AFGHANISTAN

Acute malnutrition remains widespread and severe across several provinces in Afghanistan

IPC ACUTE MALNUTRITION ANALYSIS
JUNE 2024 – MAY 2025

Published on 7 January, 2025

KEY FIGURES	JUNE 2024 - MAY 2025
Severe Acute Malnutrition (SAM)	867,300
Moderate Acute Malnutrition (MAM)	2,59 M

3.46M

the number of 0-59 months children acutely malnourished

IN NEED OF TREATMENT

1,16 M

Pregnant and breastfeeding women acutely malnourished

IN NEED OF TREATMENT

Overview

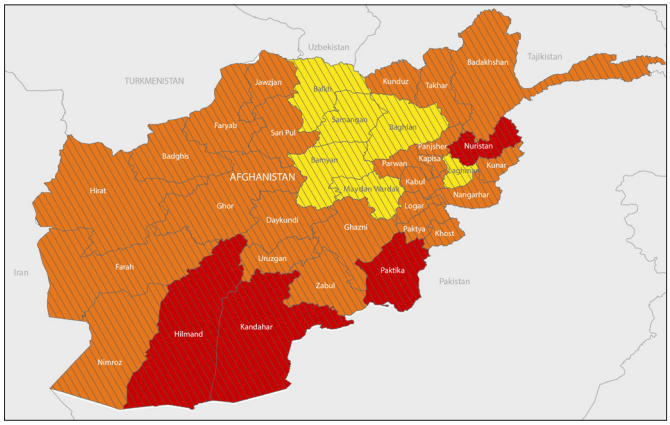
Nearly 3.5 million children, aged 6 to 59 months, are suffering or projected to suffer acute malnutrition between June 2024 and May 2025 and require urgent interventions. This includes 867,300 cases of severe acute malnutrition (SAM) and almost 2.6 million cases of moderate acute malnutrition (MAM). Additionally, 1.2 million pregnant and breastfeeding women (PBW) are expected to suffer acute malnutrition in the same period. Regarding the severity of acute malnutrition, between June and October 2024, a period considered to be current and reflecting conditions when data was collected, four provinces were classified in IPC AMN Phase 4 (Critical) including Hilmand, Kandahar, Nuristan, and Paktika. Moreover, 24 provinces were classified in IPC AMN Phase 3 (Serious) including Kabul, Kapisa, Parwan, Logar, Panjsher, Ghazni, Paktya, Khost, Daykundi, Badakhshan, Takhar, Kunduz, Sar-e-Pul, Jawzjan, Faryab, Nangarhar, Kunar, Ghor, Badghis, Hirat, Farah, Nimroz, Uruzgan and Zabul. The remaining six provinces were classified in IPC Phase 2 (Alert). In the Projection period, the overall situation is expected to largely stay the same till May 2025 with only one province (Balkh) expected to worsen from Phase 2 to Phase 3 and one province (Khost) expected to improve from Phase 3 to Phase 2.

The provinces with the highest number of malnourished children between June 2024 and May 2025 are Kabul, Helmand, Nangarhar, Hirat and Kandahar, which together account for nearly 42 percent of the country's total malnutrition caseload.

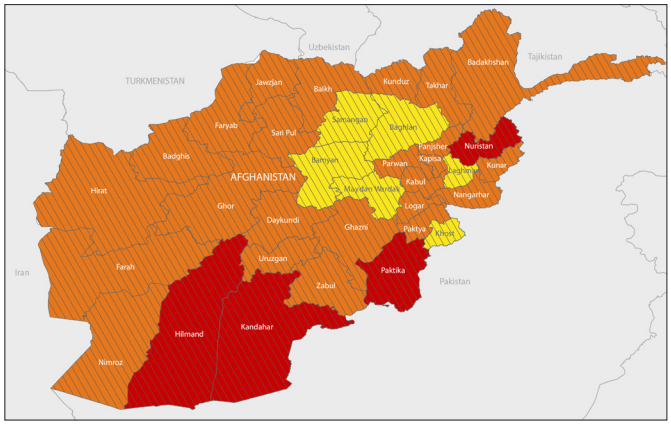
Additionally, almost 1.2 million PBW are expected to suffer acute malnutrition in the same period, with the largest number in the provinces of Kabul, Badakshan, Hirat, Balkh and Nangarhar, which together account for approximately 40 percent of the total malnutrition caseload nationwide.

The major drivers of acute malnutrition in Afghanistan include inadequate quantity and poor quality of children diets, high prevalence of diseases (diarrhea, malaria, acute respiratory infection and measles outbreaks) and inadequate access to safe drinking water, sanitation and low hygiene practices. Additionally, reduced access to health and nutrition services, suboptimal breastfeeding practices, and high levels of food insecurity exacerbate acute malnutrition. Other risk factors like widespread shocks, including drought, flooding and population displacement continue to negatively impact the nutrition situation.

Current Situation: June – October 2024



First Projected Situation: November 2024 – May 2025



Key for the Map

IPC Acute Malnutrition Phase Classification

- 1 - Acceptable
- 2 - Alert
- 3 - Serious
- 4 - Critical
- 5 - Extremely critical
- Phase classification based on MUAC
- Areas with inadequate evidence

Evidence Level

** Medium

Contributing factors

Poor dietary consumption

Sub-optimal dietary consumption in terms of quality, quantity and diversity

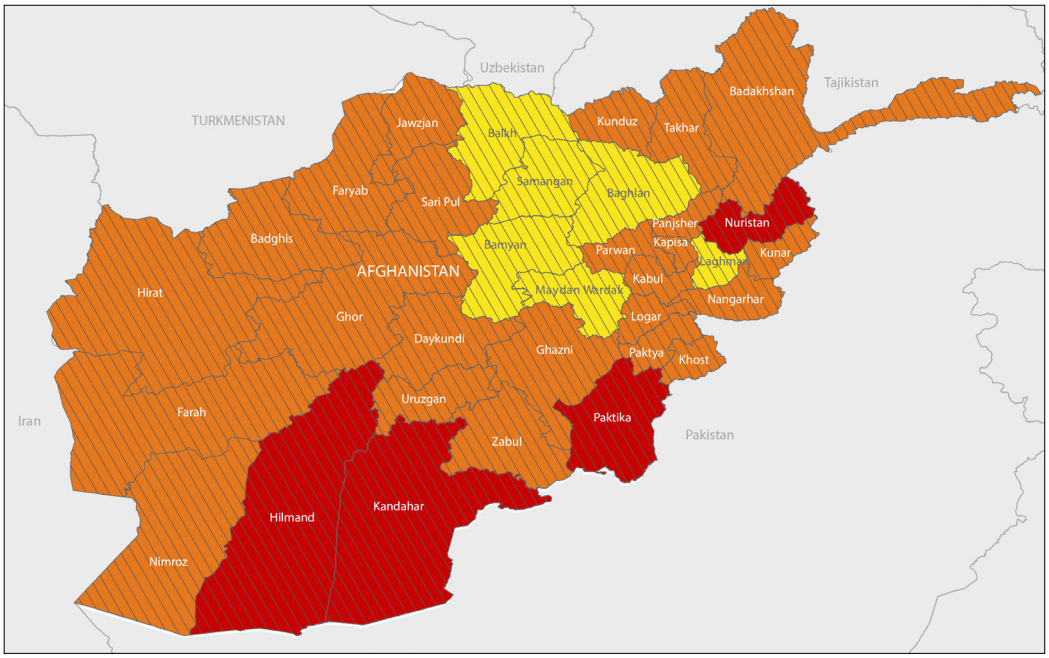
High prevalence of diseases

Prevalence of child morbidities including fever, diarrhea, acute respiratory infection and measles outbreak

