Afghanistan National Nutrition Cluster

Advocacy Strategy 2015 - 2016

May 2015 – April 2016

National Nutrition Cluster

Afghanistan Ministry of Public Health

LIST OF ACRONYMS

ACF:	Action Contre la Faim (Action Against Hunger)
CHF:	Common Humanitarian Fund
BPHS:	Basic Packages of Health Services
IMAM:	Integrated Management of Acute Malnutrition
MAM:	Moderate Acute Malnutrition
EPHS:	Essential Package of Hospital Services
FSL:	Food Security and Livelihoods
GNC:	Global Nutrition Cluster
HNO:	Humanitarian Needs Overview
IDP:	Internally Displaced People
IYCF:	Infant and Young Child Feeding
IP's:	Implementing Partners
MoPH:	Ministry of Public Health
MUAC:	Middle Upper Arm Circumference
NNS:	National Nutrition Survey
PND:	Public Nutrition Department
RNA:	Rapid Nutrition Assessment
SAM:	Severe Acute Malnutrition
SMART:	Standardized Monitoring and Assessment of Relief and Transitions
SQUEAC:	Semi-Quantitative Evaluation of Access and Coverage
WASH:	Water Sanitation and Hygiene
HF:	Health Facility
SCI:	Save the Children International
WV:	World Vision
MRRD:	Ministry of Rural Rehabilitation and Development

Nutrition Context in Afghanistan

Nutrition is both an immediate and an underlying cause of maternal and under 5 mortality in Afghanistan. Under-nutrition contributes to 45% of under-5 deaths globally in the form of fetal growth restriction, sub-optimum breastfeeding, stunting, wasting and micronutrient deficiencies such as vitamin A and zinc.

Afghanistan has one of the world's highest rate of stunting in children under five – 40.9% of which 20.9% severely stunted according to NNS 2013. (Disaggregation by age from 2004 survey reported stunting in 70% of children between 2 to 3 years of age. 55 per cent of Afghan children under the age of 5 cannot develop physically or mentally, as they should, because of chronic nutritional deficiency[1]. Inappropriate or poor feeding practices of infant and young children are strongly linked with under-nutrition. Almost all Afghan babies are breastfed, but only 58.4%of children aged less than six months are exclusively breastfed. Minimum meal frequency and minimum acceptable diversified diet with appropriate breastfeeding for 6-23 months is 52.1% and 22.1 % respectively nationally with poor practice across all geographic, wealth and educational groups.

Insufficient health services of acceptable quality remain a determinant of under nutrition because the prevalence of illness in the population remains very high. It is estimated that 60% of households now have access within two hours of walking to a Basic Package of Health Services (BPHS) facility, up from 9% in 2000. Many households still do not have the means to make optimal use of these facilities mainly due to a variety of reasons such as cost, transportation, insecurity and or cultural constraints among other reasons. In reality, basic health services are only available to around 60% of the population without taking into considerations the quality of the services provided.

The Basic Package of Health services (BPHS) is provide mainly by NGOs in the country contracted by the government through a System Enhancement of Health Actions in Transition (SEHAT) mechanism. The Essential Package of Health Services (EPHS) are provided by both NGOS and government.

The Advocacy Strategy Aim

The aim of the Advocacy Strategy is to provide targeted support to the Nutrition Cluster objectives in an overarching manner. Broader support through advocacy will aim at mobilizing high level support for the achievement of nutrition goals, through donor, policy, and systems influence. In line with the National Nutrition Cluster targets for 2015, the Advocacy Strategy will highlight the need and support higher level efforts towards - increased coverage, multi-cluster programming, quality data for nutrition interventions, and capacity building of partners and government to scale nutrition programming. The Advocacy Strategy will pursue the achievement of these goals through three basic objectives.

Advocacy Objectives

i. **Develop harmonized and coordinated, evidence-based nutrition messaging on the nutrition response.**
This will be done as a basis for lobbying at national and international level through evidence based nutrition messages. Evidence based messaging may inform joint briefing and evidence papers as tool for lobbying for resource mobilization, policy mainstreaming, and targeted programing.

ii. **Promote nutrition mainstreaming through multi-sectoral policy advocacy.**
Mobilize cross-sectoral and cross-cluster support for nutrition integration. This may be done through joint briefing papers on the linkages of nutrition across sectors as a means to initiate a cross-sectoral action oriented approach to mainstreaming nutrition. Under this banner, cross-sectoral policy and guideline analysis may occur.

