

WHO/UNICEF
Discussion paper

**The extension of the 2025 Maternal,
Infant and Young Child nutrition targets to 2030**

1. Introduction

In May 2012 the 65th World Health Assembly (WHA) endorsed a Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition that included six global targets: reducing stunting and wasting in children under 5, halting the epidemic of obesity, reducing anaemia in women of reproductive age, reducing low birth weight and increasing the rate of exclusive breastfeeding. Global targets were established to identify priority areas, inspire ambition at country level and develop accountability frameworks.

The targets were selected based on their epidemiological and public health relevance; the availability of evidence-based effective and feasible public health interventions; the coherence and alignment with targets expressed in relevant policy frameworks, such as the Infant and Young Child Feeding strategy and the UN Secretary General Global Strategy for Women's and Children's Health; the existence of surveillance systems or other data collection instruments that would allow to set a baseline and monitor changes over time; and the country capacity to monitor indicators for the proposed targets. The evidence that targets could be achieved in all countries, regardless of income level, was also considered for the choice of the targets.¹

Since then, the targets were embraced by several global policy documents, including the final Declaration of the 2nd International Conference on Nutrition. The nutrition community felt it could align behind the selection of such priorities. The WHA targets were then considered in the development of the 2030 development agenda and are referred to in target 2.2 of the Sustainable Development Goals, to “end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons”. The reference to “all forms of malnutrition” is important to acknowledge the existence of the double burden of undernutrition and overweight and other nutrition challenges, as well as to state the global nature of the nutrition challenge. Malnutrition is not a problem for low income countries only; it is a global problem.

In 2012, the target setting process included an analysis of the time trends for the selected nutrition indicators in different regions and countries. Rates of improvement observed in the top 5 to 10% of countries were used as a benchmark for the proposed level of ambition. This analysis – contained in WHO discussion papers^{1,2} - was the basis for a consultation with Member States and partners. Inputs received were reflected in the final version of the Comprehensive Implementation Plan on maternal, infant and young child nutrition, which was endorsed by the 65th World Health Assembly.

¹ Proposed global targets for maternal, infant and young child nutrition. WHO discussion paper. 6th February 2012. Available at:

http://www.who.int/nutrition/events/2012_proposed_globaltargets_backgroundpaper.pdf (Accessed December 6, 2017).

² World Health Organization. Proposed global targets for maternal, infant and young child nutrition - summary of main issues raised and who responses. World Health Organization discussion paper 2012. Available at: http://www.who.int/nutrition/events/2012_proposed_globaltargets_summary_mainissuesandresponses.pdf (Accessed December 6, 2017).

The time frame chosen for the targets was 2025, to align them with the targets for noncommunicable diseases, also set by the World Health Assembly. A 13 year interval was considered adequate for the needed advocacy and programmatic effort. When the Sustainable Development Goal (SDG) agenda was developed, with a 2030 horizon, Member States kept the reference to 2025 (“...including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age...”), but set an aspirational target of “ending” all forms of malnutrition for 2030. In the meeting of the 136th EB Member States requested WHO to clarify how the targets contained in the comprehensive implementation plan on maternal, infant and young child nutrition would be aligned with the targets in the 2030 Agenda for Sustainable Development³.

In the five years since 2012 we have been able to observe the trends in the target indicators in different regions and countries. Overall, despite important progress and considerable success in some countries, the 2025 level of ambition can still be seen as high. If the language defining the level of ambition of the 2030 agenda, “ending all form of malnutrition,” is strictly interpreted, levels of stunting, wasting and overweight should be decreased to the prevalence that could be expected in a healthy population distribution, i.e. below 3% (approximately the usual threshold equivalent to the 5th percentile from a normal distribution). However, if the targets are too aspirational, they might be labelled as unrealistic, with the potential that investment and action are demotivated.

Currently the SDG agenda refers to the WHA targets; this paper considers how the 2025 targets could track into 2030.