Hygiene and sanitation

Inadequate access to safe drinking water, poor sanitation and low hygiene practices

CURRENT SITUATION MAP AND OVERVIEW (JUNE – OCTOBER 2024)



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Current Situation Overview (June - October 2024)

The IPC AMN analysis in Afghanistan included a total of 34 provinces using the Mass MUAC Screening outcome collected between July and September 2024 through Community Nutrition Sentinel Sites. In the current period, Helmand, Kandahar, Nuristan and Paktika are classified in IPC Phase 4 (Critical). Twenty-four provinces are classified in IPC Phase 3 (Serious): Kabul, Kapisa, Parwan, Logar, Panjsher, Ghazni, Paktya, Khost, Daykundi, Badakhshan, Takhar, Kunduz, Sar-e-Pul, Jawzjan, Faryab, Nangarhar, Kunar, Ghor, Badghis, Hirat, Farah, Nimroz, Uruzgan and Zabul. In addition to six provinces classified in IPC Phase 2 (Alert): Wardak, Bamyan, Baghlan, Samangan, Balkh and Laghman. Between June and October 2024, none were classified in IPC AMN Phase 5 (Extremely Critical).

Contributing Factors & Key drivers

Afghanistan has been facing multiple contributing factors over the past few years, such as the COVID-19 pandemic, the government transition in August 2021, and a series of natural disasters including floods, earthquakes, droughts, in addition to the influx of Afghan refugees and returnees from neighbouring countries. Since 2021, despite Afghanistan's economic collapse and weak government support, households have shown some improvement in meeting basic needs. However, the economy remains stagnant, unemployment is high, and the banking sector faces challenges with international transfers and liquidity concerns. Rural resilience benefits from Afghanistan's agricultural economy, but high prices, low demand, and service disruptions impact the entire country.

Food insecurity in the past two years has slightly improved as prices have fallen from their recent peaks due to above-average 2024 harvests, a stronger Afghani reducing import costs, and declining global food prices. Afghanistan's consumer prices dropped by 6.6 percent year-on-year in July 2024, marking ongoing deflation driven by low demand. However, food costs still remain well above pre-COVID levels., Additionally, high unemployment, and household debt remain alarming. Remittances are expected to decline, and the labor market is under pressure due to returning workers from Pakistan and Iran.

The national IPC Acute Food Insecurity (AFI) analysis, which was conducted concurrently with the IPC Acute Malnutrition (AMN) analysis in October 2024 reported that 25 percent (11.6 million people) of the population are in IPC AFI Phase 3 or above. In the projection period (November 2024 to March 2025) Acute Food Insecurity is estimated to affect 32 percent

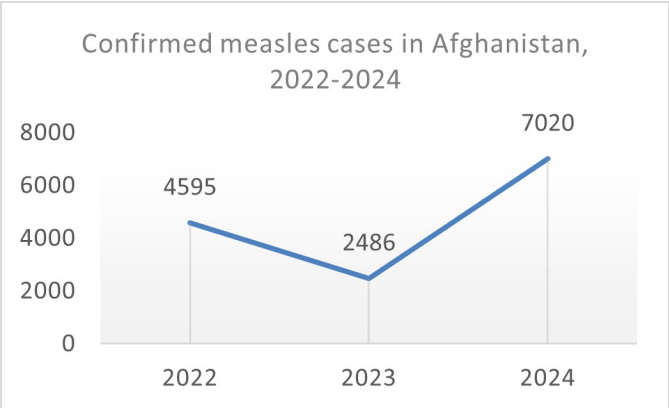
(14.8 million people) of the total population. Overall, the AFI and AMN that took place at the same time closely aligned in most areas, with differences of only one phase between the two scales observed in both the current and projected periods. The direction of these differences varies, which is symptomatic of the various levels of interplay between malnutrition, food insecurity and many other determinants of malnutrition across the country. In the current situation, AFI classification is one phase higher in Baghlan, Balkh, Bamyan, Laghman, Samangan, and Wardak, while AMN classification is one phase higher than AFI in Hilmand, Kandahar, Nuristan, Paktika, and Paktya. During the projection period, the AFI classification is expected to remain elevated in nearly the same provinces, mirroring the pattern observed for AMN classification. The tight relation of outcomes between AFI and AMN suggest a close causal tie between the two, alongside high prevalence of diseases, poor WASH conditions and dietary diversity concerns for children and PBW.

All the underlying factors of acute malnutrition accounted for in the IPC AMN analysis are driven by basic factors, such as socio-economic status, social and cultural norms, and natural disasters, including the floods and droughts experienced in the recent past. Economic shocks (90 percent) and drought (34 percent) were the most frequently reported shocks experienced by households in 2024 according to Whole of Afghanistan Assessment (WoAA), Jul-Aug 2024. However, a progressive shift in the drivers of humanitarian nutrition needs is to be noted:

- Inadequate dietary consumption: is a major contributing factor to acute malnutrition in Afghanistan. Only 14.8 percent of children consume five or more food groups, with rates ranging from 1.1 percent in Farah to 53.9 percent in Khost. Similarly, only 34.2 percent of children receive sufficient meals per day, with percentages varying from 9.4 percent in Kunar to 63 percent in Bamyan. The minimum acceptable diet (MAD) is met by only 6.8 percent of children, with percentages ranging from 0.2 percent in Farah to 39.4 percent in Khost. These poor dietary consumption indicators not only reflect inadequate nutritional intake among children but also highlight an increasing risk of acute malnutrition across the country.

- Disease outbreaks: Disease is an immediate cause of acute malnutrition, as malnutrition increases the risk of infection, while infection can also lead to malnutrition. Communicable diseases including diarrhea, malaria and acute respiratory infections (ARIs) are common and widespread in Afghanistan. Over half (60 percent) of children have been reported as sick. According to the Whole of Afghanistan Assessment (WoAA), Jul-Aug 2024, the national prevalence of diarrhea among surveyed children under five was 64 percent, fever 62 percent and ARI 27 percent in the two weeks preceding the survey. Notably, disease prevalence show further disparities in levels as depicted in provincial data. Highest prevalence of diarrhea was reported in Takhar (92 percent), followed by Kunduz (86 percent). Similarly, fever prevalence was highest in Takhar (83 percent) and Sar-e-Pul (79 percent). The highest prevalence of ARI was reported in Sar-e-Pul (57 percent) followed by Panjshir (47 percent). A consistently high number of disease cases was observed in 2024 compared to 2023. These levels, coupled with sub optimal child diets, predispose children to acute malnutrition. Urgent and multisectoral interventions are required to address the observed high levels of diseases and feeding consumption.

- Inadequate coverage of measles vaccination: The 2024 health cluster data shows that measles vaccination coverage is at 72 percent, leaving one in three eligible children unvaccinated. Only seven provinces (Kapisa, Bamyan, Nangarhar, Daykundi, Jawzjan, Laghman and Logar) reached the target of 80 percent according to the SPHERE standards. Measles coverage in 27 provinces is less than 80 percent. Zabul reported the poorest rates of measles coverage (54 percent), while Kapisa (87 percent) recorded the highest rate. The suboptimal measles coverage is further underscored by ongoing measles outbreaks reported in all 34 provinces across the country from January to October 2024. Kabul, Balkh, Kandahar and Nangarhar provinces account for the highest number of measles cases in the country. In total, 7,020 confirmed measles cases were reported in 2024, marking the highest annual count in the past three years, which represents a 182 percent increase compared to 2023.



