World Health Organization

Discussion Paper:

2025-2030 World Health Assembly global maternal, infant and young child nutrition targets and proposal for process indicators

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Abbreviations and acronyms

AARR	average annual rate of reduction
DHS	Demographic and Health Surveys
EB	WHO Executive Board
FAO	United Nations Food and Agriculture Organization
GIFT	FAO/WHO Global Individual Food consumption data Tool
GNMF	Global Nutrition Monitoring Framework
GPW	WHO's General Programme of Work
MAM	moderate acute malnutrition
MDD	minimum dietary diversity
MICS	Multiple Indicator Cluster Surveys
NEBF	not exclusively breastfed
SAM	severe acute malnutrition
SDG	Sustainable Development Goal
SUN	Scaling Up Nutrition
TEAM	WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. Executive Summary

1.1 Background

In 2012, Member States established six ambitious global nutrition targets for 2025 by endorsing the Comprehensive Implementation Plan on Maternal Infant and Young Child Feeding (hereafter "the Comprehensive Implementation Plan") during the Sixty-fifth World Health Assembly *(1)*. These targets have driven nutrition policy worldwide, with the majority of countries having included at least one target in their national policies and more than half of all countries reporting that they have included all six of these global nutritional targets in their national policies *(2).*

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) developed the Global Nutrition Monitoring Framework (GNMF) to monitor global and national progress towards the achievement of the 2025 targets *(3).* The GNMF is comprised of the six outcome indicators, five intermediate outcome indicators, six process indicators and three policy environment and capacity indicators with clear linkages connecting the intermediate, process and contextual indicators to the six target indicators.

The United Nations' (UN) 2030 Agenda for Sustainable Development prominently features the global nutrition targets. Four of the six targets are incorporated as Sustainable Development Goals (SDG) indicators under Target 2.2 under Goal 2 - End Hunger. In 2016, Member States requested an alignment of the two sets of targets (the 2025 global nutrition targets and the 2030 SDG targets) *(4).*

In 2018, WHO and UNICEF prepared a discussion paper proposing extensions of the 2025 targets to 2030. This was submitted as an annex to the WHO Executive Board (EB) session 142 biennial report (item 22) on the progress of the Comprehensive Implementation Plan. The WHO EB was requested to note the proposed extensions, which it did *(5, 6).* The proposed extension to 2030 was based on a similar methodology to that which had been employed to develop the 2025 targets and was supported by the WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring (TEAM), established in 2015 *(6).* To date, no further action has been requested nor taken by the World Health Assembly to endorse the extended targets or commit to continue pursuit of those targets beyond 2025.

The extended 2030 targets that WHO and UNICEF proposed in 2018 have already been widely adopted by the greater UN community, international organizations, and global initiatives as a natural extension of the commitments made by countries in 2012. A notable example is the adoption of the extended targets in the UN 2030 Agenda for Sustainable Development to monitor progress towards 2030 of the indicators that have been included in SDG 2.2 *(7).*

In WHO's Thirteenth General Programme of Work (GPW) *(8),* covering the period 2019 to 2025, four of the six indicators (stunting, anaemia, overweight and wasting) were included in the impact monitoring framework *(9)*, and have been proposed for inclusion in the fourteenth iteration of the GPW, which is intended to run from 2025 to 2028. Additionally, exclusive breastfeeding has been proposed as an indicator for the fourteenth iteration.

Progress towards these global targets can be affected by national programmes and as such, it is necessary to include some process targets to monitor these programmes and provide some context on countries' progress. However, neither process indicators or targets have been proposed to date, and Member States have not commented or registered their commitment towards the global monitoring of process indicators as a mechanism to drive concrete action towards targets.

As described in the Comprehensive Implementation Plan, progress towards achievement of the nutrition targets will require a broad set of actions and upstream interventions. Without diminishing the importance of cross-cutting policies and multi-sectoral coordination, there may be value in galvanizing global action around a smaller set of achievable operational targets over the next five years. Commitments to operational targets, based on key process indicators for specific interventions and behaviours, could help to drive advocacy efforts, harmonize technical assistance, and facilitate Member State collaboration, thus accelerating achievement of the outcome targets.

As we approach 2025, the World Health Assembly will consider the Comprehensive Implementation Plan and relevant next steps in May 2025. Member States will decide on whether to extend commitments for the outcome targets to 2030 to match the timeframe of the Sustainable Development Agenda.

1.2 Objectives

This discussion paper has been prepared to facilitate dialogue among Member States, civil society, academics, and other UN agencies on the best approach towards establishing new outcome and process maternal, infant, and young child nutrition targets for 2025-2030.

The objectives of this paper are to:

- evaluate the status of the progress made so far by Member States towards the 2025 targets;
- reiterate, based on the most recent available data, the rationale for the extended 2030 targets that were proposed in 2018;
- present a best-case (acceleration) scenario for what could be achieved in 2030 based on the current situation and past progress of exemplar countries;
- propose potential process indicators with clear linkages to each global nutrition target; and
- propose ambitious but feasible operational targets for 2030 for the proposed process indicators.

2. 2025-2030 targets for maternal, infant, and young child nutrition

This section will assess progress made so far towards the endorsed 2025 global nutrition targets, reiterate the 2030 extended targets that were proposed in the 2018 WHO EB 142/22 annexed discussion paper, and consider alternative 2030 targets based on the current situation and past progress.

The assessment of progress towards the 2025 targets globally is useful to set the scene for 2025-2030 agenda to be considered by Member States. In this paper, we document the expected prevalence for each indicator in 2025, based on a continuation of trends since the 2012 baseline, or "business as usual." This provides a common current status assessment across all six targets, given that the recency of data for each target is slightly different. We also project the expected prevalence in 2030, to align with the Sustainable Development Agenda timeframe, assuming that past trends will continue for the next five years.

Because the 2030 extended targets as proposed in 2018 are already being used in tracking of the SDG indicators and have been quoted in numerous other documents, we present the actual prevalence implied by these targets and plot year-by-year trends towards their achievement.

To calculate the best-case (acceleration) scenarios for 2030, we first consider the rate of improvement that could be achieved based on recent trends observed among the best-performing quintile of countries for each of the targets.10 We calculate the rate of improvement as the average annual rate of reduction (AARR) for targets where the aim is to reduce prevalence. The AARR is calculated based on the methodology established by WHO and its partners.11,12 This rate of improvement is then applied to the "current" 2025 baseline going out to 2030. These acceleration scenarios are a benchmark indicating what could be achieved in a best-case scenario. To achieve the extended 2030 targets, the world would need to progress at least at the level of the best-performing quintile of countries.

2.1 Stunting among children under 5

Stunting

TARGET: 40% reduction in the number of children under-5 who are stunted

2.1.1 Global progress towards the 2025 target

The stunting target is the only target that is based on the number affected, rather than proportion, and thus takes into consideration both population growth and prevalence. Globally, the number of stunted children under 5 has steadily declined at a rate of 1.81 per cent per year from the 177.9 million in 2012 to 148.1 million in 2022, the latest year with available data (Fig. 1) *(13).* Given current trends, we project that there will be 138.2 million stunted children in 2025, which would be a 22.3% reduction from the 2012 baseline (Table 1). This would fall short of the target of a 40% reduction in the number of stunted children, which would result in a figure of 106.7 million.

