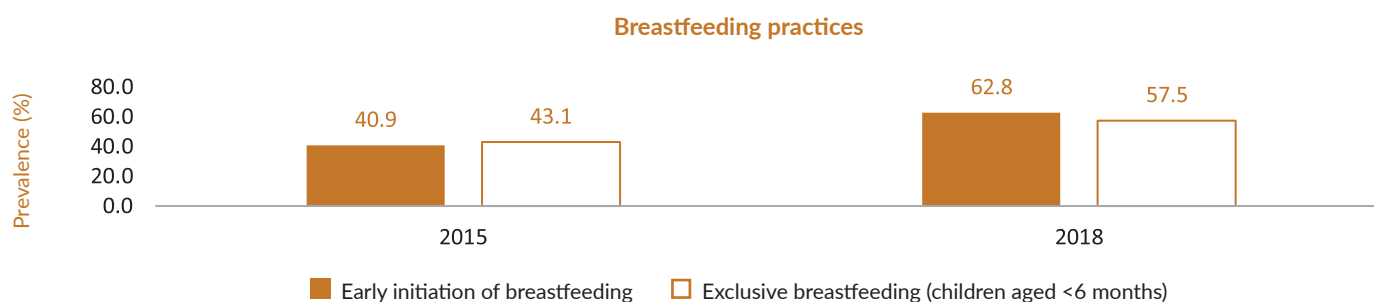
Note: The UNICEF/WHO/WB joint child malnutrition estimates for stunting and overweight are modelled at logit (log-odds) scale using a penalized longitudinal mixed-model with a heterogeneous error term. The country modelled estimates are generated using the JME country dataset, which uses the collection of national data sources. Due to this method, estimates may differ from official estimates of Member States (i.e., the stunting prevalence from a household survey for a given country in a given year is not reported as the prevalence for that country in that year; rather, it feeds into the modelled estimates). The methodology is described here: <https://www.who.int/publications/i/item/9789240025257>. Wasting is defined as a percent weight-for-height that is two or more standard deviations below the median. Stunting is defined as a percent height-for-age that is two or more standard deviations below the median. Overweight is defined as a percent weight-for-height that is two or more standard deviations above the median.

According to Afghanistan's 2018 health survey¹, the prevalence rates for wasting (defined as a weight-for-height two or more standard deviations below the median), stunting (defined as a height-for-age two or more standard deviations below the median) and overweight (defined as a weight-for-height two or more standard deviations above the median) in 2018 were 5.0%, 36.6% and 4.0%, respectively.

Source: Ministry of Public Health in Afghanistan.

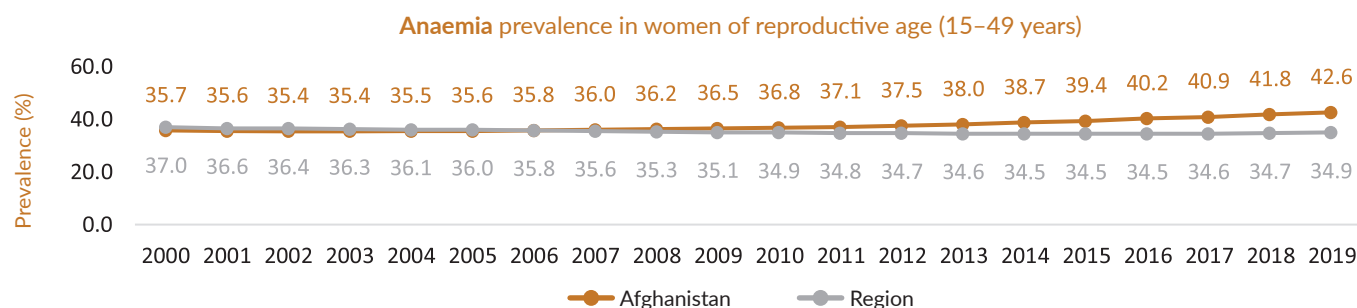
Infant and young child feeding

The prevalence of early initiation of breastfeeding (within one hour of birth) in Afghanistan increased from 40.9% in 2015 to 62.8% in 2018. During the same period, the prevalence of exclusive breastfeeding increased from 43.1% to 57.5%, making Afghanistan one of the few countries in WHO's Eastern Mediterranean Region to be on track to meet WHO's global nutrition target of increasing the rate of exclusive breastfeeding in the first six months up to at least 50%



Anaemia in women of reproductive age

The prevalence of anaemia in women of reproductive age (pregnant and non-pregnant women combined) remained close to the regional average from the period 2000 to 2010, after which it began to increase. The latest estimate for anaemia prevalence from 2019 is 42.6%, which is significantly higher than the estimate for regional prevalence.