- Inadequate access to safe drinking water, poor sanitation and low hygiene practices: Although 77 percent of households report using an improved water source, only 46 percent have enough water for drinking, cooking, bathing and washing,

highlighting significant unmet water needs across various population groups and provinces. Additionally, 15 provinces report that fewer than 60 percent of households have access to improved sanitation facilities. The critical gap in sanitation infrastructure which constitutes ongoing risks of waterborne diseases is evidenced by the high prevalence of diarrhea, 64 percent being the national average. The situation is further compounded by inadequate hygiene practices with only 42 percent of households reporting the use of soap for handwashing (WoAA 2024).

- Reduced access to health and nutrition services: Between January and September 2024, the number of Mobile Health and Nutrition Teams (MHNTs) services decreased by 52 percent compared to the same period in 2023 with 343 MHNTs (including 171 supported by UNICEF) closing operations. This reduction has significantly impacted the hard-to-reach areas and limiting access to essential health and nutrition services. Additionally, more than 450 Targeted Supplementary Feeding Program sites were closed in 2024 affecting MAM admissions. From January to September 2024, there was a decline of over 80,000 wasting admissions compared to the same period in 2023.
- High food insecurity and reduced Blanket Supplementary Feeding Program (BSFP) assistance: The October 2024 IPC AFI analysis reported that 25 percent of the population (11.6 million people) is currently in Phase 3 or above. Projections indicate this figure will increase to 32 percent (14.8 million people) between November 2024 and March 2025. Household food insecurity contributes to inadequate dietary intake among children highlighting the importance of the Blanket Supplementary Feeding Program in Afghanistan to prevent malnutrition and address food insecurity in vulnerable populations. However, BSFP coverage was reduced by 50 percent nationally from January to August 2024 affecting nearly 635,000 children (i.e. 635,000 fewer children received BSFP in 2024 compared to 2023). Reductions ranging from 30 percent in Badakhshan to 85 percent in Khost province. This reduction significantly limits preventive nutrition interventions in high-risk areas increasing vulnerability to acute malnutrition.

Trend analysis

From June to October 2024, the acute malnutrition situation in Afghanistan has worsened compared to the same period in 2022. The number of provinces in Phase 4 has doubled rising from 2 in 2022 to 4 in 2024, while the number of provinces in Phase 3 has increased from 22 to 24.

Afghanistan IPC Acute Malnutrition (IPC AMN) Phase Classification

Comparison of 2024 and 2022 analysis

	2022	Current
Period of Analysis	Sep - Oct'22	Jun - Oct'24
Provinces in Phase 5	0	0
Provinces in Phase 4	2	4
Provinces in Phase 3	22	24
Provinces in Phase 2	10	6
Provinces in Phase 1	0	0

A focus on provinces with highest severity (IPC AMN Phase 4)

In **Kandahar**, several key factors are driving malnutrition and worsening the nutrition situation including a high disease prevalence with over 60 percent of the country's polio cases reported, alongside outbreaks of measles (10 cases), malaria (58 percent prevalence) and diarrhea (47 percent prevalence). Suboptimal infant and young child feeding practices exacerbate the problem as only 44 percent of mothers practice exclusive breastfeeding, only 24.7 percent continue breastfeeding up to two years and just 15.9 percent of children receive a diversified diet and 49 percent of infants being bottle-fed. Access to food is critically inadequate, highlighted by a 75 percent reduction in BSFP coverage impacting 44,454 children in 2024. The lack of adequate WASH services compounds the issue with only 37 percent of the population using improved sanitation facilities and 39 percent relying on unimproved water sources. Access to health and nutrition services remains inadequate due to a large number of underserved areas, restrictions on house-to-house nutrition activities and the reduction of Mobile Health and Nutrition Teams which limit access to services in hard-to-reach areas. Immunization coverage remains low (61 percent for measles and 70 percent for the pentavalent vaccine). Widespread shocks, including drought affecting 72 percent of the population and economic shocks impacting 97 percent exacerbate the overall malnutrition crisis in Kandahar province.

Similarly, in **Helmand** province, malnutrition is driven by high disease prevalence, poor food consumption, inadequate access to food, limited sanitation, insufficient health and nutrition services and economic shocks. Measles outbreak was reported (26 cases), along with high incidences of diarrhea (67 percent) and fever/malaria (72 percent). The highest rates of SAM admissions are concerning, with outpatient and inpatient admissions at 12.4 percent and 15.7 percent of total country cases, respectively. Alarmingly, only 2.8 percent of children have adequate dietary diversity, exacerbated by a 55 percent reduction in BSFP coverage. Access to sanitation is limited with only 58 percent of the population using improved facilities and only 30 percent using soap for handwashing while suboptimal measles vaccination coverage (64 percent) and drought affecting 80 percent of the population further contribute to the malnutrition crisis in Helmand province.

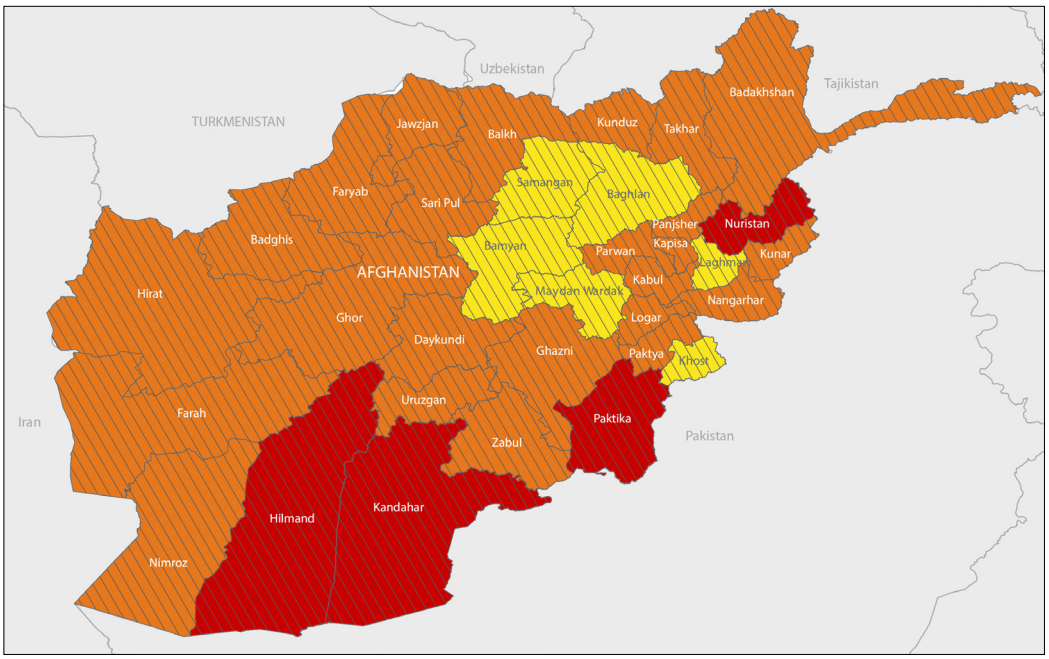
In **Nuristan**, high disease prevalence is a significant concern with 52 percent suffering from diarrhea, 63 percent from fever or malaria and 29 percent from ARI. Food consumption is poor as only 10.2 percent of children have minimum dietary diversity and just 3.8 percent meet the minimum acceptable diet criteria. Access to food is inadequate with a 36 percent reduction in BSFP coverage and 30 percent of the population facing crisis-level food insecurity (IPC AFI Phase 3 or above). Additionally, only 20 percent of residents have access to improved drinking water sources and just 44 percent have access to sanitation facilities. Access to health and nutrition services is challenging with only 65 percent of the population able to access healthcare, compounded by geographical barriers that make healthcare facilities difficult to reach. The absence of MHNTs and the lack of nutrition services in Family Health Houses further exacerbate the access problem while flooding has impacted 62 percent of the population.