The decline, although insufficient to achieve the 2025 target, far outpaces the 0.16% per year decline in the under-five population of 675.1 million in 2012 to 663.1 million in 2022 *(14).* While globally the population of children under-five has nearly stagnated, regions and countries have experienced more significant demographic changes. These demographic changes should be taken

into account when assessing progress, since efforts to reduce prevalence based on nutrition-related interventions might be hindered by population growth or expedited by population shrinkage.

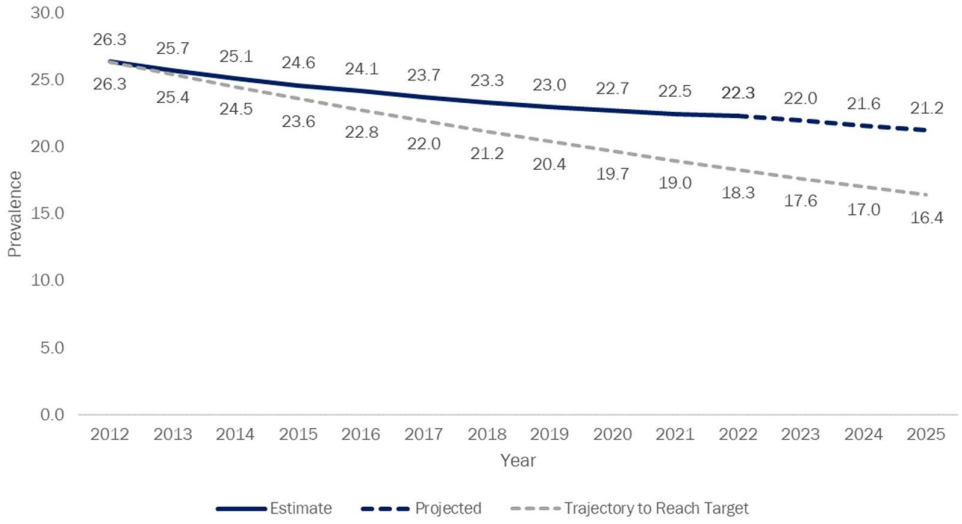
The prevalence of stunting steadily declined at a rate of 1.7% per year from 26.3% in 2012 to 22.3% in 2022. Based on current trends 21.2% of all children under-five are projected to be stunted in 2025. The 2025 target of 106.7 million stunted children target translates to a target prevalence of 16.4%, accounting for estimated demographic changes.

Table 1. Stunting among child under 5 – 2012 baseline, 2025 target and 2025 projections for numbers affected (millions) and prevalence (%).

Stunting among children under 5	Numbers Affected (millions)	Prevalence (%)
2012 baseline	177.9	26.3
2025 target based on Comprehensive Implementation Plan	106.7	16.4
2025 projection (% change since 2012)	138.2 (-22%)	21.2 (-19%)

Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

Fig. 1. Actual and projected global progress on prevalence of childhood stunting (%) and the required trajectory to reach the 2025 target.



Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

2.1.2 2030 Extended target: 50% reduction of the number of stunted children

In the 2018 discussion paper for the WHO EB, WHO and UNICEF proposed that the 2030 target be for a 50% reduction in the number of children, with 2012 as the baseline *(6).* The rationale for this target was that the highest quintile of progress exhibited by countries, measured as AARR, was 3.8% per year, very close to the AARR required to reach the 2025 target. Applying this AARR over the 18-year period of 2012 to 2030 would result in a reduction of approximately 50%.

A 50% reduction from the 2012 baseline of 177.9 million stunted children would result in a 2030 target of 88.9 million children. In percentage terms, this translates to a 2030 target prevalence of 13.5% (Table 2).

Based on current trends observed from 2012 to 2022, it is projected that 19.5% of all children will be stunted in 2030, equivalent to 128.5 million children. If current trends continue, by 2030 the world will achieve a total reduction of 28% in the number of stunted children since 2012, a shortfall of 22 percentage points compared to the proposed 2030 target.

Table 2. Stunting among children under 5 – 2012 baseline, previously proposed 2030 target and 2030 projection for numbers affected and prevalence (%).

Stunting among children under 5	Numbers Affected (millions)	Prevalence (%)
2012 Baseline	177.9	26.3
2030 Target based on 2018 discussion paper	88.9	13.5
2030 Projection - Business as usual (% Reduction from 2012)	128.5 (28%)	19.5 (26%)

Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

2.1.3 What if the world progressed at the rate of the highest performing countries from 2025?

Should current trends continue, 21.2% of all children are projected to be stunted in 2025, and the world would need to reduce the prevalence of stunting by 8.6% per year to reach the 2030 target of 13.5%. This represents a total reduction of 36% compared to the 2025 baseline, which is an unrealistic rate of progress for any country.

An analysis of the progress achieved by countries from 2012 to 2022 based on the latest available data, showed that the highest quintile of countries exhibited an AARR of stunting prevalence of at least 4.09% per year. Applying this AARR from the 2025 projection would result in a 2030 prevalence of 17.2%, equivalent to 113.1 million stunted children under 5 (Fig. 2).

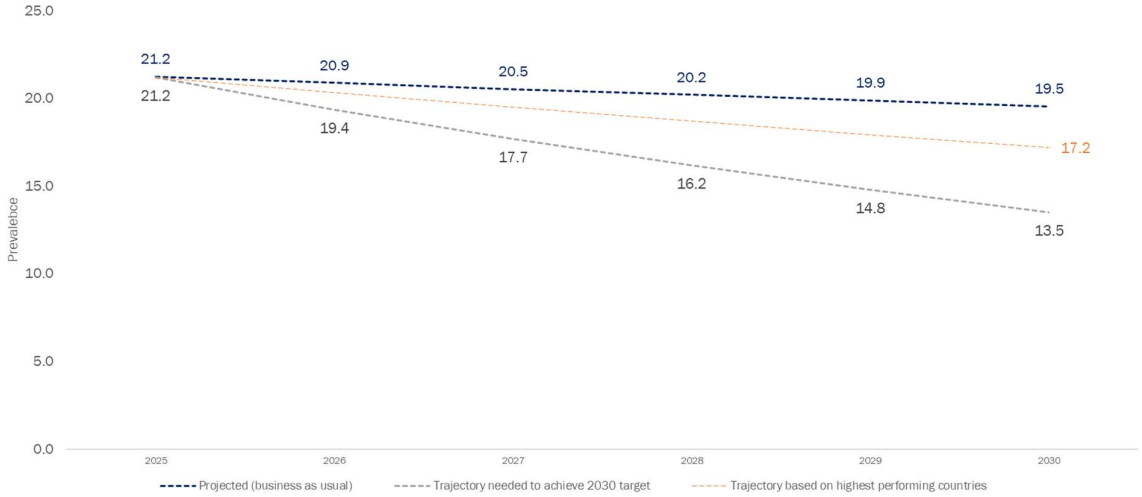
Thus, should the world accelerate progress at the rate of the highest performing countries starting from 2025, the world could reduce the total number of children stunted by 36.4% compared to the baseline of 2012 (Table 3). This best-case scenario, where the global average would perform as champions, would avert 25 million children under 5 from being stunted in 2030, representing a visionary but feasible target.