The aspiration to end all forms of malnutrition is a critical message in the SDGs. In this sense, past achievements are not necessarily the standard against which to set ambitions and the “new normal” might instead be a world where malnutrition is made history. This paper suggests a set of potential operational targets that may be used in defining success in 2030 not only for stunting, wasting and overweight – the indicators selected for SDG 2.2 – but for all WHA targets, given that the SDG target refers to “all forms of malnutrition”. Clearly, each country would have to select its own level of ambition. This implies a decision on the level of investment, as well as the political and institutional readiness to establish and scale up actions.

³ EB138/2016/REC/2 p.173

Section 2. The 2030 targets

With sustained global commitment, progress on childhood stunting, overweight, wasting, exclusive breastfeeding, low birth weight, and anaemia in women of reproductive age needs to continue towards the goal to “end all forms of malnutrition.” These six nutrition targets endorsed by the WHA for 2025 encompass many, although admittedly not all, of the main nutrition issues throughout the life cycle. The formulation of the nutrition targets for 2030 can build on those, considering new available information since their endorsement by Member States in 2012.

In the present paper, the proposed extension of the targets to 2030 for stunting is based on the projection of the required progress rate between 2012 and 2025 extended five more years. For anaemia and low birth weight, a re-analysis of trends called for keeping the same target as proposed for 2025. For exclusive breastfeeding, increased ambition beyond the rate of progress between 2012 and 2025 was proposed and for wasting and overweight, the goal of elimination to a level of no concern (prevalence less than 3%) is considered feasible.

Rationale

The rationale behind the proposed targets are based on an approach similar to that used for the 2025 maternal, infant and young child (MIYC) nutrition targets. The distribution of the rates of improvement in the period 1999 to present in countries starting at high levels of malnutrition, served as the basis to set the level of ambition of the targets for 2030. Rates of improvement in the top 20% of countries with high malnutrition levels (defined according to the indicator) were used as a benchmark to define progress feasibility.

Stunting in children under 5 years of age

Even though stunting rates are decreasing in all regions worldwide, Africa faces a rising number of stunted children. In Asia, the number of children affected by stunting has decreased from 134 to 87 million, a relative decrease of 35% in 16 years.⁴ Southern Asia, where 67% of the stunted children lived in 2000, had a relative decrease of 32% between 2000 and 2016 (from 89 to 61 million), while the remaining sub-regions together had a decrease of 43% in the same period (from 45 million to 26 million). Despite the decrease observed in stunting prevalence from 38.3% to 31.2%, the number of children affected increased in Africa from 50 to 59 million between 2000 and 2016, with the largest relative increase observed in the western sub-region, where about one third of the stunted children under-five years live. The stunting target is the only amongst the six MIYC nutrition targets that is based on the number affected, and thus takes into consideration population growth and prevalence.

Child stunting, being a chronic outcome of poor nutrition and environment, can be prevented through interventions that enhance nutritional status in women of reproductive age, targeting interventions during pregnancy, appropriate infant and young child feeding as well as an adequate and diverse diet during childhood and adolescence.⁵ WHO and UNICEF have developed updated guidance in several areas, including provision of vitamins and minerals in different age groups, fortification of staple foods, management of acute malnutrition, and dietary goals for preventing obesity and diet-related

⁴ United Nations Children’s Fund, World Health Organization, World Bank Group. UNICEF-WHO-WB Joint Child Malnutrition Estimates - 2017 edition. Available at <http://www.who.int/nutgrowthdb/estimates> (Accessed December 6, 2017).

⁵ World Health Organization. Childhood stunting: context causes and consequences. WHO conceptual framework. Geneva: World Health Organization; Available at <http://www.who.int/nutrition/healthygrowthproj/en/index1.html> (Accessed 06/12/2017).

noncommunicable diseases. While effective nutrition actions exist, often they remain to be implemented on a sufficiently large scale to make a difference.