Paktika province faces high disease prevalence with 70 percent of the population experiencing diarrhea and 52 percent suffering from fever. Poor dietary practices contribute to malnutrition as only 12.8 percent of children consume a diversified diet. Access to food is critically inadequate with a 63 percent reduction in BSFP coverage in 2024 and 30 percent of the population facing crisis-level food insecurity (IPC AFI Phase 3 or above). Furthermore, 70 percent of residents lack access to improved sanitation services and suboptimal immunization coverage leaves the population vulnerable, particularly with measles immunization at only 66 percent. Environmental shocks also play a significant role as 51 percent of the population has been affected by floods. Paktika province has reported persistently high levels of acute malnutrition, with prevalence rates consistently exceeding 10 percent indicating deep-rooted vulnerabilities in this province.

Kabul and Herat, currently in IPC Phase 3, face multiple factors that risk pushing them into IPC Phase 4. In **Kabul**, disease prevalence is a significant issue with high rates of measles (28 cases, the highest nationally), malaria (57 percent), diarrhea (59 percent) and ARI (42 percent). Infant and young child feeding practices are poor with only 47.8 percent breastfeeding for two years, 34.8 percent meeting dietary diversity and only 13.4 percent achieving the minimum acceptable diet. Food access is insufficient due to the highest national reduction in BSFP coverage (impacting 75,964 children in 2024), in addition to rising food costs. Kabul also bears the heaviest burden of acute malnutrition nationwide (11 percent of the total cases) and has the second highest SAM admissions (9.7 percent outpatient and 6 percent inpatient). Access to health and nutrition services is limited by a shortage of health facilities, inadequate MAM services (SAM admissions comprise 60 percent of total admission), restrictions on house-to-house nutrition activities and Mahram requirements limiting women access to nutrition services. Economic shocks affect 85 percent of Kabul population with high unemployment (especially among women) and an expected high influx of returnees.

Herat similarly faces a series of shocks impacting the population, including an earthquake affecting 54 percent, floods (27 percent), drought (20 percent), economic shocks (53 percent) and a high number of vulnerable internally displaced population (IDPs) from nearby drought affected provinces and earthquake affected districts. Food access is severely limited, with Herat experiencing the second highest reduction in BSFP coverage in the country (impacting 67,643 children in 2024). Malnutrition rates are high with the province having the second highest inpatient department SAM (IPD SAM) admissions (8.8 percent of total) and the third highest acute malnutrition burden (7 percent). Food consumption is poor with only 7.4 percent of children achieving adequate dietary diversity, only 4.5 percent meeting the minimum acceptable diet and exclusive breastfeeding at just 45.2 percent. Disease prevalence further compounds the risk with high rates of diarrhea (59 percent) and fever/malaria (51 percent). Health and nutrition services are insufficient due to a suspension of community outreach services and restricted access to nutrition services for mothers of malnourished children under five due to the Mahram requirement.

PROJECTED SITUATION MAP AND OVERVIEW (NOVEMBER 2024 – MAY 2025)



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Evidence Level

** Medium

Projected Situation Overview (November 2024 - May 2025)

During the projection period, between November 2024 and May 2025, Afghanistan's acute malnutrition situation is expected to remain heightened. Only minor shifts are projected: one province (Khost) is expected to improve from IPC AMN Phase 3 (Serious) to Phase 2 (Alert), while another may worsen (Balkh) from Phase 2 to Phase 3. The projected worsening situation in Bakh province is driven by inadequate dietary intake, a high prevalence of diseases (such as diarrhea and acute respiratory infections), low measles vaccination coverage, poor access to adequate quantity of water and widespread shocks including droughts and floods. The projected improvement in the situation in Khost province is attributed to several key factors including less severe weather conditions and limited shocks, a reduction in disease cases, improved access to sufficient water and the anticipated expansion of nutrition services, including the planned integration of nutrition services in 18 FHHs. The remaining 32 provinces are expected to stay in their current phases, indicating widespread and persistent acute malnutrition across the country.

Key Assumptions for the Acute malnutrition situation in November 2024 - May 2025 - most likely scenario

1. **Increased risks of infectious disease outbreaks:** The rise in acute respiratory infections along with ongoing measles, polio and acute watery diarrhea outbreaks exacerbate malnutrition.
2. **Limited access to health and nutrition services:** Limited access to essential health and nutrition services during the winter season will make it difficult for children and women to utilize the nutrition services and contribute to higher acute malnutrition risks.
3. **Poor food production:** Reduced agricultural production and decreased availability of food directly impacts nutrition.
4. **Decline in economic activities and casual labor opportunities:** Economic hardships including a drop in casual labor opportunities during the winter season exacerbate the risk of acute malnutrition.
5. **Poor dietary diversity among children under five years of age:** Poor dietary diversity continues to be prevalent and contributes to acute malnutrition.
6. **Impact of winter on livestock and food supplies:** Harsh winter conditions on livestock health reduce both food availability and household income and make it challenging for families to maintain adequate nutrition during the colder months.
7. **Increased pressure on health and nutrition services:** A potential influx of returnees and deportees from neighboring countries will likely stretch the health and nutrition services.

TOTAL NUMBER OF CASES OF CHILDREN 0-59 MONTHS AND PREGNANT AND BREASTFEEDING WOMEN AFFECTED BY ACUTE MALNUTRITION AND IN NEED OF TREATMENT - FROM JUNE 2024 TO MAY 2025

Provinces	# of Children under 5			# of Pregnant and Breastfeeding Women
	GAM Treatment	MAM Treatment	SAM Treatment	Total #
Badakhshan	164925	131096	33829	93050
Badghis	51159	40707	10452	37337
Baghlan	83198	63380	19818	28506
Balkh	95525	76852	18673	69477
Bamyan	29707	22852	6855	13841
Daykundi	100130	85415	14715	18548
Farah	70200	46205	23995	14906
Faryab	128409	93031	35378	39570
Ghazni	70803	51904	18899	36287
Ghor	76910	56669	20241	57263
Hilmand	375746	236214	139532	51946
Hirat	246476	199472	47004	90588
Jawzjan	56157	44813	11344	20884
Kabul	379128	283699	95429	147623
Kandahar	193694	118039	75655	40444
Kapisa	33324	28088	5236	6975
Khost	69450	57369	12081	20379
Kunar	109262	81428	27834	36115
Kunduz	127201	97684	29517	25118
Laghman	47459	41934	5525	24790
Logar	44111	28702	15409	17420
Nangarhar	248619	215882	32737	64414
Nimroz	27853	20212	7641	18128
Nuristan	37913	27240	10673	13202
Paktika	62561	43169	19392	21219
Paktya	59491	41977	17514	4628
Panjsher	21451	8731	12720	3227
Parwan	56155	46870	9285	21698
Samangan	35728	29308	6420	18284
Sar-e-Pul	88985	71012	17973	10450
Takhar	148240	111325	36915	56082
Uruzgan	50149	39266	10883	14308
Wardak	34455	26486	7969	13918
Zabul	31908	22143	9765	8721
Total	**3,456,482**	**2,589,174**	**867,308**	**1,159,346**

LINKAGES BETWEEN ACUTE FOOD INSECURITY AND ACUTE MALNUTRITION CLASSIFICATIONS IN AFGHANISTAN

Overall, the acute food insecurity and acute malnutrition classifications align closely, with only a one-phase difference observed in both the current and the projection period. However, the direction of these differences varies. In the current situation, the food insecurity classification is one phase higher in Baghlan, Balkh, Bamyan, Laghman, Samangan, and Wardak, while the acute malnutrition classification is higher in Ghazni, Helmand, Kandahar, Khost, Nuristan, Paktika, and Paktya. For the projection period, the food insecurity classification is expected to remain elevated in nearly the same provinces, mirroring the pattern observed in the malnutrition classification.