2015 PRIORITY INTERVENTIONS

1. Enhance access to treatment of acute malnutrition through expansion of nutrition services and enhanced community screening and referral.

2. Increase access to integrated preventive nutrition specific programs such as Micronutrient supplementation and promotion of infant and young child feeding and nutrition sensitive integrated multi-cluster programing.

3. Ensure timely quality community and facility-based nutrition information for program monitoring and decision making.

4. Enhance the capacity of government and partners to respond and deliver quality programs at scale.

TARGET BENEFICIARIES

- 2.1million People:

- Children 0-59 months, with treatment directed to provinces with SAM >1.5%.

- All Children 6-59months will be targeted for vitamin A supplementation.

- Children 6-23 months with micronutrient powders supplementation in provinces with a SAM >3%.

- Pregnant and lactating women will receive treatment of acute malnutrition, infant and young child feeding promotion messages, and micronutrient supplementation across the country as part of the IMAM.

[1] http://www.unicef.org/afghanistan/health_nutrition

iii. Contribute to dialogue and awareness raising on the state of nutrition in Afghanistan

In an effort to mobilize support and resources for the ongoing nutrition efforts in Afghanistan, dialogue at subnational, national, international, and donor levels is essential. Evidence informed dialogue for nutrition key messaging to target nutrition priorities may be raised with government and donors, with view to prioritize nutrition programme resourcing both human and financial.

Nutrition Cluster Strategy in Brief

The Cluster estimates (using the NNS,2013) that 1.2 million boys and girls 0-59 months (500,000 SAM and 700,000 MAM) are in need of treatment for acute malnutrition annually. Constricted by partner capacities, accessibility, and resource availability, the Cluster's strategy for 2015 will focus on initial expansion of services to reach 499,615 beneficiaries (155,279 SAM and 210,265 MAM children 0-59months and 134,071 PLW) approximately 30 per cent of the need across the country ensuring at least 50 per cent coverage in high burden provinces with SAM>3%. Activities are influenced by the need to address both the immediate and underlying causes of acute malnutrition in Afghanistan as highlighted in the NNS 2013 as well as the need to address current program challenges and gaps.[2]

Focus on Strengthening Health Systems and Building Capacity

The Cluster has been in discussion with government, BPHS partners and donors to ensure that nutrition services should be integral to all BPHS contracts and that contracting should be long-term in order to take advantage of capacity building efforts to existing partners. The Nutrition Cluster acknowledges the technical capacity gaps among partners due to staff turnover and will continue capacity building efforts to improve the technical capacity of partners. Nutrition in emergencies, IMAM, assessments, cluster coordination, IYCF in emergencies, General national nutrition quick fix trainings are planned in 2015 to further strengthen partner capacity to deliver quality services.[3]

Cross-Cutting Challenges in Implementing Nutrition Interventions in Afghanistan

Human Resources

The 2014 report on the "Assessment of nutrition component in the BPHS and EPHS health facilities in Afghanistan", (ANR) was published in partnership with PND, MoPH and under EU financing. It identified significant limitations within the human resourcing of nutrition within the BPHS and EPHS systems. The findings were confirmed by key stakeholders from the National Nutrition Cluster such as EU, WHO, USAID, MRRD, MoPH. Human resource constraints in the nutrition programmes in Afghanistan can be characterized by deficits in staffing, capacity building, monitoring and supervision.

i) Staffing

Lack of sufficient human resources in BPHS and EPHS guidelines/protocols to provide quality nutrition services with sufficient coverage (guidelines do not take into account – major - variations between health facility catchment population, which, along with the caseload, should be referred to when calculating human resources needs for nutrition and health services delivery).

The ANR found that in facilities where patient load is heavy, staff were overloaded and prioritized providing health services other than nutrition. As a result, the nutrition services could not be effectively offered through BPHS and EPHS health facilities and was often neglected. There are no dedicated staff at the BPHS facilities employed specifically to implement nutrition component as part of the BPHS. In most provinces in the country Partners such as WFP, UNICEF, WHO,CHF and some bilateral donors have provided additional staffing costs to cover for additional staff for partners to be able to deliver IMAM services. Nutrition staffing tends to vary based on an urban-rural divide. In the ANR, some urban facilities were found to adhere to staffing guidelines, whereas rural facilities were found to be significantly understaffed as they were considered less desirable by staff due to lack of resourcing at facility and high patient loads – thus impacting significantly nutrition service delivery.

ii)Capacity Building

There is a lack of appropriate nutrition orientation within the national health curriculum, because nutrition was only integrated in 2010 review of the BPHS/EPHS packages. Health staff on the ground possess limited knowledge on nutrition, and need on the job support. To ensure future generation of health staff are properly capacitated on nutrition, the nutrition component of the health curriculum needs to be strengthened in all training of health cadres in the country.