According to the last estimates⁴ (JME, May 2017 edition), to reach the 2025 global target of 99 million stunted children by 2025 (40% reduction from 165 million in 2012), and based on the under-five population projections (UN Population Division 2015 round), the target stunting rate for 2025 is estimated as 14.7%. This translates to a required annual average rate of reduction (AARR) of approximately 4% per year. Recent trends at the global level indicate insufficient progress if the global target is to be achieved, with an AARR of 2.3% per year. This means that to reach the target for 2025, progress needs to be nearly doubled. The World Bank, Results for Development Institute (R4D), and 1,000 Days, in partnership with the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation, have estimated that it will cost approximately an additional \$8.50 per child per year to scale-up high-impact, proven interventions focused in the 1,000-day window and meet the global stunting target.⁶ They provided basis for what is required to achieve global success, and indicate the target of 40% reduction in number of stunted children by 2025 is possible.

The question is whether the annual progress rate of reduction (AARR) in stunting prevalence of 4% required at the global level is feasible for countries. Without taking population into consideration, based on data from the period 1999 to present,⁴ there were 86 countries with a prevalence of 20% or higher⁷ at their earliest year with available data that had at least two data points in the period enable the estimation of AARR. Among the 86 countries, the top quintile (top 20%) all showed an AARR ≥ 3.8 . These countries had under-5-years population varying between 28 thousand and 5 million children with no pattern between population and rate of improvement. Applying this AARR over 18 years between 2012 and 2030 results in a 50% reduction in prevalence. The global under-5 population is projected to grow very little until 2030 (663 million in 2012 to 680 million in 2030, 2.5% growth in 18 years).⁸ Hence, the 50% reduction in prevalence can be applied to the number of stunted children at global level.

Thus, a 50% reduction in the number of stunted children is the target that may be used for 2030. It is aligned with the 2025 target, applying nearly the same required annual rate for 5 additional years. A 50% reduction will not meet the aspirational SDGs ambition of ending all forms of malnutrition by 2030, but it is important to recognize that linear growth retardation is a condition that occurs mainly in the first 2 years of life and that is, in most of the cases, irreversible. It will consequently require more than one generation to bring stunting prevalence globally to very low levels.

⁶ The World Bank group. Reaching the Global Target to Reduce Stunting: How Much Will it Cost and How Can We Pay for it? Available at <http://pubdocs.worldbank.org/en/460861439997767818/Stunting-Costing-and-Financing-Overview-Brief.pdf> (Accessed December 6, 2017)

⁷ Stunting prevalence of $\geq 20\%$ is considered high or very high (de Onis et al. Prevalence thresholds for wasting, overweight and stunting in children under 5 years. In submission. 2018.)

⁸ The United Nations, Department of Economic and Social Affairs, Population Division. World Population Prospects, 2015 Revision. The United Nations World Population Prospects, 2017 Revision.

Wasting in children under 5 years of age

Wasting continues to threaten the lives of almost 52 million children, or 8% of children under five years of age. More than half of those (27.6 million) live in Southern Asia, and over a quarter, in Africa.

Wasting is a major health problem and, owing to its associated risks for morbidity, requires urgent attention from policy-makers and programme implementers alike. Addressing wasting is of critical importance because of the heightened risk of disease and death for children who lose too much of their body weight. It will be difficult to continue improving rates of child survival without improvements in the proportion of wasted children receiving timely and appropriate life-saving treatment, alongside reductions in the number of children becoming wasted in the first place (prevention). The main underlying causes of wasting are: poor access to appropriate, timely and affordable health care; inadequate caring and feeding practices (e.g. exclusive breastfeeding or low quantity and quality of complementary food); poor food security – not only in humanitarian situations, but also an ongoing lack of food quantity and diversity, characterized in many resource-poor settings by a monotonous diet with low nutrient density, together with inadequate knowledge of patterns of food storage, preparation and consumption; and lack of a sanitary environment, including access to safe water, sanitation and hygiene services. The majority of wasted children live outside of the humanitarian context, which is more commonly associated with high levels of wasting and is where treatment programmes have traditionally focused. It is estimated that, globally, less than 15% of wasted children are currently being reached by treatment services, and in some countries this percentage is considerably lower. These statistics are of serious global concern, given the well-established link between wasting and mortality.⁹