According to the IPC report on malnutrition, the relatively high acute malnutrition in these provinces was attributed to the following factors:

- **Disease:** High rates of illnesses, including acute respiratory infections, measles, and diarrhoea, exacerbated by poor access to healthcare services, economic challenges, and insufficient access to healthy diets contribute to higher phases of acute malnutrition. These conditions are likely to persist in the projection period.
- **Suboptimal childcare and nutrition practices:** Inadequate infant and young child feeding practices, coupled with a lack of support for pregnant and breastfeeding women, are highlighted as significant issues affecting child health and nutrition across the country.
- **Limited access to healthcare:** During the projected period, severe weather conditions (heavy snowfall, harsh winters) and natural disasters (floods, droughts) are expected to restrict access to health clinics, particularly in remote areas. This is likely to keep malnutrition levels high during the projection period which coincides with the peak of the lean season.
- **Hygiene:** Poor hygiene practices, including inadequate access to soap and clean water, contribute to health problems, particularly in mobile or marginalized communities.
- **Gender restrictions:** Local regulations limiting women's roles hinder female health professionals from providing essential services and restrict women's access to healthcare.
- **Socioeconomic barriers:** In remote areas, low socioeconomic status, rising fuel and food prices, and local economic challenges limit access to healthcare and reduce families' purchasing power, leading them to rely on traditional healers and reduce meal frequency. This exacerbates malnutrition and restricts access to balanced diets, particularly where agricultural production is impacted by climate and economic factors.

These points underscore the interconnectedness of access to healthcare services, economic conditions, food security, and disease prevalence, highlighting the complex challenges faced by populations in these regions.

IPC Scale & Season	AFI Current -Post Harvest Season-	AMN Current -Peak of Malnutrition season-	AFI Projection -Lean Season-	AMN Projection -Low season of Malnutrition-
Period of analysis	September - October 2024	June - October 2024	November 2024 - March 2025	November 2024 - March 2025
Baghlan	3	2	3	2
Balkh	3	2	3	3
Bamyan	3	2	3	2
Ghazni	2	3	3	3
Helmand	3	4	3	4
Kandahar	3	4	3	4
Khost	2	3	3	2
Laghman	3	2	3	2
Nuristan	3	4	3	4
Paktika	3	4	3	4
Paktya	2	3	3	3
Samangan	3	2	3	2
Wardak	3	2	3	2

Key factors contributing to higher food insecurity classification include reduced remittances, lack of agricultural income during winter, limited non-agricultural job opportunities, and rising food prices due to market inaccessibility, all of which heighten vulnerability. In the projection period, the situation is further worsened by the deterioration of livestock, energy shortages, and inadequate humanitarian aid. In Nimroz, remittances from Iran are expected to decline significantly due to forced deportations and limited labour opportunities for Afghan migrants. Furthermore, purchasing power is anticipated to remain low, as income from non-agricultural wage labour is likely to fall below average amid economic slowdowns and increased competition for jobs. These interconnected challenges highlight the urgent need for activities targeted to improve food security and enhance economic stability in the region.

RECOMMENDATIONS FOR ACTION

Immediate/short-term recommendations

Curative Interventions:

- Sustain and scale up the Integrated Management of Acute Malnutrition Program: Ensure that treatment services are both accessible and of high quality for children under five years of age, in addition to pregnant and breastfeeding women affected by acute malnutrition. Specific actions to consider include:
  - Nutrition service gap assessment: Conduct a comprehensive analysis to identify gaps in existing nutrition services and determine areas needing immediate attention.
  - Integration of nutrition services in Family Health Houses: Use existing family health houses to incorporate nutrition services and increase access for vulnerable populations in underserved/white areas.
  - Innovative solutions for screening and referrals: Develop and deploy creative strategies to enhance early screening and referrals, especially during winter months when access may be limited.

Prevention Interventions:

- Scale-Up of Blanket Supplementary Feeding Programs: Increase coverage of BSFP for children under five and pregnant and breastfeeding women in high-risk and hotspot areas to prevent malnutrition.
- Strengthen Maternal, Infant and Young Child Nutrition Messaging: Enhance individual and group counseling at both health facilities and community levels to promote exclusive breastfeeding and improve dietary practices among young children.
- Accelerate full integration of basic nutrition interventions within the BPHS/EPHS and identify bottlenecks to optimal uptake

Promote Inter-Sectoral Collaboration:

- Enhance Primary Health Care services: Continue interventions to reduce the prevalence of infectious diseases among children which can exacerbate malnutrition and improve immunization coverage to protect against preventable diseases.
- Strengthen WASH Interventions: Strengthen WASH interventions to improve access to safe water and sanitation facilities. Activities include:
  - Providing access to safe water through the rehabilitation of water facilities, with water trucking as a last resort.
  - Providing access to sanitation facilities to prevent open defecation and reduce contamination risks.
  - Promoting hygiene education to encourage safe practices that reduce the risk of disease transmission.
- Prepare for disease outbreaks and malnutrition peaks: Develop comprehensive preparedness and response plans for potential disease outbreaks and seasonal increases in malnutrition. This should include:
  - Prepositioning and stockpiling of essential supplies, including therapeutic foods and medical supplies to respond quickly to crises.

Medium to long-term recommendations

- Strategic scale-up of multi-sectoral response in the most vulnerable provinces: Strengthen multi-sectoral approaches by prioritizing interventions in provinces with the highest levels of vulnerability.
- Develop nutrition early warning and early action systems: Establish a robust nutrition early warning and action system to monitor risks and anticipate nutrition crises.
- Strengthen healthcare infrastructure and services in underserved/white areas: Invest in expanding healthcare infrastructure and services in underserved or "white" areas where facilities are lacking.
- Ensure continuous humanitarian food assistance: Maintain consistent humanitarian food assistance to support vulnerable populations facing food insecurity.
- Build sustainable food systems and improve livelihoods: Build resilient food systems by supporting sustainable agricultural practices and improving livelihoods through skills training and economic opportunities.
- Ensuring Food Security and Agriculture programs are designed and implemented to address seasonal dietary deficits and monitor Outcome and Impact.