Source: WHO Global Health Observatory.

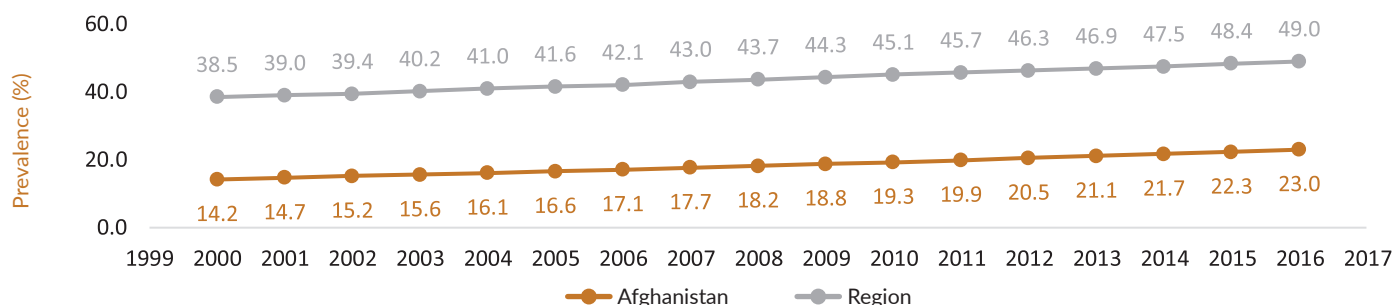
Note: The WHO global anaemia estimates are derived from a hierarchical Bayesian mixture model that uses all available data to make estimates for each country and year. In the model, estimates for each country are informed by data from that country itself, if available, and by data from other countries, especially those in the same region. Due to this method, the estimates may differ from official estimates of Member States. The methodology is described here: https://cdn.who.int/media/docs/default-source/anaemia-in-women-and-children/hb-methods-for-gather.pdf?sfvrsn=da0fbb5f_11 and here: <https://pubmed.ncbi.nlm.nih.gov/25103581/>.

¹ Afghanistan health survey 2018. Kabul: Ministry of Public Health; 2018 (<https://www.kit.nl/wp-content/uploads/2019/07/AHS-2018-report-FINAL-15-4-2019.pdf>, accessed 6 July 2022).

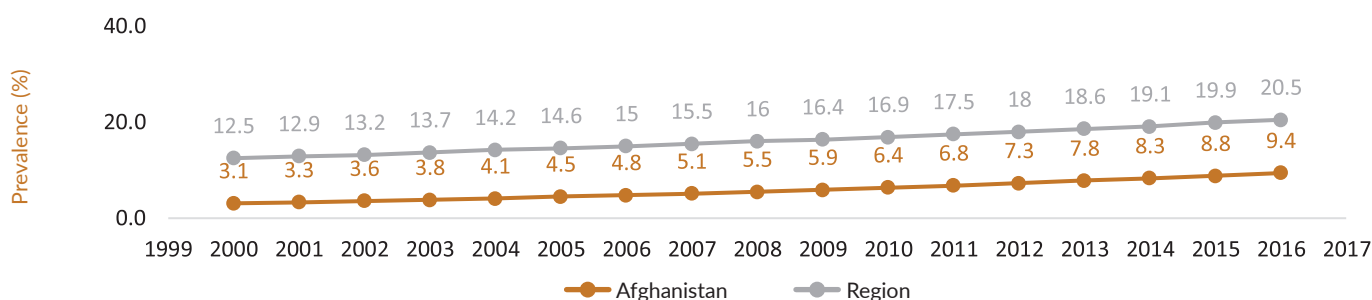
Overweight and obesity

An increase in the prevalence of overweight among adults in Afghanistan was recorded between 2000 and 2016 (from 14.2% to 23%). Also, the prevalence of overweight among children and adolescents aged 5–19 has risen from 3.1% in 2000 to 9.4% in 2016.