Acknowledging the need for external/technical support to nutrition service delivery at health facility level (it is in the EU ANR that only HF supported by partners like SCI, WV or ACF have health staff with capacity to deliver some nutrition services),

[2] *Strategic Response Plan , Humanitarian Country Team, 2015*
[3] *Ibid*

this on the job support and process of capacitation of health staff should be scaled up to support effective expansion of nutrition services across the country.

Many health facilities do not have a consistent and continued program for training as a means to ensure skills and protocol implementation around nutrition response. Only 50 percent of facilities surveyed in the ANR reported their staff (medical doctors, midwifes, nurses) had received training on nutrition in the previous year. Facilities in rural and insecure areas were less likely to have staff trained beyond their initial qualification training, therefore serving our most vulnerable communities under capacitated in the latest nutrition protocols and guidelines.

In March 2015, ACBAR, funded by the UK's Department for International Development (DFID), have begun a Twinning Program (1.9 Million GBP) that will build the capacity of National NGOs (NNGO) to respond to humanitarian needs. Through this project international NGOs will be twinned with national NGOs and work closely to mentor them. The NNGO's will be engaged in capacity development to increase their technical coordination capacities for a strong national humanitarian response in Afghanistan. The project will not only address capacity issues in nutrition but also in WASH, Health and food security clusters. The Twinning Program specifically aims to address capacity deficits through a rigorous program which provides practical on the job training and mentoring, combined with trainings which strengthen the tailored institutional capacities of each organization.

The inability of the health sector to build capacities has significantly impacted service provision quality, with various surveys reporting poor quality and coverage of nutrition services. For BPHS Implementing Partners the lack of capacity of provincial and central level monitoring and evaluation of the nutrition system jeopardizes quality and coverage of nutrition services as IP's are not incentivized to provide quality of care or service coverage.

In preparation for the successful rollout of the new Integrated Management of Acute Malnutrition (IMAM) protocols and guidelines and standard Operating Procedures (SOP) at provincial and district level, skills and capacities of BPHS/EPHS health staff to deliver the nutrition package must be improved through (i) strengthening of nutrition courses under national health curriculum, (ii) provision of comprehensive on the job training and mentoring endorsed by MoPH, and iii) strengthened monitoring and supervision. The planned twinning Program, quick-fix training and EU Nutrition Diploma programme will help to address some of these deficits; however comprehensive institutionalized support will still be required to address the deficits in human resourcing within nutrition.

iii)Monitoring and Supervision

The limited monitoring and supervision of Provincial Nutrition Officers (PNOs) has been a cause of concern for the nutrition community. This is cited at MOPH and PND level as a lack of human capacity and financial resources to carry out the activities. Facility based staff do not receive regular specialized on-the-job monitoring and supervision even in the event of protocol or procedural change. UNICEF has secured funds for improved monitoring of supervision of the nutrition interventions in the country and currently in the process of agreeing with PND, PNO and UNICEF zonal nutrition officers for a comprehensive monitoring and supervision plan. Where possible most of the monitoring should be joint involving PNOs, BPHs implementers, UNICEF, WHO and WFP as the key stakeholders in the delivery of nutrition interventions. WFP is using its third part monitors as well as programme monitors to monitor activities. UNICEF is also in the process of identifying third party monitoring firm that will ensure monitoring of activities in areas that are not accessible to its field based officers.

In the SQUEAC conducted in Samangan by ACF, following review of adherence to nutrition protocol at facility level, it was found that from a sample of 84 treatment cards from Hazrat Sultan OTP, not one of the cards analyzed were properly filled out and protocols followed.[4] The SQUEAC also found that in this facility, no On Job Training (OJT), supervision and cascaded training to nutrition implementing staff was provided hence providing some correlation between supervision and training and adherence to procedure in nutrition programme implementation.

Financial Resources

Amongst the barriers to strengthening nutrition service delivery identified in the ANR, was the scarcity of BPHS and EPHS funds allocated to the nutrition package provision. A*ctual* expenditures have never been assessed against *required* expenditures to assess gaps in financing and eventually achieve large scale and quality service delivery.