Table 3. Stunting among children under 5 – 2012 baseline, 2030 acceleration scenario and 2030 "business as usual" projection for numbers affected and prevalence (%).

Stunting among children under 5	Numbers Affected (millions)	Prevalence (%)
2012 Baseline	177.9	26.3
2030 Acceleration scenario based on highest performing countries from 2025 baseline (% change from 2012)	113.1 (-36%)	17.2 (-35%)
2030 Projection - Business as usual (% change from 2012)	128.5 (-28%)	19.5 (-26%)

Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

Fig. 2. Stunting among children under 5 - projected global prevalence (%), 2025-2030, and the trajectory needed to achieve the 2030 target and the trajectory based on highest performing countries.



Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

2.2 Anaemia in women of reproductive age

Anaemia

TARGET: 50% reduction of anaemia in women of reproductive age

2.2.1 Global progress towards 2025 target

Globally the prevalence of anaemia in women of reproductive age has steadily increased at a rate of 0.72% per year from the 2012 baseline of 28.5% to reach 29.9% in 2019, the latest year with available data (Fig. 3) *(15).* Based on the current trends from 2012 to 2019, we project that 31.2% of all women aged 15-49 years will suffer from anaemia in 2025 (Table 4). This is an increase of 10% compared to the baseline in 2012. As it stands, therefore, the world will fail to reach the 2025 target of 14.3%.

Nevertheless, the ambitious target signed up by Member States in 2012 has mobilized the nutrition community, as well as other health-related communities, to take action to tackle anaemia. This action has included evaluation of countries' efforts to reduce anaemia, raising awareness about the challenges in accurately measuring haemoglobin concentrations and diagnosing anaemia, and promoting recognition of the multiple aetiologies of anaemia, which require the collaboration of multiple sectors along with delivery of nutrition-specific interventions.

This mobilization has resulted in updating the WHO Guideline on haemoglobin cutoffs to define anaemia in individuals and populations *(16)* and the development of a Comprehensive framework for action on accelerating anaemia reduction *(17).*

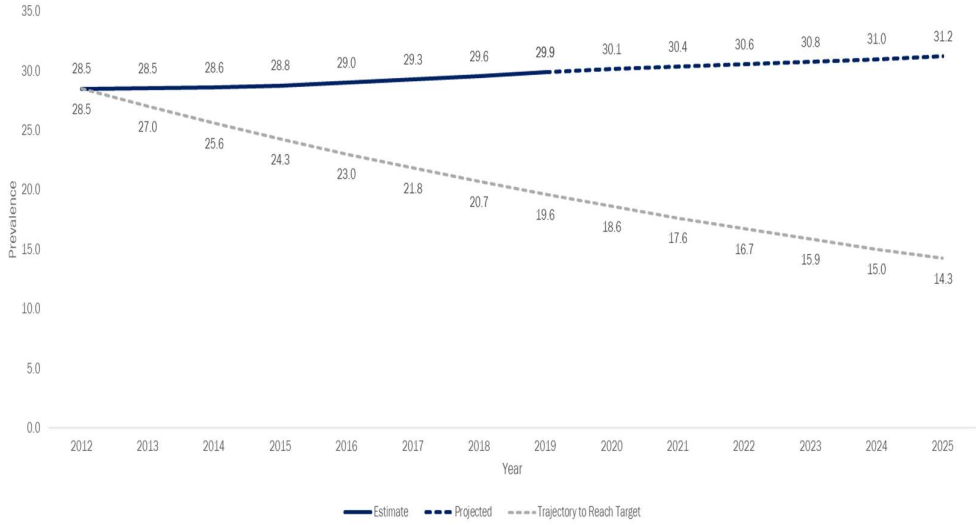
Table 4. Anaemia in women of reproductive age – 2012 baseline, 2025 target and 2025 projections for prevalence (%).

Anaemia in women of reproductive age	Prevalence (%)
2012 baseline	28.5

2025 target based on Comprehensive Implementation Plan	14.3
2025 projection (% change from 2012)	31.2 (+10%)

Source: WHO Global Health Observatory *(15).*

Fig. 3. Actual and projected global progress on prevalence of anaemia in women of reproductive age (%) and the required trajectory to reach the 2025 target.



Source: WHO Global Health Observatory *(15).*

2.2.2 Proposed 2030 extended target: 50% reduction of the prevalence of anaemia in women of reproductive age

In 2018, WHO and UNICEF proposed the 2030 target of a 50% reduction in the prevalence of anaemia in women of reproductive age as the 2030 target with 2012 as the baseline *(6).* In other words, the proposed target for 2030 remained unchanged from the original 2025 target. This meant that there was no increase in the ambition, but that instead countries were provided an additional five years to achieve the targets which they had committed to reach by 2025. The rationale for this approach was the lack of progress observed by countries and recognition of the need to issue recommendations for the effective implementation of interventions to address the country-specific determinants of anaemia in women of reproductive age. A 50% reduction from the 2012 baseline of 28.5% would result in a 2030 target of 14.3%.

Based on current trends observed from 2012 to 2019, we project that 32.3% of all women of reproductive age will suffer from anaemia in 2030. If current trends continue, the world will have increased the prevalence of anaemia by 13% since the endorsement of the Comprehensive Implementation Plan in 2012.

Table 4. Anaemia in women of reproductive age – 2012 baseline, proposed 2030 target and 2030 "business as usual" projection for prevalence (%)

Anaemia in women of reproductive age	Prevalence (%)
2012 baseline	28.5
2030 target based on 2018 discussion paper	14.3

2030 projection - business as usual (% change from 2012)	32.2 (+13%)

Source: WHO Global Health Observatory *(15).*

2.2.3 What if the world progressed at the rate of the highest performing countries from 2025?

Should current trends continue, 31.2% of all women of reproductive age are projected to suffer from anaemia in 2025, and the world would need to reduce the prevalence of anaemia by 14.5% per year to reach the 2030 target of 14.3%. This is equivalent to a total reduction of 54% compared to the 2025 baseline, which is an unrealistic AARR for any country.