RISK FACTORS TO MONITOR

It is imperative that the following risk factors are monitored, and the IPC AMN projections are updated as needed, based on the changes in the risk factors:

- Acute malnutrition admissions (trends): Monitor trends in admissions of children with acute malnutrition.
- Immunization coverage: Track immunization rates and outbreaks, especially in areas with restricted healthcare access and mobility.
- Food insecurity: Use early warning systems to monitor food insecurity levels, with attention to impacts on vulnerable populations.
- Morbidity pattern: Track seasonal diseases, such as diarrhea and fever which are expected as a result of inadequate living conditions and restricted access to clean water.
- Health and nutrition service access: Monitor the availability, access, and utilization of essential services, including healthcare, clean water, and sanitation.
- Climatic shocks: Track weather-related risks, including winter conditions affecting households and summer droughts.
- Humanitarian assistance: monitor levels of food and nutrition assistance, noting any constraints due to funding and access limitations.
- Population influx: Track the impact of returnees on local resources, particularly in urban area

Situation monitoring and update

- Conduct national nutrition surveys: SMART surveys are essential for accurately tracking acute malnutrition trends. Without recent SMART surveys across all provinces, IPC AMN analysis remains limited, hindering a comprehensive assessment of the national situation.
- Strengthen the nutrition surveillance system: Expand and strengthen the nutrition surveillance system by scaling up facility-based and community sentinel sites and improving data management and usage.
- Conduct mass MUAC screening: Regularly conduct mass MUAC screenings at the community level to identify and refer cases of acute malnutrition early.
- Improve program monitoring and referral services: Strengthen the monitoring of nutrition programs and referral services across inpatient and outpatient care for acute malnutrition, ensuring high-quality and reliable data.
- Sustain AIM technical working group meetings: Maintain regular AIM TWG meetings to review and assess the nutrition situation and response capacity.
- Keep disease preparedness and response plans updated: Ensure that disease preparedness and response plans are current, addressing disease outbreaks and seasonal increases in malnutrition.

TOTAL NUMBER OF CHILDREN AFFECTED BY ACUTE MALNUTRITION AND IN NEED OF TREATMENT - JUNE 2024 TO MAY 2025

The expected number of cases of acute malnutrition among children (6-59 months) was calculated using the following formula: n*p*k, where n is the number of children under the age of five years (under five population obtained from the recent population number issued by OCHA, November 2024), p is the combined prevalence of acute malnutrition and k is the incident correction factor. The recent MUAC data is used and adjustments applied to estimate the combined prevalence of acute malnutrition (https://www.ennonline.net/fex/61/gamafghanistan). In line with the global recommendation, an incident factor of 2.6 was used in the formula to calculate the total number of SAM and MAM cases. The number of PBW malnutrition cases is calculated by multiplying the prevalence of acutely malnourished PBW (PBW prevalence obtained from SMART 2022) by the PBW population.

Provinces	Children under 5							Pregnant and Breastfeeding women		
	Total #	Combined GAM %	Combined MAM %	Combined SAM %	Estimated number of GAM cases	Estimated number of MAM cases	Estimated number of SAM cases	Total #	AMN %	# of cases AMN
Badakhshan	310167	22.3%	18.1%	4.2%	164925	131096	33829	186100	50.0%	93050
Badghis	151775	14.1%	11.5%	2.6%	51159	40707	10452	91065	41.0%	37337
Baghlan	273050	12.7%	9.9%	2.8%	83198	63380	19818	163830	17.4%	28506
Balkh	452321	8.8%	7.3%	1.6%	95525	76852	18673	271393	25.6%	69477
Bamyan	96115	12.9%	10.2%	2.7%	29707	22852	6855	57669	24.0%	13841
Daykundi	154569	27.3%	23.6%	3.7%	100130	85415	14715	92742	20.0%	18548
Farah	148759	19.5%	13.3%	6.2%	70200	46205	23995	89255	16.7%	14906
Faryab	285501	18.7%	13.9%	4.8%	128409	93031	35378	171301	23.1%	39570
Ghazni	278703	10.4%	8.0%	2.4%	70803	51904	18899	167222	21.7%	36287
Ghor	197187	16.2%	12.3%	3.9%	76910	56669	20241	118312	48.4%	57263
Hilmand	446275	34.6%	22.6%	12.0%	375746	236214	139532	267765	19.4%	51946
Hirat	629081	16.4%	13.6%	2.9%	246476	199472	47004	377449	24.0%	90588
Jawzjan	150675	15.6%	12.7%	2.9%	56157	44813	11344	90405	23.1%	20884
Kabul	1065104	14.8%	11.4%	3.4%	379128	283699	95429	639062	23.1%	147623
Kandahar	347453	22.9%	14.5%	8.4%	193694	118039	75655	208472	19.4%	40444
Kapisa	116251	12.1%	10.3%	1.7%	33324	28088	5236	69750	10.0%	6975
Khost	244355	11.8%	10.0%	1.8%	69450	57369	12081	146613	13.9%	20379
Kunar	225438	20.2%	15.4%	4.7%	109262	81428	27834	135263	26.7%	36115
Kunduz	214684	24.7%	19.4%	5.3%	127201	97684	29517	128810	19.5%	25118
Laghman	165269	11.9%	10.8%	1.0%	47459	41934	5525	99161	25.0%	24790
Logar	125687	14.5%	9.8%	4.7%	44111	28702	15409	75412	23.1%	17420
Nangarhar	613465	17.1%	15.0%	2.1%	248619	215882	32737	368079	17.5%	64414
Nimroz	82103	14.1%	10.5%	3.6%	27853	20212	7641	49262	36.8%	18128
Nuristan	62865	25.0%	18.5%	6.5%	37913	27240	10673	37719	35.0%	13202
Paktika	117884	22.0%	15.6%	6.3%	62561	43169	19392	70730	30.0%	21219
Paktya	202980	12.2%	8.8%	3.3%	59491	41977	17514	121788	3.8%	4628
Panjsher	53790	16.0%	6.9%	9.1%	21451	8731	12720	32274	10.0%	3227
Parwan	170586	13.8%	11.7%	2.1%	56155	46870	9285	102351	21.2%	21698
Samangan	106547	14.1%	11.8%	2.3%	35728	29308	6420	63928	28.6%	18284
Sar-e-Pul	139327	26.7%	21.8%	5.0%	88985	71012	17973	83596	12.5%	10450
Takhar	311564	19.8%	15.3%	4.6%	148240	111325	36915	186938	30.0%	56082
Uruzgan	106935	19.6%	15.7%	3.9%	50149	39266	10883	64161	22.3%	14308
Maidan Wardak	162219	8.9%	7.0%	1.9%	34455	26486	7969	97332	14.3%	13918
Zabul	75701	17.5%	12.5%	5.0%	31908	22143	9765	45420	19.2%	8721
Total	**8,284,383**	**N.A.**	**N.A.**	**N.A.**	**3,456,482**	**2,589,174**	**867,308**	**4,970,630**	**N.A.**	**1,159,346**

PROCESS AND METHODOLOGY

The Afghanistan Acute Malnutrition IPC Analysis was conducted on the 6 – 17 October 2024 to assess the acute malnutrition situation in Afghanistan. The Nutrition Cluster and Strategic Advisory Group (SAG) in collaboration with Public Health Nutrition Directorate (PND) led the management and coordination, under the oversight of the IPC Global Support Unit (IPC GSU). This involved a series of consultative and technical meetings with various stakeholders to plan, prepare and implement the IPC AMN analysis. Lessons learnt drawn from the 2022 IPC AMN, being the first in the country, informed planning particularly increasing NGOs participation and ensuring regional level representation in the analysis. Importantly this was also viewed as opportunity to build national capacity in Afghanistan.