The lack of nutrition programme funding has also been attributed to a lack of comprehensive information about the costing of nutrition interventions. Inappropriate evaluation of the cost of nutrition activities is estimated to have a detrimental effect on the ability of BPHS/EPHS implementing partner to strengthen nutrition service delivery, including (i) coverage, and (ii)

[4] *SQUEAC - Hazrat-e-Sultan District, Samangan Province, Afghanistan. November, 2014. Ben Allen ACF UK for ACF Afghanistan.*

quality of the service. UNICEF in collaboration with PND is planning on costing all the nutrition interventions to help partners and donors to estimate and budget for nutrition interventions.

Supply Chain Management

The Nutrition supplies (F100, F75, Resomal Ready to Use Therapeutic Food (RUTF) and Ready to Use Supplementary Food (RUSF)) are not a part of the Essential Medicines List of BPHS/EPHS, instead they are managed through an external supply chain by PND, UNICEF and WFP. UNICEF and WFP currently supply these commodities as they are not part of the SEHAT budgets that NGOS and government receive. Efforts are ongoing to get the nutrition supplies to be considered into the essential drugs list as well to be part of the SHEAT budgets.

From January 2015 all supplies for SAM treatment from UNICEF are being channeled through PND as a measure to simplify and streamline the administrative processes. Disrupted supply is an enduring obstacle to nutrition service provision. With this new supply chain management, it is hoped that there will be minimal supply stock outs in the country for prioritized provinces. Various studies have pointed to supply chain blockages are related to human resource shortages for stock management, weak follow up mechanisms, lack of training on tools and databases.

Information Systems

Since the release of the 2013 National Nutrition Survey indicating high rates of acute malnutrition, momentum has grown amongst donors, policy-makers, and humanitarian agencies on the urgency of expanding nutrition services in Afghanistan. Building on this momentum, stakeholders have over the last year successfully mobilized resources for expanding and improving nutrition service delivery across the country. In 2014, the financial requirements of the Nutrition Cluster were funded at 97% of the total 2014 CHAP request of $48million according to the UNOCHA managed Financial Tracking System (FTS).

In this process of expanding nutrition services, the limitations of accurate and updated nutrition data has revealed a major barrier to making informed decisions on where to allocate resources, and how to effectively increase coverage and enhance quality of IMAM services. This challenge of unavailable, incomplete, or inaccurate data applies to both (i) routine data/monitoring; (ii) nutrition assessments, (iv) financial reports and (iii) coverage evaluation. In the absence of such crucial data to inform policy-makers, donors, and implementing partners, decisions hence the risk of inappropriate or inefficient allocation of resources.

Leadership and Governance

The government department directly dedicated to nutrition under the MOPH is PND, (under the directorate of preventative medicine). The MoPH now funds a core PND national team and a cadre of 34 provincial nutrition officers (one per province); however resourcing for monitoring and programme management capacity remains lower than expected. A number of the key technical officers in PND are supported through National technical Assistance by WHO, UNICEF and WFP.

The Grants and Contracts Management Unit (GCMU) of the Ministry of Public Health oversees the award and management of BPHS service delivery grants to NGOs contracted under SEHAT. Nearly all funds for delivery of basic services are managed by this unit (more than 50% of the total government health budget). MSH and other consultants and INGOs have assisted the GCMU in building its capacity in financial and contract management to meet USAID+WB+EU pre-qualifications for directly receiving the funds. The GCMU team manages the improvement of service delivery grants to ensure that planned service outputs and community coverage for services are achieved. The GCMU has limited capacity to monitor and supervise whether the BPHS partners are carrying out the activities as planned in their contracts.

The Nutrition Cluster is the coordinating body for emergency nutrition in Afghanistan. Due to the protracted and complex nature of the humanitarian situation and a thin line between development and emergency nutrition, the nutrition cluster often assumes the coordination of all nutrition activities in the country. Linkages and coordination between PND and MoPH still needs to be strengthened between central and provincial levels. Due to the increased profile of nutrition in the country coordination of nutrition activities is paramount.
There is a recently established Nutrition Program Coordination Committee, chaired by PND for the development of coordination of nutrition within the government in preparation for the phasing out of the Nutrition Cluster in the coming years. Presently PND has limited capacity to take on this coordination role in full, however the membership. The NPCC membership still needs to be reviewed to include all development partners if it is to assume the coordination role in the coming years.