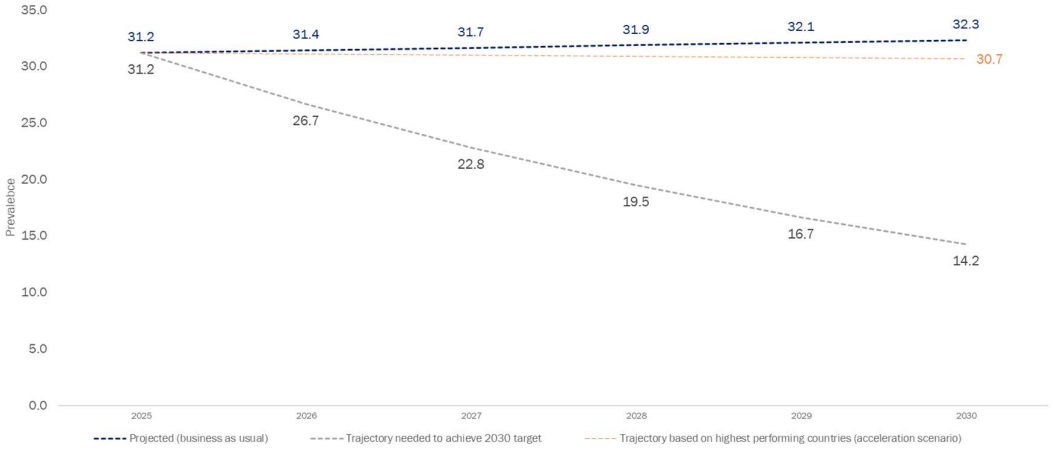
An analysis of the progress achieved by countries from 2012 to 2019 based on the latest available data, showed that the highest quintile of countries exhibited an annual rate of reduction of anaemia prevalence of at least 0.34 per cent per year. Applying this AARR from the 2025 projection would result in a 2030 prevalence of 30.7% (Table 5, Fig. 4). This modest rate of reduction shown by the best performers indicates that progress towards addressing anaemia has been slow in all countries.

Table 5. Anaemia among women of reproductive age – 2012 baseline, 2030 acceleration scenario and 2030 "business as usual" projected prevalence (%).

Anaemia in women of reproductive age	Prevalence (%)
2012 baseline	28.5
2030 acceleration scenario based on highest performing countries from 2025 baseline (% change from 2012)	30.7 (+8%)
2030 projection - business as usual (% change from 2012)	32.3 (+13%)

Source: WHO Global Health Observatory *(15).*

Fig. 4. Prevalence (%) of anaemia in women of reproductive age – "business as usual" projection and the trajectories needed to achieve the 2030 target and the acceleration scenario based on highest performing countries.



Source: WHO Global Health Observatory *(15).*

2.3 Low birth weight

Low birth weight

TARGET: 30% reduction in low birth weight

2.3.1 Global progress towards 2025 target

Globally the prevalence of low birth weight in newborns has stagnated from 15.0% in 2012 to 14.7% in 2020, the latest year with available data *(18)*. Globally the prevalence of low birth weight has declined at the modest rate of 0.30% per year. Based on the current trend from 2012 to 2020, we project that 14.4% of all newborns will be born weighing below 2 500 g (Table 6). This translates to a 4% reduction in the prevalence of low birth weight when compared to the 2012 baseline, falling far short of the 30% reduction target for 2025 (which would result in a prevalence of 10.5%) (Fig. 5).

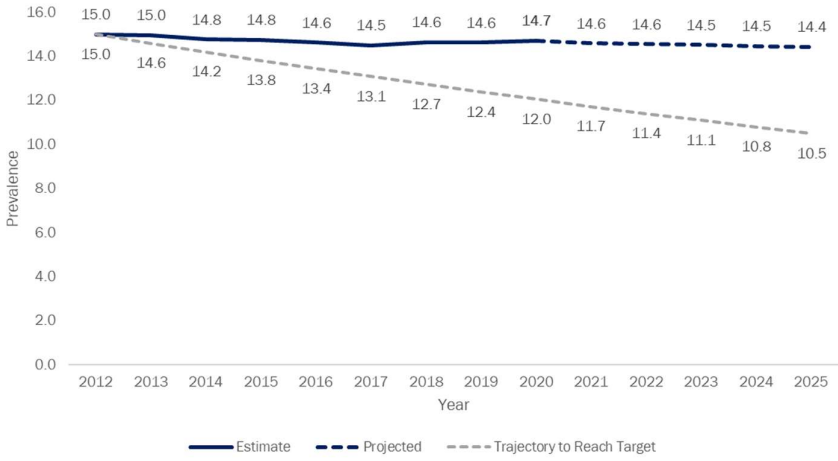
There is little time to accelerate progress to achieve the 2025 prevalence target of 10.5%, and urgent action is required if the world is to start steadily reducing the prevalence of low birth weight.

Table 6. Prevalence of low birth weight – 2012 baseline, 2025 target and 2025 projection (%).

Low birth weight	Prevalence (%)
2012 baseline	15.0
2025 target based on the Comprehensive Implementation Plan	10.5
2025 projection (% change from 2012)	14.4 (-4%)

Source: UNICEF, WHO *(18).*

Fig. 5. Low birth weight – estimated and projected prevalence (%) and the trajectory required to reach the 2025 target.



Source: UNICEF, WHO *(18).*

2.3.2 2030 Extended Target: 30% reduction of low birth weight among newborns

In 2018, WHO and UNICEF proposed the 2030 target of a 30% reduction in the prevalence of low birth weight among newborns, maintaining the target prevalence from the original target for 2025 *(6).* The rationale for maintaining that target was that the latest data at the time showed that, based on the progress observed by countries, the progress that could feasibly be achieved by 2030 would

fall short of the 2025 target. Despite this negative assessment, the two agencies argued that – given the aspirational nature of the targets – the best course of action would be to keep the same level of ambition as for the 2025 target. In doing so, it was hoped to galvanize the global community towards action and driving change. A 30% reduction from the 2012 baseline of 15.0% would result in a target of 10.5% for 2030 (Table 7).

Based on the observed trend from 2012 to 2020, we project that 14.2% of all newborns will be born weighing less than 2 500 g in 2030. If current trends continue, the world will have reduced the prevalence of low birth weight by only 5% since the endorsement of the Comprehensive Implementation Plan, far short of the target for a 30% reduction by 2030.

Table 7. Prevalence (%) of low birth weight – 2012 baseline, 2030 target and 2030 "business as usual" projection.

Low birth weight	Prevalence (%)
2012 baseline	15.0
2030 target based on 2018 discussion paper	10.5
2030 projection - business as usual (% change since 2012)	14.2 (-5%)

Source: UNICEF, WHO *(18).*

2.3.3 What if the world progressed at the rate of the highest performing countries from 2025?

Should current trends continue, 14.4% of all newborns are projected to be born with low birth weight in 2025. This means that the world would need to reduce the prevalence of low birth weight by 6.2% every year from 2025 to reach the proposed 2030 target of 10.5%, equivalent to a total reduction of 27% over the five-year period from 2025 to 2030.

An analysis of the progress achieved by countries from 2012 to 2020 based on the latest available data, showed that the highest quintile of countries exhibited an AARR of low-birth-weight prevalence of at least 0.66% per year. Applying this AARR from the 2025 projection for the period 2025-2030 would result in a 2030 prevalence of 13.9%.