The IPC process began in late July 2024, starting with the development of a detailed implementation plan and timeline and an inventory of available information and an assessment of data needs. Initial tasks included planning for alternative plausible approaches for outcome data given absence of SMART surveys in 2024. mass MUAC screening and monitoring the status of Community Nutrition Sentinel Sites.

The primary data sources for this analysis were collected between July and September 2024 through Community Nutrition Sentinel Sites and Mass MUAC Screening in 34 provinces. The Community Nutrition Sentinel Sites covering 21 provinces were implemented by UNICEF, while the Mass MUAC Screening was led by the Nutrition Cluster and PND with support from UNICEF and various partners. Findings from the Community Nutrition Sentinel Sites and Mass MUAC Screening were reviewed and validated by the IPC GSU and AIM-TWG. Additional secondary data sources included routine nutrition and health program data as well as the Whole of Afghanistan Assessment (WoAA 2024).

The IPC analysis was conducted in person between 7 and 17 October, 2024 with participation of 40 individuals representing Nutrition Cluster partners, UN agencies and PND. Prior to the analysis a four-day IPC AMN Level 1 training was conducted. Eight groups, each comprising experts from various sectors were formed to conduct province-level meta-analyses. Facilitation was provided by a certified IPC Level 3 lead facilitator, assisted by three co-facilitators experienced in previous analyses. The IPC Global Support Unit offered overall support and guidance to the analysis team.

Sources

The main data source for the analysis was Community Nutrition Sentinel Sites and mass MUAC screening findings conducted between July to September 2024.

Other data sources were:

- Afghanistan Multiple indicator cluster survey (MICS)-2022-23.
- Afghanistan AIM-WG Nutrition Assessment Matrix 2015-2022.
- Afghanistan DHIS 2 data 2021-2024.
- Afghanistan HMIS data 2021-2024.
- Afghanistan NIS data 2021-2024.
- Blanket Supplementary Feeding Program (BSFP) coverage data 2022-2024.
- Previous Afghanistan National Nutrition SMART survey 2025-2022.
- Whole of Afghanistan Assessment (WoAA) 2024.
- Health Cluster Bulletin. Routine Immunization Admin Coverage Performance and Challenges. National EPI. July 2024
- Afghanistan IPC Acute Food Insecurity analysis results, October 2024.

Limitations of the Analysis

As this was only the second IPC AMN analysis conducted in the country, most analysts had limited prior knowledge and experience with IPC. However, a 4-day training was provided to build the teams capacity before the IPC AMN analysis. Due to lack of updated SMART survey data, the MUAC data was used as the main source of Outcome data.

Acute Malnutrition Phase name and description

Phase 1 Acceptable	Phase 2 Alert	Phase 3 Serious	Phase 4 Critical	Phase 5 Extremely Critical
Less than 5% of children are acutely malnourished.	**5–9.9%** of children are acutely malnourished.	**10–14.9%** of children are acutely malnourished.	**15–29.9%** of children are acutely malnourished. The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely to be compromised.	**30% or more** children are acutely malnourished. Widespread morbidity and/or very large individual food consumption gaps are likely evident.

What is the IPC and IPC Acute Malnutrition:

The IPC is a set of tools and procedures to classify the severity and characteristics of acute food insecurity and acute malnutrition crises as well as chronic food insecurity based on international standards. The IPC consists of four mutually reinforcing functions, each with a set of specific protocols (tools and procedures).

The core IPC parameters include consensus building, convergence of evidence, accountability, transparency and comparability. The IPC analysis aims at informing emergency response as well as medium and long-term food security policy and programming.

The IPC Acute Malnutrition Classification provides information on the severity of acute malnutrition, highlights the major contributing factors to acute malnutrition, and provides actionable knowledge by consolidating wide-ranging evidence on acute malnutrition and contributing factors.

Contact for further Information

Koki Kyalo

Nutrition Cluster Coordinator

Email: kkyalo@unicef.org

IPC Global Support Unit
www.ipcinfo.org

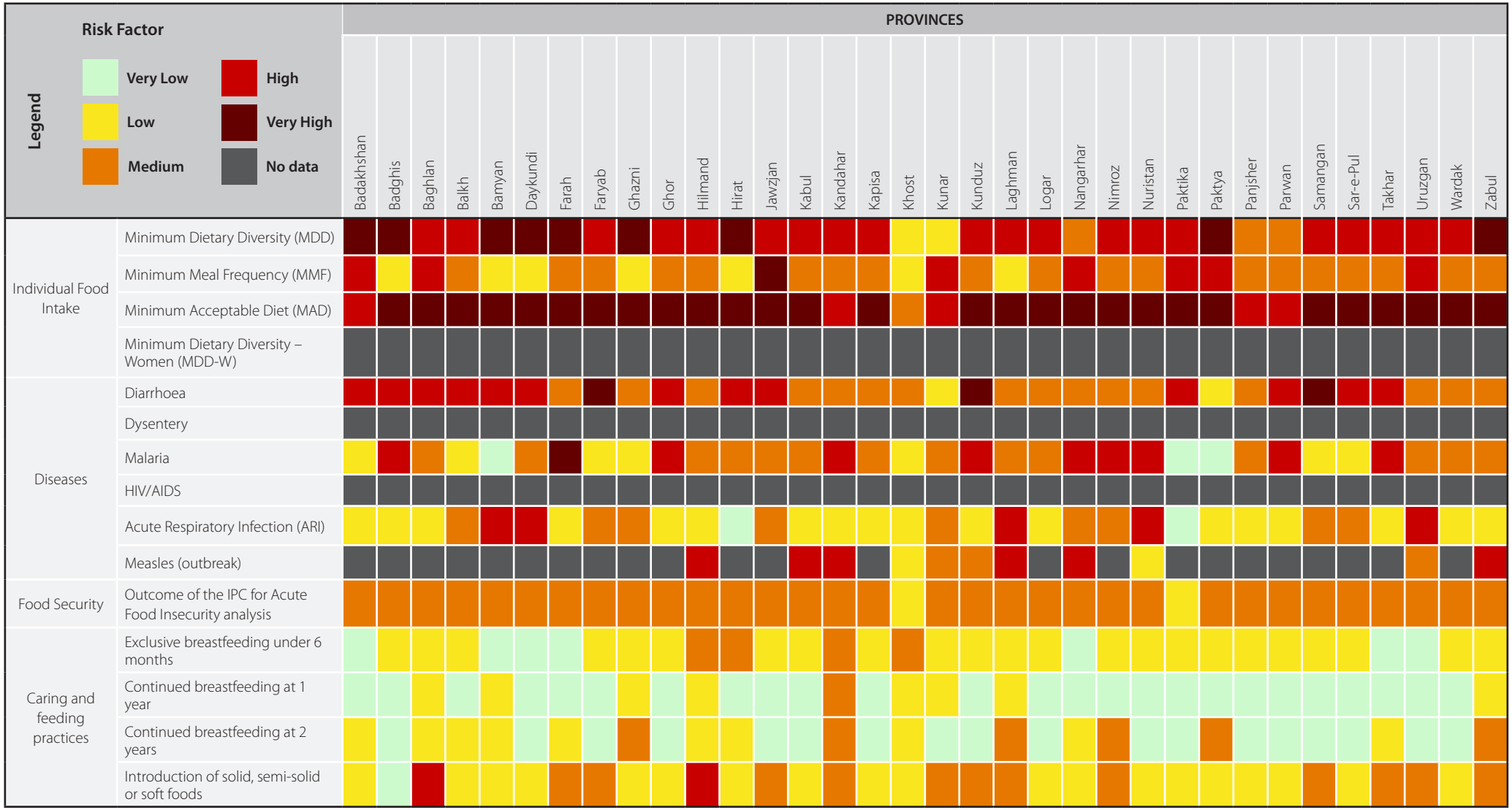
This analysis has been conducted by the Nutrition Cluster and the Public Nutrition Directorate (PND) of the Ministry of Public Health (MoPH). It has benefited from the financial support of the United Nations Children's Fund (UNICEF)