STRATEGIC OBJECTIVE 1: EXCESS MORBIDITY AND MORTALITY REDUCED (NON-CONFLICT) **OUTCOME 1.2: REDUCED INCIDENCE OF MALNUTRITION**	
CLUSTER OBJECTIVE 1: The incidence of acute malnutrition and related deaths is reduced through Integrated management of acute malnutrition (IPD SAM, OPD-SAM, OPD MAM, community outreach) among boys and girls 0-59month, pregnant and lactating women	**RESULT INDICATOR:** **Proportion of admitted boys & girls 0-59months cured**
Activity 1: Community & facility-based screening & referral of acutely malnourished children 0-59 months in all provinces.	**Target:** 1,483,317 children 0-59months
Activity 2: Admit and treat severe and moderately acute malnourished boys and girls 0-59 months in all provinces	**Target:** 155,279 SAM 210,265 MAM children
Activity 3: Admit and treat acutely malnourished pregnant and lactating women in provinces with SAM>3%	**Target:** 105,600 PLW
CLUSTER OBJECTIVE 2: Enhance prevention of acute malnutrition through promotion of infant and young child feeding and micronutrient supplementation in children 0-59month, pregnant, and women	**RESULT INDICATOR:** **Proportion of targeted mothers receiving IYCF promotion messages**
Activity 1: Promotion/counselling on infant and young child feeding (IYCF)	**Target:** 624,554
Activity 2: Nutrition, health and hygiene promotion to caregivers of boys and girls 0-59 months, pregnant and lactating women	**Target:** 471,144
Activity 3: Vitamin A supplementation for boys and girls 0-59 months	**Target:** 1,483,317
Activity 4: Micronutrient powders supplementation to children 6-23 months in areas SAM >3%	**Target:** 594,036
Activity 5: Micronutrient tablet supplementation to PLW	**Target:** 105,600
CLUSTER OBJECTIVE 3: Timely quality community and facility-based nutrition information is made available for program me monitoring and decision making through regular nutrition surveys, rapid assessments, coverage assessments, and operational research	**RESULT INDICATOR:** **Average coverage rate in priority areas**
Activity 1: Conduct nutrition surveys& coverage assessments in priority areas	**Target:** 38*
Activity 2: Roll out nutrition sentinel site surveillance system	**Target:** 19 priority areas
STRATEGIC OBJECTIVE 3: TIMELY RESPONSE TO AFFECTED POPULATIONS **OUTCOME 3.2: TIMELY PROVISION OF LIFESAVING ASSISTANCE TO NEW INTERNALLY DISPLACED & NATURAL DISASTER AFFECTED POPULATIONS**	
CLUSTER OBJECTIVE 4: The capacity of partners to respond at scale to Nutrition in Emergencies, Assessments, Contingency Planning and Coordination is enhanced	**RESULT INDICATOR:** **Proportion of staff trained in Assessment skills**
Activity 1: Training on Nutrition in Emergencies/coordination for partners	**Target:** 400
Activity 2: Training on Assessments/surveys/surveillance for partners	**Target:** 600
Activity 3: Develop a cluster contingency plan	**Target:** 1
Activity 4: Training on supply chain management/ project cycle management for partner staff	**Target:** 200

**Afghanistan National Nutrition Cluster – Strategy Brief*[5]*

[5] Afghanistan Humanitarian Response Plan, 2015

Advocacy Approaches

To support the achievement of the Nutrition Cluster Advocacy and strategy objectives, a number of approaches will be employed, and a selection of these are listed below under key thematic areas.

Policy Monitoring, Review and Analysis

- Policy-related advocacy efforts will commence with observation and monitoring of the implementation and effectiveness of policies already in place relating to nutrition. In the cluster this would include lobbying for key nutrition champions (as nutrition mainstreaming advocates) to be embedded in relevant intersecting clusters such as WASH, Health, FSAC, ERM, to address cross cutting issues.
- Policy review and analysis will be achieved through the analysis of research and national data and literature available, particularly from partners own project analysis and findings. The Nutrition Cluster Advocacy Task Team will develop and contribute to publications such as position papers, briefing papers, and policy recommendation summaries which support the key cluster objectives.

Evidence-Based Key Messaging

- Advocacy key messaging will be underpinned by field evidence supporting advocacy efforts. This evidence based key messaging will provide a coordinated and evidence base for targeted lobbying efforts when engaging with donors and other international and national stakeholders.