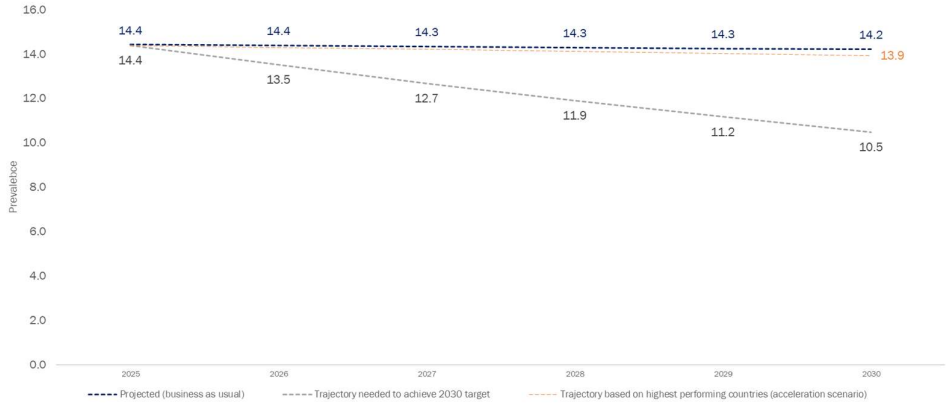
Should the world accelerate progress at the rate of the highest performing countries starting from 2025, we project that the world would reduce the prevalence of low birth weight by 7% compared to the baseline of 2012. This best-case scenario based on past performance is certainly uninspiring, and countries should aim to significantly increase their efforts through a multisectoral approach towards the reduction of low birth weight.

Table 8. Prevalence (%) of low birth weight – 2012 baseline, 2030 acceleration scenario target and 2030 "business as usual" projection.

Low birth weight	Prevalence (%)
2012 baseline	15.0
2030 acceleration scenario based on highest performing countries from 2025 baseline (% change since 2012)	13.9 (-7%)
2030 projection - business as usual (% change since 2012)	14.2 (-5%)

Source: UNICEF, WHO *(18).*

Fig. 6. Low birth weight – projected "business as usual" prevalence (%) and the trajectories needed to achieve the 2030 and acceleration scenario targets



Source: UNICEF, WHO *(18).*

2.4 Childhood overweight

Childhood overweight

TARGET: No increase in childhood overweight

2.4.1 Global progress towards 2025 target

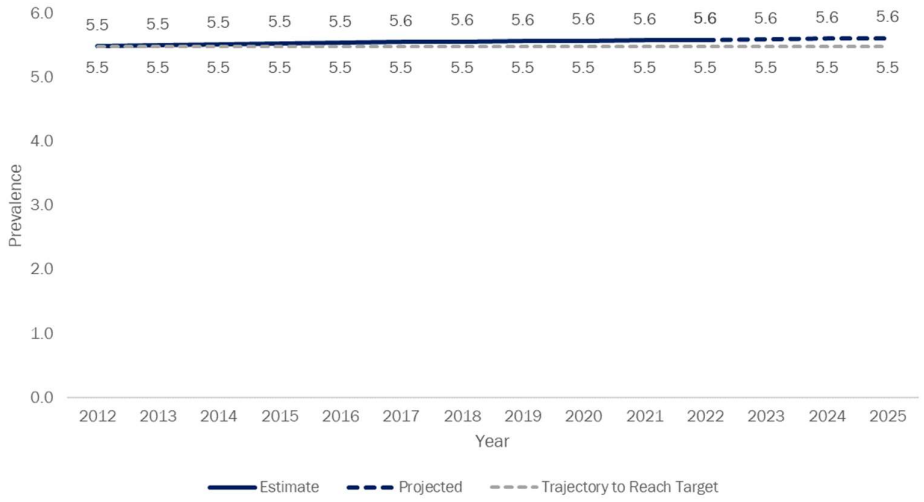
Globally there has been very little change in the prevalence of overweight in children under 5 years. Since the launch of the Comprehensive Implementation Plan, the global prevalence of childhood overweight has increased at an annual rate of 0.17% per year from 5.5% in 2012 to 5.6% in 2022, the latest year with available data (Table 9) *(13).* Based on the current trend from 2012 to 2022, we project that 5.6% of all children under 5 will be affected by overweight in 2025. This translates to an increase in prevalence of 2.3% compared to the 2012 baseline. Overall, the world is on track to achieve the 2025 target of no increase in childhood overweight (Fig. 7). While globally we are statistically within that target, countries where childhood overweight is of public health concern were encouraged to monitor their prevalence of childhood overweight through global monitoring tools *(19).*

Table 9. Prevalence (%) of childhood overweight – 2012 baseline, 2025 target and 2025 projection.

Childhood overweight	Prevalence (%)
2012 baseline	5.5
2025 target based on Comprehensive Implementation Plan	5.5
2025 projection (% change since 2012)	5.6 (+2.3%)

Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

Fig. 7. Childhood overweight – observed and project prevalence (%) and the trajectory required to meet the 2025 target.



Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

2.4.2 2030 Extended target: Reduce and maintain childhood overweight to less than 3%

In 2018, WHO and UNICEF proposed that the 2030 target be to reduce and maintain childhood overweight to less than 3% with 2012 as the baseline *(6).* As with stunting, the highest quintile of progress exhibited by countries at that time, measured as AARR, was 5.5% per year. Applying this AARR over the 18-year period from 2012 to 2030 would result in a 62% reduction. However, a 62% reduction from the baseline would result in a final target of 2.2% and – given the significant challenges in reverting the upwards trend in childhood overweight – WHO and UNICEF proposed that the target level be set at 3%.

Based on the current trend observed from 2012 to 2022, we project that 5.7% of all children under 5 will be affected by overweight in 2030 (Table 10). If this current trend continues, the world will have increased the prevalence of childhood overweight by 3% compared to the 2012 baseline.

Table 10. Prevalence (%) of childhood overweight – 2012 baseline, proposed 2030 target and 2030 projection.

Childhood overweight	Prevalence (%)
2012 baseline	5.5
2030 target based on 2018 discussion paper	3
2030 projection - business as usual (% change since 2012)	5.7 (+3%)

Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

2.4.3 What if the world progressed at the rate of the highest performing countries from 2025?

Should current trends continue, 5.6% of all children under 5 years of age are projected to be overweight in 2025, respectively. The world would need to reduce the prevalence of overweight by 11.8% per year to reach the 2030 target of 3%. This translates to a total 47% reduction in the

prevalence of childhood overweight over the five-year period from 2025 to 2030, which would be unrealistic progress for any country.

An analysis of the progress achieved by countries from 2012 to 2022 based on the latest available data, showed that the highest quintile of countries exhibited an annual rate of reduction of childhood overweight prevalence of at least 2.92% per year. Applying this AARR from the 2025 projection for the period 2025-2030 would result in a 2030 prevalence of 4.8% (Table 11).