Overweight prevalence among adults (age-standardized estimate)



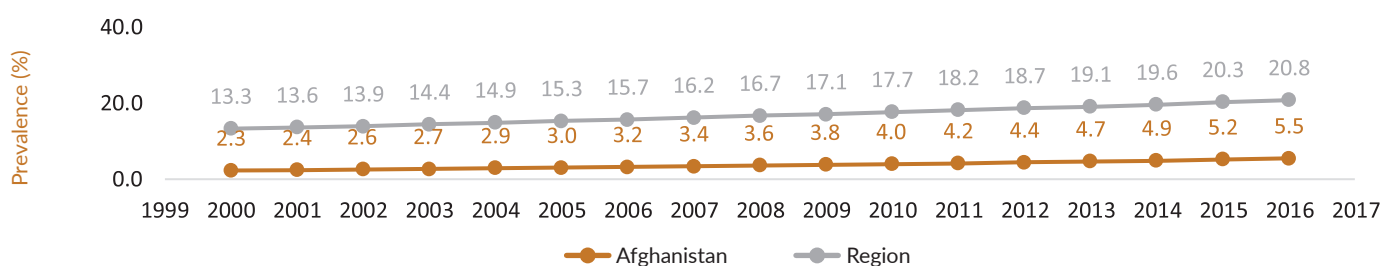
Overweight prevalence (weight for height >+2 standard deviation from the median of the WHO Child Growth Standards) among children and adolescents (5–19), (crude estimate)



BMI = body mass index. (Overweight in adults is defined as a BMI of 25 or greater, and in children and adolescents as a BMI one or more standard deviations above the median. Obesity in adults is defined as a BMI of 30 or greater, and in children and adolescents as a BMI two or more standard deviations above the median.)

Afghanistan is one of the countries in the Region that has a low incidence of obesity among adults but the prevalence of obesity increased from 2.3% to 5.5% between 2000 and 2016, and among children and adolescents aged 5–19 significantly increased between 2000 and 2016 from 0.6% to 3.1%.¹

Obesity prevalence among adults, (age-standardized estimate)



Obesity prevalence among children and adolescents (5–19), (crude estimate)



Source: WHO Global Health Observatory; Institute for Health Metrics and Evaluation.

¹ Country profiles [website]. Seattle, WA: Institute for Health Metrics and Evaluation, University of Washington; 2021 (<https://www.healthdata.org/results/country-profiles>, accessed 11 July 2022).

Note: The WHO estimates for overweight and obesity are derived from a Bayesian hierarchical model, which uses NCD-RisC database of population-based data. The model has a hierarchical structure in which estimates for each country and year are informed by its own data, if available, and by data from other years in the same country and from other countries, especially those in the same region with data for similar time periods. Due to this method, the estimates may differ from official estimates of Member States. The methodology is described here: <https://pubmed.ncbi.nlm.nih.gov/29029897/>.

Micronutrient status

In 2013, the prevalence of vitamin A deficiency (measured as serum retinol ≤ 0.70 $\mu\text{mol/L}$) was 50.4% among pre-school children aged 6-59 months.¹ The iodization of salt was scaled up and the estimated median urinary iodine concentration among school children was 171 $\mu\text{g/L}$ in 2013, hence iodine intake in Afghanistan was considered adequate (100–299 $\mu\text{g/L}$).²

Source: WHO Micronutrients Database. Vitamin and Mineral Nutrition Information System.

Nutrition policies and strategies

Key national programmes

		Date
Development of national nutrition strategy or action plan ^a	✓	For 2015–2020
Plan of action for obesity prevention	✗	
Strategy or plan of action on infant and young child feeding ^b	✓	2016
Code of marketing of breast milk substitutes ^{a, c, d}	✓	Since 2009
Child growth monitoring ^b	✓	Since 2002
School feeding programme	✗	
Integrated management of acute malnutrition ^{b, e, f}	✓	Updated 2018

Policies	Policy to reduce salt/sodium consumption	Tax on sugar sweetened beverages	Policy to limit trans-fatty acid intake	Policy to reduce the impact of marketing of food to children	Policy on salt iodization ^{a, b, g}	Front-of-pack nutrition labelling for food	Wheat flour fortification ^{b, f, h}
	✗	✗	✗	✗	✓	✗	✓

✓ = Policy/programme implemented

✗ = Policy/programme not implemented

^a Policies in Afghanistan. In: Global database on the Implementation of Nutrition Action [website]. Geneva: World Health Organization; 2022 (<https://extranet.who.int/nutrition/gina/en/policies/1368>, accessed 6 June 2022).

^b Programmes/actions in Afghanistan. In: Global database on the Implementation of Nutrition Action [website]. Geneva: World Health Organization; 2022 (<https://extranet.who.int/nutrition/gina/en/programmes/1368>, accessed 6 June 2022).