The State of Food Security and Nutrition in the World 2017 states that addressing food insecurity and malnutrition in conflict-affected situations requires a conflict-sensitive approach that aligns actions for immediate humanitarian assistance, long-term development and sustaining peace.¹⁰

The 2025 MIYC nutrition target for wasting is to attain a rate of less than 5% as the global level for wasting. The SDG calls for the end of all types of malnutrition by 2030. Programmes such as “No Wasted Lives,” a coalition that includes Action Against Hunger, UNICEF, the Children’s Investment Fund Foundation, the United Kingdom government, and the European Union, are inspiring and can break the current stagnation of the progress towards these targets. The alliance is calling for scaling up treatment of severely malnourished children, committing to support further innovative programming for greater cost-effectiveness and performance, and help governments make informed decisions on nutrition action and prevention.

Looking at how countries have been progressing between 1999 and the present,^{4,11} 38 countries had wasting prevalence 10% or higher at their earliest year with available data that had at least two data points in the period enable the estimation of AARR. Among those, the group of countries with the 20%

⁹ World Health Organization. WHA Global Nutrition Targets 2025: Wasting Policy Brief. Available at http://www.who.int/nutrition/topics/globaltargets_wasting_policybrief.pdf (Accessed December 6, 2017).

¹⁰ FAO, IFAD, UNICEF, WFP and WHO. 2017. The State of Food Security and Nutrition in the World 2017. Building resilience for peace and food security. Rome, FAO. Available at <http://www.fao.org/3/a-17695e.pdf> (Accessed December 6, 2017).

¹¹ Cautionary note: there are limitations in the interpretation of trend analyses for wasting, as it is an indicator for which survey estimates are not necessarily immediately comparable across time for the reason that it is affected by seasonal factors, such as harvest, natural disasters, conflicts, etc.

highest AARR were reducing wasting at the AARR rate of 5% or more per year. Applying this rate over 18 years between 2012 and 2017 results in a 60% reduction, taking the 2012 level of wasting from 8% to 3.2% by 2030.

The proposed target for 2030 for wasting could thus be to bring the level of wasting to less than 3% by 2030. This would require continued efforts to bring the 2025 target of less than 5% down to 3% for 2030. It would also be aligned to the concept of eliminating malnutrition, as worded in target 2.2 of the SDGs, to be put into practice while also establishing a new normal for wasting.

Overweight in children under 5 years of age

Childhood obesity is one of the most serious public health challenges of the 21st century. The problem is global and is steadily affecting many low- and middle-income countries, particularly in urban settings.¹² The prevalence has increased at an alarming rate. Globally, in 2016 the number of overweight children under the age of five, is estimated to be over 41 million. Almost half of all overweight children under 5 lived in Asia and one quarter lived in Africa.⁴

Overweight and obese children are likely to stay obese into adulthood and more likely to develop noncommunicable diseases like diabetes and cardiovascular diseases at a younger age. Overweight and obesity, as well as their related diseases, are largely preventable. Prevention of childhood obesity therefore needs high priority. Recommendations to fight this rising epidemic include: to increase consumption of fruit and vegetables, as well as legumes, whole grains and nuts; limit energy intake from total fats and shift fat consumption away from saturated fats to unsaturated fats; limit the intake of sugars; and be physically active - accumulate at least 60 minutes of regular, moderate- to vigorous-intensity activity each day that is developmentally appropriate.