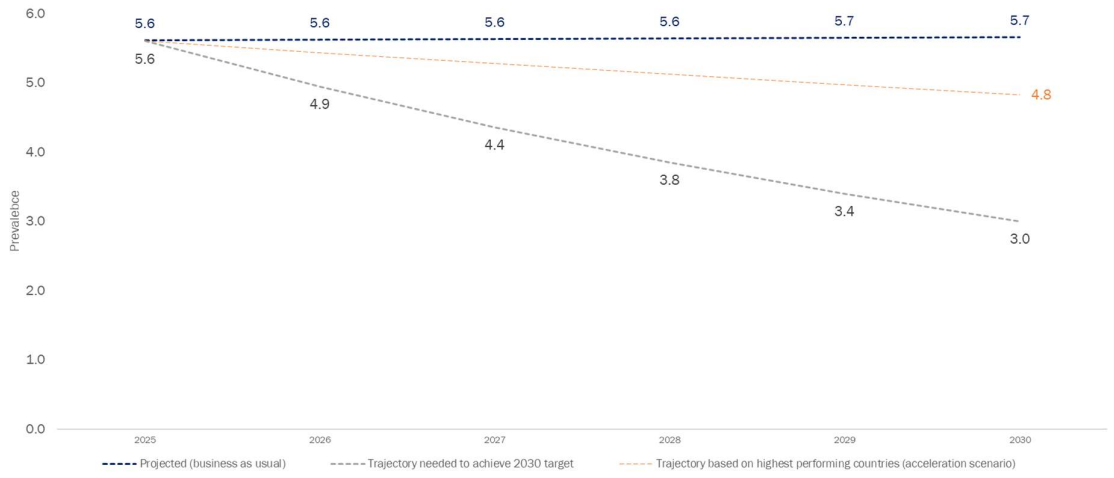
Should the world accelerate progress at the rate of the highest performing countries starting from 2025, the global prevalence of childhood overweight would reduce by 12% compared to the 2012 baseline (Fig. 8). Even this best-case scenario does not sufficiently address this major public health challenge, given the risks presented by this condition later in life *(20)*.

Table 11. Prevalence (%) of childhood overweight – 2012 baseline, 2030 acceleration scenario target and 2030 'business as usual" projection.

Overweight in children	Prevalence (%)
2012 baseline	5.5
2030 acceleration scenario based on highest performing countries from 2025 baseline (% change since 2012)	4.8 (-14%)
2030 projection - business as usual (% change since 2012)	5.7 (+3%)

Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

Fig. 8. Childhood overweight – projected prevalence (%) 2025 to 2030 and the trajectory required to achieve the 2030 target and the acceleration scenario trajectory.



Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

2.5 Exclusive breastfeeding

Breastfeeding

TARGET: Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%

To maintain consistency with other indicators, which are monitored based on reduction in contrast to increase as in the exclusive breastfeeding target, the monitoring and analyses of this indicator are based on the proportion of infants under 6 months that are **not exclusively breastfed** (NEBF). This is calculated as 100 minus the proportion of infants exclusively breastfed.

2.5.1 Global progress towards 2025 target

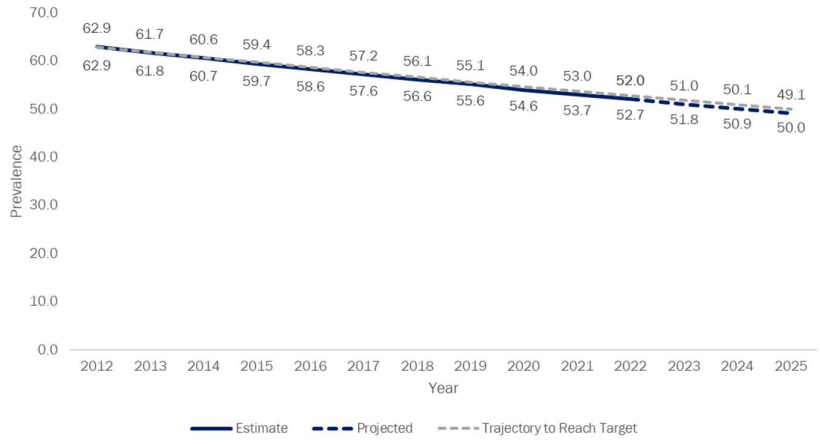
Globally, the prevalence of infants that are NEBF has declined at a rate of 1.9% per year from the baseline of 62.9% in 2012 to 52.0% in 2022, the latest year with available data *(21)*. Based on the current trend from 2012 to 2022, we project that 49.1% of all infants below the age of 6 months will not be exclusively breastfed in 2025 (Table 12). This represents a reduction of 22% in NEBF prevalence compared to the 2012 baseline. This projection translates to 51% prevalence of exclusive breastfeeding among children under 6 months of age, meaning the world is on track to achieve the global target of at least 50% exclusive breastfeeding prevalence by 2025.

Table 12. Proportion (%) of infants under 6 months that are not exclusively breastfed – 2012 baseline, 2025 target and 2025 projection.

Not exclusively breastfed	Prevalence (%)
2012 baseline	62.9
2025 target based on Comprehensive Implementation Plan for MIYCN	50
2025 projection (% change since 2012)	49.1 (-22%)

Source: UNICEF *(21).*

Fig. 9. Proportion (%) of infants under 6 months that are not exclusively breastfed – estimated prevalence 2012 to 2022, the projected prevalence to 2025, and the required trajectory to meet the 2025 target.



Source: UNICEF *(21).*

2.5.2 2030 Extended target: Reduce the rate of NEBF in the first 6 months to 30%.

In 2018, WHO and UNICEF proposed the more ambitious 2030 target to reduce the rate of NEBF in the first 6 months of life to 30% with 2012 as the baseline *(6).* This translates to an exclusive breastfeeding rate of 70% in 2030. The rationale for increasing the level of ambition was that the highest quintile of progress exhibited by countries, measured as AARR, was 3.4% per year. Applying this AARR over the 18-year period of 2012 to 2030 would result in NEBF prevalence of 33% by 2030. WHO and UNICEF proposed that setting the target to 30% was feasible given the fact that global

initiatives such as the Global Breastfeeding Collective, Scaling Up Nutrition (SUN) movement and the 1 000 Days initiative would drive action towards achieving the 30% target level.

Based on current trends observed from 2012 to 2022, however, we project that 44.7% of all infants below the age of 6 months will not be exclusively breastfed in 2030 (Table 13). If these trends continue, the world will have reduced the prevalence of NEBF by 29% compared to the 2012 baseline. Although still feasible given the potential quick impact of interventions on this indicator, as we stand now, the world is currently off track to meet the proposed target for 2030.

Table 13. Proportion (%) of infants under 6 months that are not exclusively breastfed – 2012 baseline, 2030 target and 2030 projection.

Not exclusive breastfeeding	Prevalence (%)
2012 baseline	62.9
2030 target based on 2018 discussion paper	30
2030 projection - Business as usual (% change since 2012)	44.7 (-29%)

Source: UNICEF *(21).*

2.5.3 What if the world progressed at the rate of the highest performing countries from 2025?

Should current trends continue, 49.1.% of all infants below 6 months are projected to not be exclusively breastfed in 2025, and the world would need to reduce the prevalence of NEBF by 9.4% per year to reach the 2030 target of 30%. This translates to a 39% reduction in the prevalence of NEBF over the five-year period from 2025 to 2030.