Strategic engagement in dialogue on nutrition and health policy and practice

- This approach includes the dissemination of publications, reviews, and Nutrition Cluster implementer project findings, at an international or donor level as a means to contribute to informed global dialogue around nutrition. The advocacy efforts of the Nutrition Cluster will contribute to boosting this dialogue in strong partnership with Government and IP's in order to present uniform and action motivated dialogue hopefully bringing in benefits of attracting international financial resources.

Mobilization of key influencers

- Mobilization of support of key influencers will be achieved through one to one direct lobbying, utilizing cross-cluster platforms, international conferences, campaign alliance, to identify and recruit supporters, at national and sub-national level support through regular coordination meetings with communities, implementers, policy makers, and key decision makers. At community level influencers that may be engaged include Health Shura's and Imams.

Media and Communications

- Where exceptional, print, television, radio and other media to could be engaged for raising awareness to attract support. Press releases, media statements, IEC and BCC materials (about IYCF, MN, IMAM, GMP) may also be employed as a component of a coordinated campaign.

Alliance building and strategic partnerships

- Build strategic partnerships with organizations, departments, private partnership, and other platforms which share common nutrition/health related goals such as the FSAC, Health, WASH, protection and education Clusters. Linking to Evidence based key messaging; there is also opportunity to partner with influential players to release joint statements, papers which add momentum and weight to ongoing Nutrition messaging and advocate for the nutrition agenda.

Key Objectives, Messaging, and Activities

CLUSTER OBJECTIVE 1

The incidence of acute malnutrition and related deaths is reduced through integrated management of acute malnutrition (IPD SAM, OPD-SAM, OPD MAM, community outreach) among boys and girls 0-59month, pregnant and lactating women)

ADVOCACY OBJECTIVE 1

Seek bilateral and multilateral donors' support for increased multi-year funding of IMAM services.

KEY MESSAGING

- *Underfinancing of IMAM services is severely restricting nutrition service implementation in the country.*

ADVOCACY ACTIVITIES

- **Position Paper 'State of IMAM in Afghanistan: Deficits and Challenges'.**

  Purpose: to advocate towards donors for the costing and funding of nutrition interventions. Raise understanding of current state of IMAM funding and deficits, to better inform nutrition programing (particularly for BPHS implementers). Includes case studies presenting key IMAM challenges from the field.

- **Round table on the State of Nutrition: A facilitated roundtable focusing on IMAM underfunding with key nutrition actors**. Includes key nutrition actors and is nutrition Investors (Key donors, UN Agencies, MoPH – GCMU and PND, NGOs).

  Purpose: Raising awareness of nutrition sector challenges around IMAM with aim to call for donor commitment and INGO technical support to national NGOs.

  Roundtable Secondary Output: Produce a key recommendations paper to be disseminated to all.

- **Case Studies Paper: The reality of IMAM services in the Community** – Case studies presenting key IMAM challenges from the field.

  Purpose: Field nutrition actors in advocacy efforts towards mobilization of funds and resources for improvement of IMAM services.

  Activity Facilitators: ACTD, AKDN, WFP, WHO, ACF, PU-AMI, Nut Cluster coordination team, SDO, UNICEF, WHO, PND

CLUSTER OBJECTIVE 2

Enhance prevention of acute malnutrition through promotion of infant and young child feeding and micronutrient supplementation in children 0-59month, pregnant, and lactating women

ADVOCACY OBJECTIVE 2

Enabling environment to address acute and chronic malnutrition is built to accelerate actions at subnational level on the promotion of IYCF and micronutrient supplementation for children under 5, and Pregnant and Lactating Women.

KEY MESSAGING

- *Systematic and harmonized joint nutrition interventions at health facility and community level are essential for successful integration of treatment and prevention of malnutrition.*

ADVOCACY ACTIVITIES

- **Scripted radio drama series/TV advertisements/Radio Shows for raising awareness on nutrition issues**

  Purpose: Community level nutrition promotion, awareness, screening and referral for malnutrition. Enhanced prevention of under-nutrition.

- **Selected Sub-national Cluster Coordination focal points engage with Imams to deliver nutrition promotion messages in identified community/public forums.**

  Purpose: Community level promotion and awareness of under-nutrition including signs of under nutrition, prevention, and treatment.