The Sustainable Development Goals identify prevention and control of noncommunicable diseases as core priorities. Among the noncommunicable disease risk factors, obesity is particularly concerning and has the potential to negate many of the health benefits that have contributed to increased life expectancy. Progress in tackling childhood obesity has been slow and inconsistent. The Commission on Ending Childhood Obesity was established in 2014 to review, build upon and address gaps in existing mandates and strategies. Having consulted with over 100 WHO Member States and reviewed nearly 180 online comments the Commission has developed a set of recommendations to successfully tackle childhood and adolescent obesity in different contexts around the world.¹³

The MIYC nutrition target for childhood overweight is to have no increase from the 2012 baseline prevalence, which is estimated at 6%, that is, maintain the prevalence to less or equal that level. Countries with high levels of overweight in children are encouraged to decrease their levels. In addition to the prevention and control of noncommunicable diseases, the SDGs has childhood overweight as one of its indicators in its call for ending all kinds of malnutrition by 2030.

Based on data from 142 countries with prevalence estimates in the period between 1999 and present,⁴ trend analysis was carried out to look into the distribution of progress rates in countries starting from a high level of overweight. Out of the 142 countries, 35 had overweight prevalence 10% or higher at

¹² World Health Organization. Global strategy on diet, physical activity, and health: childhood overweight and obesity. Available at <http://www.who.int/dietphysicalactivity/childhood> (Accessed December 6, 2017).

¹³ World Health Organization. Report of the Commission on Ending Childhood Obesity. 2016. Available at http://apps.who.int/iris/bitstream/10665/204176/1/9789241510066_eng.pdf?ua=1&ua=1 (Accessed December 6, 2017).

their earliest year with available data that had at least two data points in the period enable the estimation of AARR. Amongst those, the 20% top performers reduced overweight at a AARR rate of 5.5% or more per year. At this rate, a 62% reduction would be expected in 18 years, taking the 2012 overweight global level from 6% to 2.2% by 2030. Not undermining the current challenges in reverting an upwards trend in childhood overweight and implementing interventions based on recommendations above, the proposed target is to decrease the global childhood overweight prevalence to a level less than 3%. This target is aspirational and it is aligned to the 2025 target, as it is not higher than 6%, but more ambitious in nature. It will also be aligned to the SDG 2.2 call for the elimination of malnutrition to be actively pursued, as 3% would be close to a level of no concern for this indicator.

Anaemia in women of reproductive age

The 2025 target is to reduce anaemia prevalence in women of reproductive age by 50%. With an estimated baseline prevalence of 30.3% in 2012,¹⁴ the target would be to achieve a prevalence of 15.2% in 2025. This improvement would be equivalent to a 5.2% AARR between 2012 and 2025.

While enhanced prevention efforts that include scaled-up programmes to reduce micronutrient deficiencies and improve women's health are greatly needed, no country is currently on track to meet the WHA 2025 target of 50% reduction. Based on latest estimates,¹⁴ no country was assessed as “on track”, and only thirty percent of the countries presented some progress towards the 50% reduction target. Out of 189 countries with modelled data, 17 countries started from a 2012 baseline lower than 25%, and all of them showed some progress with an average AARR of 1.7% per year. In addition, there are 12 countries that have baseline prevalence above 40%, and all of them also showed some progress with an average progress rate of 1.2% per year.¹⁵ An important note is that, although model estimates are provided for countries for every year between 2000 and 2016, survey data on haemoglobin levels were available for 116 countries, out of which only 30 countries had data beyond the 2012 baseline. Nevertheless, country trends confirm little or no progress for the great majority. Unlike the other targets discussed in this document, no country is currently on track to meet the WHA 2025 anaemia target of 50% reduction.

Based on model-based country estimates between 2000 and 2016 for 198 countries,¹⁴ analyses were carried out to look at the group of countries starting with high levels of anaemia and highest rates of improvement. Among all 198 countries, 47 countries had 40% or higher prevalence in 2000, all with an AARR estimate available (modelled data). The 20% best performers had an AARR of 1.15 or more. If this rate is applied over 18 years between 2012 and 2030, a total reduction of 34% would be achievable globally, compared to the 50% target for 2025.