An analysis of the progress achieved by countries from 2005 to 2022 based on the latest available data, showed that the highest quintile of countries exhibited an annual rate of reduction in NEBF prevalence of at least 3.29% per year. Applying this AARR from the 2025 projection to the period 2025-2030 would result in a 2030 prevalence of 41.5% (Table 14).

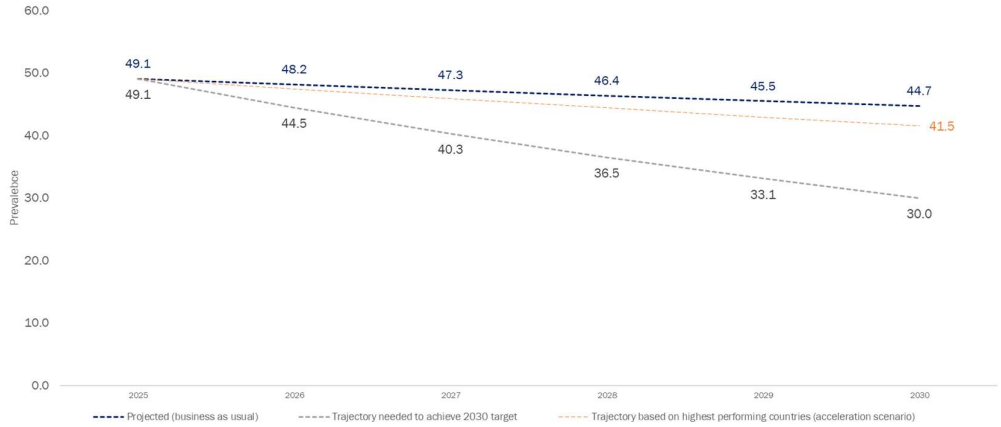
Should the world accelerate progress at the rate of the highest performing countries starting from 2025, therefore, we project that the world would reduce the prevalence of NEBF by 34% compared to the baseline of 2012 (Fig. 10). This is equivalent to a 58.5% prevalence of exclusive breastfeeding among infants below 6 months old in 2030. Thus, the proposed 2030 target might have been overly optimistic.

Table 14. Proportion (%) of infants under 6 months that are not exclusively breastfed – 2012 baseline, 2030 acceleration scenario and 2030 "business as usual" projection.

Not exclusively breastfed	Prevalence (%)
2012 baseline	62.9
2030 acceleration scenario based on highest performing countries from 2025 baseline (% change since 2012)	41.5 (-34%)
2030 projection - business as usual (% change since 2012)	44.7 (-29%)

Source: UNICEF *(21).*

Fig. 10. Proportion (%) of infants under 6 months that are not exclusively breastfed – projected prevalence 2025-2030, the required trajectory to meet the 2030 target and the acceleration scenario.



Source: UNICEF *(21).*

2.6 Wasting in children under 5 years of age

Wasting

TARGET: Reduce and maintain childhood wasting to less than 5%

2.6.1 Global progress towards 2025 target

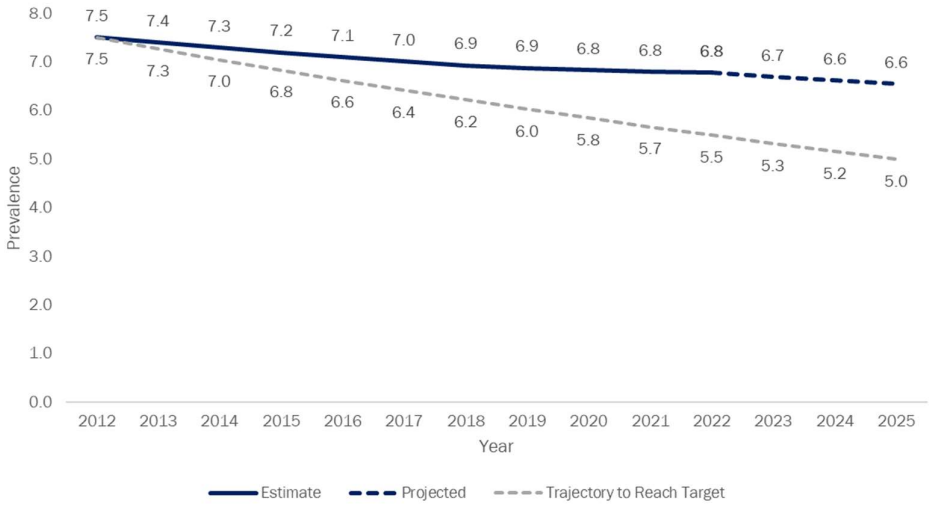
The global average prevalence of wasting in children under 5 years has declined at a rate of 1.04% per year from the baseline of 7.5% in 2012 to 6.8% in 2022, the latest year with available data *(13).* Based on the current global average trends from 2012 to 2022, we project that 6.6% of all children under 5 years will be wasted in 2025 (Table 15). This translates to a reduction of 13% in prevalence when compared to the 2012 baseline. Globally the world is not on track to achieve the 2025 target to reduce and maintain childhood wasting to less than 5%.

Table 15. Prevalence (%) of wasting in children under 5 – 2012 baseline, 2030 target and 2025 projection.

Wasting in children under 5	Prevalence (%)
2012 baseline	7.5
2025 target based on Comprehensive Implementation Plan	5
2025 projection (% change since 2012)	6.6 (-13%)

Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

Fig. 11. Prevalence (%) of wasting in children under 5 – estimated prevalence 2012-2022, projected prevalence to 2025 and trajectory required to reach the 2025 target.



Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

2.6.2 2030 Extended target: Reduce and maintain childhood wasting to less than 3%

In 2018, WHO and UNICEF proposed the 2030 target to reduce and maintain childhood wasting to less than 3% with 2012 as the baseline *(6).* The target was proposed because the highest quintile of progress exhibited by countries, measured as AARR, was 5% per year. Applying this AARR over the 18-year period of 2012 to 2030 would result in a target wasting prevalence of 3.2% by 2030. WHO and UNICEF proposed setting the target to 3%, as this would align with SDG target 2.2 on eliminating malnutrition.

Based on current trends observed from 2012 to 2022, we project that 6.2% of children under 5 will be wasted in 2030. If current trends continue, the world will have reduced the prevalence of childhood wasting by 17% compared to the 2012 baseline (Table 16).

Table 16. Prevalence (%) of wasting in children under 5 – 2012 baseline, 2030 target and 2030 "business as usual" projection.

Wasting in children	Prevalence (%)
2012 baseline	7.5
2030 target based on 2018 discussion paper	3
2030 projection - business as usual (% change since 2012)	6.2 (17%)

Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

2.6.3 What if the world progressed at the rate of the highest performing countries from 2025?

Should current trends continue, 6.6.% of all children under 5 years are projected to be wasted in 2025, and the world would need to reduce the prevalence of childhood wasting by 14.5% per year to reach the 2030 target of 3%- this would represent a 54% reduction in the prevalence of childhood wasting over the five-year period from 2025 to 2030.