  Activity Facilitators: ACTD, WFP, WHO, ACF, Nut. Cluster coordination team, UNICEF, WHO, PND

CLUSTER OBJECTIVE 3

Timely quality community and facility-based nutrition information is made available for programme monitoring and decision making through regular nutrition surveys, rapid assessments, coverage assessments, and operational research

CLUSTER OBJECTIVE 4

The capacity of partners to respond at scale to Nutrition in Emergencies, Assessments, Contingency Planning and Coordination is enhanced

ADVOCACY OBJECTIVE 3.1

Enhanced understanding of national, donor and multilateral agencies on improving programme monitoring and decision making through standardized nutrition surveillance and research.

ADVOCACY OBJECTIVE 3.2

Resources to develop regional contingency plans for partners enhanced for key partners including capacity to respond to emergencies.

KEY MESSAGING

- ***3.1*** *Key nutrition partners are capacitated to conduct systematic nutrition monitoring for sustainable nutrition interventions in Afghanistan.*
- ***3.2*** *Key nutrition partners capacitated in conducting emergency assessments and surveillance to inform nutrition response.*

ADVOCACY ACTIVITIES

- **Nutrition Capacities Mapping:** Capture a map of the available skills and technical capacity of nutrition cluster actors, and in what area.

  Purpose: To understand capacity deficits, gaps, and opportunities for skills sharing and support. For use as an advocacy tool in lobbying partners and donors, for support in the areas of deficits within the area of nutrition monitoring and assessment.

  Activity Facilitators: WHO, ACTD, Nutrition Cluster coordination team, ACF, WFP, UNICEF, PND,

Annex 1

Activity Logframe						
Activity	**Objective**	**Output**	**Indicators**	**Target**	**Participants**	**Implementation Timeline**
Position Paper 'State of IMAM: Deficits and Challenges'.	**Develop a joint understanding and consensus among partners on the deficits and challenges of IMAM implementation in Afghanistan.** **Identify and develop opportunities and recommendations for IMAM delivery improvement.**	- IMAM partner consultation workshop for gathering consensus on content and key challenges and deficits - Cluster validated IMAM Position Paper - Brief detailing the alignment of nutrition Cluster targets and budget deficits attached to specific IMAM deficits.	- Government and partners equally contribute to construction of the paper as an indicator of agenda prioritization - Government and partners agree on common deficits and challenges in IMAM - Government and partners promote and distribute Position Paper through their networks - Government and partners engage donors directly in action oriented discussion on how to address IMAM deficits and challenges - utilizing the key messaging of the PP.	Nutrition investors, donor governments.	ATT in collaboration with: ACTD, AKDN, WFP, WHO, ACF, PU-AMI, Nutrition Cluster Coordination Team (NCCT), SDO, UNICEF	**July - August**

Round table on the State of Nutrition: A facilitated roundtable focusing on IMAM underfunding with key nutrition actors.	**Raising awareness towards donors on nutrition sector challenges around IMAM implementation in Afghanistan and secure financial and resource commitments to fill specific challenge priority areas.**	- Round table discussion with donors, government field staff, PND and partners. - Commitments incorporated into a plan of action for 2016 - Donor and partner commitments made toward specific deficits identified - including both technical and financial resource for 2015/16.	- Participant targets reached and donor participation secured. Donors enabled to make commitments during round table discussions. - Development of final action plan - validated by donors and Nutrition Cluster - X % of financial gap in Cluster budget filled and dedicated towards x specific intervention ***See activity 1: To be determined as deficits identified and aligned with cluster budget deficits and targets	Nutrition investors, donor governments	ATT in collaboration with: ACTD, AKDN, WFP, WHO, ACF, PU-AMI, NCCT, SDO, UNICEF	**November – Early Dec**
Selected Sub-national Cluster Coordination focal points engage with Imams to deliver nutrition promoting messaging in identified community/public forums.	**Increase services admissions through awareness raising supported and facilitated by Imams.** Strengthen central cluster and provincial level collaboration for health promotion Break community stigma towards under-nutrition in	- Provincial Health Committee (PHC) and Imams assisted by ATT to develop provincial level nutrition messaging in key[6] provinces with SAM >3% - Key messaging templates and spokesperson notes on key	- Admissions increase in target provinces (comparative data over 6 month period of same year) - Short random community survey on behavior change targeting IMAMS as health promoters and wider community.	Imams and community leaders. PLW's and Male guardians as family decision makers.	ATT in collaboration with: ACTD, WFP, WHO, ACF, NCCT, UNICEF	**July – August** message development and consultation **September – February** Implementation

[6] Dependent on funding. Ideally should target the 3 most vulnerable provinces identified by SQUEAC assessment.