There is an urgent need to further investigate the country-specific determinants of anaemia in women of reproductive age, followed by the adoption of recommendations for effective implementation of

¹⁴ Global Health Observatory, 2017. Available at <http://apps.who.int/gho/data/node.main.ANAEMIAWOMEN?lang=en>.

¹⁵ World Health Organization and the United Nations Children's Fund (UNICEF) Technical Expert Advisory Group on Nutrition Monitoring (TEAM). Methodology for monitoring progress towards the global nutrition targets for 2025 – technical report. 2017. Licence: CC BY-NC-SA 3.0 IGO. Available at <http://www.who.int/nutrition/publications/team-methodology-monitoring-technicalreport> (Accessed December 6, 2017)

nutrition-sensitive and -specific interventions. In addition, the monitoring of the implementation of interventions will be essential to ensure their efficacy.

Given the challenges presented above, the target for 2030 could be to maintain the target of 2025, that is, to reach the prevalence of anaemia in women of reproductive age by 2030 to levels that are at least 50% lower than those observed in 2012. This translates into a 3.8% average annual rate of reduction between 2012 and 2030.

Although the required progress between the 2025 and the 2030 targets lack alignment when looking at the entire period between baseline and target years (5.2% versus 3.8%), both targets are aspirational to encourage countries to increase efforts in implementing sustainable nutrition-specific and – sensitive interventions.

Exclusive breastfeeding during the first six months of life

Exclusive breastfeeding – defined as the practice of only giving an infant breast-milk for the first 6 months of life (no other food or water) – has the single largest potential impact on child mortality of any preventive intervention. It is part of optimal breastfeeding practices, which also include initiation within one hour of life and continued breastfeeding for up to 2 years of age or beyond.¹⁶

Exclusive breastfeeding is a cornerstone of child survival and child health because it provides essential, irreplaceable nutrition for a child’s growth and development. It serves as a child’s first immunization – providing protection from respiratory infections, diarrhoeal disease, and other potentially life-threatening ailments. Exclusive breastfeeding also has a protective effect against obesity and certain noncommunicable diseases later in life.

Globally, in 2012 only 38% of infants aged 0 to 6 months were exclusively breastfed. In 2016 this proportion increased to 40%.¹⁷ The 2025 target for exclusive breastfeeding is to achieve a rate of 50% at the global level. Countries that have already surpassed this target are encouraged to continue progressing towards higher rates.

Since agreement on the 2025 targets, the Global Breastfeeding Collective was established under the leadership of WHO and UNICEF where a high level of ambition towards 2030 was suggested.

Based on data available between 1999 and present for 135 countries,¹⁷ 94 countries had majority (higher than 50%) of children not exclusively breastfed (NEBF)¹⁵ in their earliest year with available data and also had another data point in a later year to enable the estimation of an AARR estimate. Among those, the 20% best performers had a reduction of 3.4% or more per year in the proportion NEBF. At this rate, a 66% reduction in NEBF would be achieved in 18 years between 2012 and 2030, from 62% in 2012 to 33% in 2030 of children that will not be exclusively breastfed in their first six months of life, or 67% of children that will be exclusively breastfed.

With support of the Global Breastfeeding Collective, which has the aim to galvanize political, financial and social support to scale up breastfeeding programmes, as well as support from other

¹⁶ World Health Organization. WHA Global Nutrition Targets 2025: Breastfeeding Policy Brief. 2014. Available at http://www.who.int/nutrition/publications/globaltargets2025_policybrief_breastfeeding (Accessed December 6, 2017).

¹⁷ United Nations Children’s Fund. Infant and Young Child Feeding database. Available at <https://data.unicef.org/topic/nutrition/infant-and-young-child-feeding> (Accessed December 6, 2017).

players like SUN and the 1000 days initiative, together with evidence from countries that this level of ambition is achievable, a target of at least 70 % exclusive breastfeeding may be achieved by 2030.