^c Al Jawaldeh A, Sayed G. Implementation of the International Code of Marketing of Breastmilk Substitutes in the Eastern Mediterranean Region. East Mediterr Health J. 2018(1):25–32. doi.org/10.26719/2018.24.1.25.

^d Marketing of breast milk substitutes: national implementation of the international code, status report 2020. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/i/item/9789240006010>, accessed 6 June 2022).

^e Global nutrition policy review 2016–2017: country progress in creating enabling policy environments for promoting healthy diets and nutrition. Geneva: World Health Organization; 2018 (<https://www.who.int/publications/i/item/9789241514873>, accessed 6 June 2022).

^f Marketing of breast milk substitutes: national implementation of the international code, status report 2020. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/i/item/9789240006010>, accessed 6 June 2022).

^g Ministry of Public Health data, 2018.

^h Doggui R, Al-Jawaldeh H, Al-Jawaldeh A. Trend of iodine status in the Eastern Mediterranean Region and impact of the universal salt iodization programs: a Narrative Review. Biol Trace Elem Res. 2020; 198, 390–402 doi.org/10.1007/s12011-020-02083-1.

ⁱ Al Jawaldeh A. E. The Regional assessment of the implementation of wheat flour fortification in the Eastern Mediterranean Region. International Journal of Scientific Research and Management. 2019; 7(03), 28–37. <https://doi.org/10.18535/ijssrm/v6i3.ft01>.

¹ Saad F, Rogers L, Doggui R, Al-Jawaldeh A. Assessment of vitamin A supplementation practices in countries of the Eastern Mediterranean Region: evidence to implementation. Journal of Nutritional Science and Vitaminology, 2021; 67(1), 1–12. doi.org/10.3177/jnsv.67.1.

² Doggui R, Al-Jawaldeh H, Al-Jawaldeh A. Trend of iodine status in the Eastern Mediterranean Region and impact of the universal salt iodization programs: a narrative review. Biol Trace Elem Res. 2020; 198, 390–402. doi.org/10.1007/s12011-020-02083-1.

Success stories

Baby-friendly villages in Afghanistan

To ensure that as many babies as possible are born into an environment that supports, promotes and protects breastfeeding, it is important to not only recognize the important role that baby-friendly hospitals play but to ensure that community-based facilities are supportive. In Afghanistan, a baby-friendly village project has been established in Takhar, Badakhshan and Kunduz provinces. In Takhar province, 40 villages across 10 districts were selected in 2009. The aim was to promote appropriate infant feeding practices among mothers and their broader communities and social support networks. The influence of husbands and mothers-in-law over infant feeding was considered particularly important. The project aimed, therefore, to improve the knowledge, attitudes and practices of pregnant and lactating mothers and to raise awareness and promote supportive attitudes to infant and young child feeding among husbands and mothers-in-law. The intervention took place at the village level – through support groups – and at health facilities, through the work of infant and young child feeding counsellors. At the end of the project, survey data suggest that initiation of breastfeeding increased from 41.7% at baseline to 86.4% by the end of the project, while the rate of exclusive breastfeeding for 6 months had increased from 47.4% to 79.4%. The project suggested that establishment of community-level support groups for breastfeeding is possible and are accepted by the community. This experience fed into the development by the Ministry of Public Health of a national community-based nutrition programme in 2017.

Sentinel-site based nutrition surveillance in Afghanistan

The Ministry of Public Health in Afghanistan established a sentinel site-based nutrition surveillance system, with the support of WHO and UNICEF and funding from the Government of Canada. Since 2013, this health facility-based system collects data on key nutrition indicators to inform the planning, implementation, monitoring and evaluation of programmes to improve nutrition in the country, particularly for women and children. There are 175 sentinel sites in health facilities in all 34 provinces and these gather anthropometric data for children up to two years. A total of 953 health posts act as community-based sentinel sites and gather data with the support of community health workers. Since 2013, WHO has supported the training of over 1500 health workers to take accurate nutrition measurements and assessments. Data generated by the system are analysed on a quarterly basis. When surveillance revealed high levels of neural tube defects in newborns and low haemoglobin levels of pregnant women, this resulted in a strengthening of the provision of iron and folic acid supplements to pregnant women during antenatal care visits. The system promotes detection of malnutrition and enables action to be taken at an early stage.

Ministry of Public Health website: <https://moph.gov.af/en/>

WHO-EM/NUT/290/E