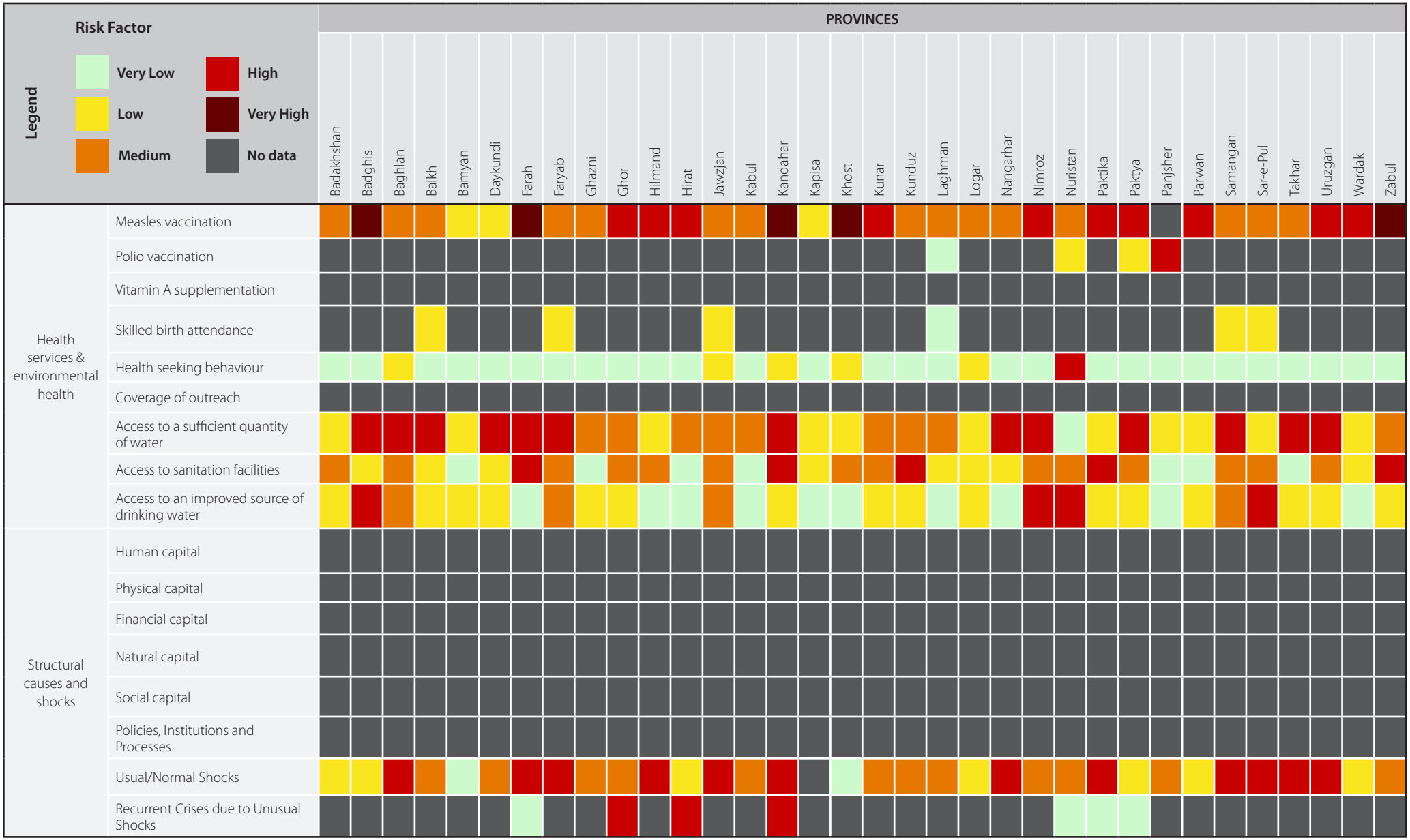
Classification of food insecurity and malnutrition was conducted using the IPC protocols, which are developed and implemented worldwide by the IPC Global Partnership - Action Against Hunger, CARE, CILSS, EC-JRC, FAO, FEWSNET, Global Food Security Cluster, Global Nutrition Cluster, IFPRI, IGAD, Oxfam, PROGRESAN-SICA, Save the Children, UNDP, UNICEF, WFP, WHO and World Bank.

Analysis Partners:

ACTION AGAINST HUNGER · AHDS Afghan Health & Development Services · ADA Agency for Assistance and Development of Afghanistan · Care of Afghan Families CAF · care · موسسه اداره و انکشاف صحت Organization For Health Promotion & Management · HEALTHNET TPO · International Medical Corps · IOM • OIM · JACK · ORCD AFGHANISTAN · WADAN · baran · Premiere Urgence Aide Medicale Internationale · unicef for every child · UNFPA United Nations Population Fund · REACH Informing more effective humanitarian action · Save the Children · WELT HUNGER HILFE WHH For a world without hunger · WFP World Food Programme · World Health Organization · World Vision

ANNEX: SUMMARY CONTRIBUTING FACTORS TO ACUTE MALNUTRITION




Legend
Risk Factor
Very Low
Low
Medium
High
Very High
No data
PROVINCES
Badakhshan
Badghis
Baghlan
Balkh
Bamyan
Daykundi
Farah
Faryab
Ghazni
Ghor
Hilmand
Hirat
Jawzjan
Kabul
Kandahar
Kapisa
Khost
Kunar
Kunduz
Laghman
Logar
Nangarhar
Nimroz
Nuristan
Paktika
Paktya
Panjsher
Parwan
Samangan
Sar-e-Pul
Takhar
Uruzgan
Wardak
Zabul
Health services & environmental health
Measles vaccination
Polio vaccination
Vitamin A supplementation
Skilled birth attendance
Health seeking behaviour
Coverage of outreach
Access to a sufficient quantity of water
Access to sanitation facilities
Access to an improved source of drinking water
Structural causes and shocks
Human capital
Physical capital
Financial capital
Natural capital
Social capital
Policies, Institutions and Processes
Usual/Normal Shocks
Recurrent Crises due to Unusual Shocks

Legend: Risk Factor		PROVINCES																																						
Very Low / Low / Medium / High / Very High / No data		Badakhshan	Badghis	Baghlan	Balkh	Bamyan	Daykundi	Farah	Faryab	Ghazni	Ghor	Hilmand	Hirat	Jawzjan	Kabul	Kandahar	Kapisa	Khost	Kunar	Kunduz	Laghman	Logar	Nangarhar	Nimroz	Nuristan	Paktika	Paktya	Panjsher	Parwan	Samangan	Sar-e-Pul	Takhar	Uruzgan	Wardak	Zabul
Other nutrition issues	Anaemia among children 6-59																																							
	Anaemia among pregnant women																																							
	Anaemia among non-pregnant women																																							
	Vitamin A deficiency among children 6-59 months																																							
	Low birth weight																																							
	Fertility rate																																							