Low birth weight

The 2025 target is to reduce the prevalence of low birth weight by 30%, from a baseline of 15% in 2012 (implying an AARR of 2.7%). The causes of low birth weight are multifactorial¹⁸ and interventions are needed in numerous sectors, including nutrition, health services, water and sanitation, family planning, and education.¹⁹

Low birth weight is a very important indicator that is difficult to collect in populations with low hospital delivery coverage. In such settings with low rates for weighing at birth, recent data are derived from household surveys, in which birth weights are estimated by recall and corrected from other responses. MICS and DHS surveys include questions on birth weight as well as the mothers' subjective assessment of the infant's size at birth (i.e. very large, larger than average, average, smaller than average, very small), for births in the last 2 to 5 years. In many surveys only a small proportion of babies are weighed at birth. Weighed babies may be a biased sample and the proportion of low birth weight infants may be underestimated²⁰ which is why the estimates used in the global database are adjusted to account for potential biases.

Low birth weight can result from prematurity and/or intrauterine growth retardation. The latter is defined as being born with a birth weight under the 10th percentile of the birth-weight-for-gestational-age reference curve. Every year an estimated 20 million infants are born with low birth weight (15.5% of all births) out of which 13 million are estimated to be born with intrauterine growth restriction²⁰. In low income countries approximately one child in six is born with low birth weight (16.5%), more than twice what happens in higher income countries (7%). In some Asian countries, up to one in every three children is affected.²¹ In 36 countries with stunting prevalence 20% or higher, the prevalence of low birth weight ranged between 9% and 30%, with intrauterine growth retardation accounting between 4% and 24%.²²

A collaboration between UNICEF, WHO, London School of Hygiene and Tropical Medicine and John Hopkins University is working on developing country estimates modelled based on survey and routine data. These estimates are currently undergoing the country consultation process. Based on these preliminary estimates for 148 countries with data, 69 had LBW rates higher or equal to 10% in 2000. Among those, countries with the 20% highest rate of progress had a AARR of 0.935 or higher between 2000 and 2015. This rate applied over 18 years between 2012 and 2030 results in a 15% reduction, much lower than the 2025 target of 30% reduction for 2025.

¹⁸ Ohlsson A and Shah P. Determinants and Prevention of Low Birth Weight: A Synopsis of the Evidence. Institute of Health Economics: Alberta, Canada, 2008.

¹⁹ World Health Organization. Global nutrition targets 2025: low birth weight policy brief. 2014. Available at http://www.who.int/nutrition/topics/globaltargets_lowbirthweight_policybrief.pdf (Accessed December 6, 2017).

²⁰ AK Blanc, T Wardlaw. Monitoring Low Birth Weight : an evaluation of international estimates and an updated estimation procedure. Bull WHO 2005; 83:178-185.

²¹ United Nations Children's Fund and World Health Organization, Low Birthweight: Country, regional and global estimates. UNICEF, New York, 2004.

²² RE Black, LH Allen, ZA Bhutta, LE Caulfield, M de Onis, M Ezzati, C Mathers, J Rivera. Maternal and child undernutrition: global and regional exposures and health consequences. The Lancet 2008, 371;243-260.

Global initiatives such as the Every Woman, Every Child effort led by United Nations (UN) Secretary-General Ban Ki-moon, and the Every New-born Action Plan launched by WHO and the United Nations Children's Fund (UNICEF), are mobilizing resources and attention to improving maternal health to prevent preterm birth and low birth weight. With continued global commitment, it is perhaps possible to accelerate country progress contributing to the global success towards the 30% target.

Given that current trends points to a significant short fall, the target for 2030 could be to maintain the target of 2025, that is, to reach the prevalence of low birth weight by 2030 to levels that are at least 30% lower than those observed in 2012. Similar to the anaemia target, there is lack of alignment with the progress required for 2025 but they share the same high level of ambition and should be aspirational and should encourage countries to make commitments and take actions.

Section 3. Discussion

Global nutrition challenges are multifaceted and to tackle them in a sustainable way requires a life-cycle approach, emphasizing the three major underlying causes related to food, care and environment²³. Governments and development actors need to be engaged when setting country and regional targets, and to fine-tune the global ambitions, in order to provide a way forward on the agenda for global development.