	families and promote good nutritional practices in the home through blanket community education. Provincial level partners in collaboration with central level activate engagement of Imams and partner nutrition focal points as public health promoters to increase awareness of under-nutrition signs and interventions available.	nutrition messaging. - X number of community gatherings across Six months				
Radio Communications Mini-Campaign - ***Nutrition services advertisement series*** - ***Scripted radio drama series*** - ***Talk-back radio shows*** ***(Open campaign with advertisements to generate general interest, follow advertisements with scripted radio drama. 1 month into radio drama begin talk back community***	**To develop a three pronged radio communications rolling mini-campaign across targeted vulnerable provinces to:** Increase services admissions through Imams engaging with l communities on nutritional and services available. Strengthen provincial level led health promotion activities. Promote consistent and sustained messaging around good nutritional practices in the home through blanket community education by utilizing accessible character driven narratives over a six month period.	- x number of radio advertisements across 6 month period in number of provinces (provinces which radio drama reaches) - x number of Imam and PHC representative led talkback radio shows in x number of provinces - on nutrition advice (Q and A talkback), identification, and service awareness raising. - 1 x radio drama series storyline nutrition storyline 2 x weekly across 6 months	- Admissions increase in target provinces (comparative data over 6 month period of same year) - Survey Questions on behavior change to be incorporated into NRC program effectiveness evaluation survey. - Listenership data from broadcaster - Level of engagement in talkback show element.	Target broadcast audience; PLW's, Male guardians as family decision makers. Target engaged as participants: Imam, select allied health staff, PPHD, Provincial Cluster. Radio talkback and advertising activities: targeting 3 most vulnerable provinces. Kandahar, Helmand, Uruzgan	ATT in collaboration with: ACTD, WFP, WHO, ACF, NCCT, UNICEF	**July/ August** planning. **October – March** broadcast.

engagement directly after airing of bi-weekly radio drama)				Radio Drama: south east Afghanistan listenership		
Nutrition Capacities Mapping	Capture a map of the available skills and technical capacity of nutrition cluster actors by area. To understand: Capacity deficits, gaps, and opportunities for skills sharing and support. For use as an advocacy tool in lobbying partners and donors, for support in the areas of deficits within the area of nutrition monitoring and assessment.	- Survey monkey survey - Half day review and validation workshop - Nutrition Capacities Map - 'Gaps and Matches' summary paper	- High Stakeholder engagement from cluster in mapping survey - Validation of Capacities map. - Commitments made by stakeholders and donors based on 'Gaps and Matches' summary paper	Cluster stakeholders, nutrition investors and government donors.	ATT in collaboration with: WHO, ACTD, NCCT, UNICEF ACF, WFP	**October-December 2015**

Annex 2

Activity Budget Estimate						
Activity	**Budget Breakdown**		**Donors**	**Budget Estimate**	**Current Budget**	**Budget Gap**
Position Paper 'State of IMAM: Deficits and Challenges'.	Printing Catering Room Hire Per diems Flights	500 2,000 3,000 1,000 1,000	----	7,500	0	7,500
Round table on the State of Nutrition: A facilitated roundtable focusing on IMAM underfunding with key nutrition actors.	Printing Catering (60p) Room hire	500 3,000 3,000	---	6,500	0	6,500
Selected Sub-national Cluster Coordinators engage with Imams to deliver nutrition promoting messaging in identified community/public forums	X 10 PROVINCES Local Transport Flights Catering Room Hire IEC material Printing/ Pop Up Banners Per diems	 1500 6,000 6,000 6,000 7,500 3,000	---	30,000	0	30,000
Scripted radio drama series/Radio advertisements/Radio talkback show.	Radio Advertisements Radio Drama Radio Talk back Flights Per diems	 10,000 25,000 15,000 2,500 1,000	---	53,500	0	53,500
Nutrition Capacities Mapping	Printing Catering (40p) Room hire Transport	500 1,600 2,500 2,500	---	7,100	0	7,100
Evaluation of impact of surveillance	Catering (40p)	1,600	---	6,600		6,600

	Room hire Transport	2,500 2,500				
Nutrition Cluster Advocacy Strategy **Printing and dissemination** **+ End of year Final evaluation report**	Printing Catering (40p) Room hire Flights	2,500 3,000 3,000 5,000	---	13,500	0	13,500
					Grand Total **USD: 124,700**	**Budget Gap** **USD: 124,700**