Currently, nearly one in three persons globally suffers from at least one form of malnutrition – undernutrition, micronutrient deficiency, overweight or obesity – and a large part of the world’s population is affected by diet related non-communicable diseases (NCDs).²⁴

Lessons learnt specific to nutrition in the Millennium Development Goals (MDG) framework include the realization that the focus on undernutrition was too narrow, and that synergies between nutrition and other sectors were underexploited.²⁵

To date, even though improvements have been made, countries are far from meeting the agreed global nutrition targets of reducing stunting, wasting, low birth weight and overweight in children under five years of age, improving exclusive breastfeeding rates and reducing anaemia in women of reproductive age. Globally, in 2016 there are still 155 million children under five years of age who are stunted (too short for their age) and 52 million children under five years of age who wasted (too thin for their height) while 41 million children under five years of age who are overweight.

The impacts of malnutrition on development, society, health and well-being are serious and lasting, for individuals and their families, for communities and for countries. Different forms of malnutrition co-exist – within the same country, community, household or individual during the life-cycle.

Improvements in food security and nutrition are an obvious part of achieving the global nutrition targets, however when these strategies are disconnected the nutrition situation is not improved.

Under the new framework of the Sustainable Development Goals (SDGs) it is clear that more sectors have to be involved as nutrition derives of interacting processes that link economic, cultural and social conditions such as health, care, education, sanitation and hygiene practices, access to resources and women empowerment.

The world needs to step up its efforts to eliminate malnutrition in all its forms and break the intergenerational cycle of poverty. More sectors, beyond health and agriculture, and more actors need to be involved.²⁶

This multi-sectoral approach calls for collaborative work to develop strategies that will involve poverty reduction, education, women protection, improvements in maternal health to reduce child

²³ UNICEF. UNICEF’s Approach to Scaling Up Nutrition, June 2015.

²⁴ United Nations Decade of Action on Nutrition. Work Programme. May 2017. Available at: <http://www.who.int/nutrition/decade-of-action/workprogramme-doa2016to2025-en.pdf> (Accessed December 6, 2017).

²⁵ Nutrition Targets and Indicators for the Post-2015 SDGs. Accountability for the measurement of Results in Nutrition. A technical note. February 2015. Available at: https://www.unscn.org/files/Publications/Post_2015_Nutrition_Targets_and_Indicators_final_March_2015_website_.pdf (Accessed December 6, 2017).

²⁶ By 2030, end all forms of malnutrition and leave no one behind. Discussion paper. Available at: <https://www.unscn.org/uploads/web/news/NutritionPaper-EN-14apr.pdf> (Accessed December 6, 2017).

mortality. With a combination of cost-effective interventions, political will, widespread advocacy, and smart investments, ending child malnutrition within a generation is possible if the global community truly comes together to accelerate and sustain financing and action.⁶

The 2030 Agenda calls for transformational change, which can only be achieved by comprehensive and coherent shifts in actions, programmes and policies addressing both underlying and immediate causes of malnutrition. This agenda puts people, their health, well-being, dignity and rights at the centre of the strategy, while also prioritizing sustainable management of natural resources.²⁴

The targets described in this paper for 2030 follow the same rationale behind the 2025 nutrition targets endorsed by the Member States in the 65th World Health Assembly in 2012, and adjusts the levels of ambitions based on new data available. They are aligned in great part to the Sustainable Development Goals ambition levels, albeit keeping a balance between feasibility and aspiration to maintain the momentum for improving nutrition for health and development. These targets are, by 2030:

- 50% Reduction in the number of children under-5 who are stunted
- 50% Reduction of anaemia in women of reproductive age
- 30% Reduction in low birth weight
- Reduce and maintain childhood overweight to less than 3%
- Increase the rate of exclusive breastfeeding in the first 6 months up to at least 70%
- Reduce and maintain childhood wasting to less than 3%