An analysis of the progress achieved by countries from 2005 to 2022 based on the latest available data, showed that the highest quintile of countries exhibited an annual rate of reduction of the prevalence of wasting in children under 5 of at least 6.37% per year. Applying this AARR from the 2025 projection to the period 2025-2030 would result in a 2030 prevalence of 4.7%.

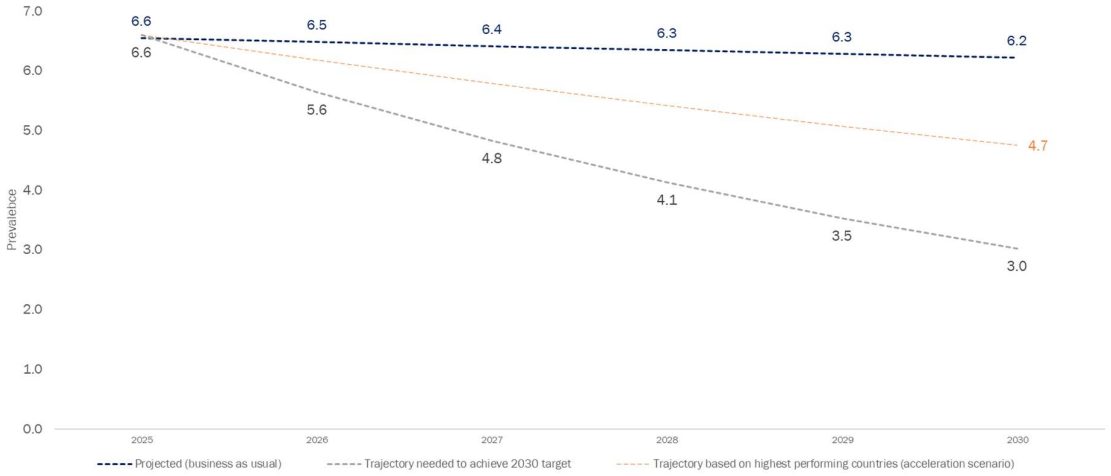
Should the world accelerate progress at the rate of the highest performing countries starting from 2025, we project that the world would reduce the prevalence of childhood wasting to 4.7%, a 37% decline compared to the baseline of 2012 (Table 17, Fig. 12). Although far from the inspirational target of 3%, it would nonetheless represent important progress in protecting children's health.

Table 17. Prevalence (%) of wasting in children under 5 – 2012 baseline, 2030 acceleration scenario and 2030 "business as usual" projection.

Wasting in children	Prevalence
2012 baseline	7.5
2030 acceleration scenario based on highest performing countries from 2025 baseline (% Reduction from 2012)	4.7 (37%)
2030 projection - business as usual (% Reduction from 2012)	6.2 (17%)

Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

Fig. 12. Prevalence (%) of wasting in children under 5 – projected "business as usual" prevalence 2025-2030, trajectory required to achieve the 2030 target and the acceleration scenario trajectory.



Source: UNICEF, WHO and International Bank for Reconstruction and Development/The World Bank *(13).*

3. Proposal for process indicators and operational targets for the global nutrition targets

The six global nutrition targets for maternal, infant, and young child nutrition establish goals for nutrition outcomes. In order to galvanize concrete progress towards these goals in the remaining years until 2030, there is value in focusing attention on a small list of operational targets that are achievable, measurable, and reflective of actions causally linked to the outcome targets. Below, potential process indicators for 2030 operational targets are set out. The proposed indicators were selected to meet specific criteria.

- The indicator needs to be causally linked to the nutritional outcomes or else serve as a reasonable proxy for indicators that are causally linked.
- Data on the indicator must be available for a large number of countries, defined here as a minimum of 50 countries. Although global objectives are sometimes set with the expectation that data will be collected in the future, we believe that the short timeframe until 2030, and the need to set a clear baseline, necessitates having accessible data.
- The indicator needs to be changeable in a reasonably short timeframe through public health measures. While upstream determinants of health such a socioeconomic status or women's empowerment are important drivers of nutritional status, they are not considered nutrition actions per se.
- The indicator needs to be measurable on a continuum to allow countries to make progress over time. A simple yes/no indicator for a country would not lead to concerted efforts towards improvement.

The operational targets are proposed to be associated with a specific nutritional outcome, although it is recognized that improving coverage of interventions or changing prevalence of certain behaviours would be beneficial for other nutritional outcomes as well. For example, while increasing children's dietary diversity is proposed as an operational target to reduce stunting, it would also be beneficial to prevent wasting and child overweight. Improving access and quality of antenatal care – to take another example – could reduce rates of low birthweight as well as increase the prevalence of exclusive breastfeeding.

We present the most recent estimates of each indicator, calculating a global percentage based on a weighted average of country estimates. This may be used as a baseline for establishing operational targets.

Two methods can be considered for setting global nutrition targets that are ambitious but also feasible:

i. where data are available, the rate of improvement in coverage observed in recent trends is calculated. As with exclusive breastfeeding described above, where the target is to increase coverage of a positive behaviour rather than decrease an adverse condition, the AARR in the prevalence of <u>not</u> engaging in the desirable action (i.e., 100% - coverage) is calculated. An ambitious, but also feasible, target for 2030 can then be based on the highest (unweighted) quintile of progress across all countries with data. We refer to these countries with the best performance as exemplars.
ii. where trend data are not available, setting a target based on the coverage achieved in the best (unweighted) quintile of countries is proposed. For behaviours for which the aim is to increase, the highest quintile is used and for behaviours for which the aim is to decrease (e.g., consumption of sugar-sweetened beverages), the lowest quintile is used.

3.1 Stunting among children under 5

3.1.1 Percent of children aged 6 to 23 months consuming minimum dietary diversity

Inadequate nutrition is one of the many causes of stunting in children. Interventions carried out to address other global nutrition targets, including those for anaemia, low birth weight, breastfeeding and wasting can all contribute to reducing rates of stunting. Evidence suggests that greater dietary diversity, particularly during the period of complementary feeding, is associated with improved linear growth *(22).* WHO recommends that children 6-23 months of age consume a diverse diet, including meat, poultry, fish, eggs, dairy, fruits and vegetables *(23).*

A multisectoral approach to improving children's diets will be necessary to effectively improve dietary diversity *(24).* Agricultural policies to increase availability of diverse nutritious foods, parental education on optimal diets and social safety net programmes to support low-income families are all necessary to address the barriers to appropriate complementary feeding.

The WHO-UNICEF indicators on infant and young child feeding define minimum dietary diversity as the percentage of children 6-23 months who consumed foods and beverages from at least five out of eight defined food groups during the previous day *(25).*

While the GNMF originally included an indicator on minimum acceptable diet, this was replaced in 2017 by minimum dietary diversity (MDD) on the basis that the latter is simpler and more universally relevant *(3).*

3.1.1.1 Latest prevalence levels

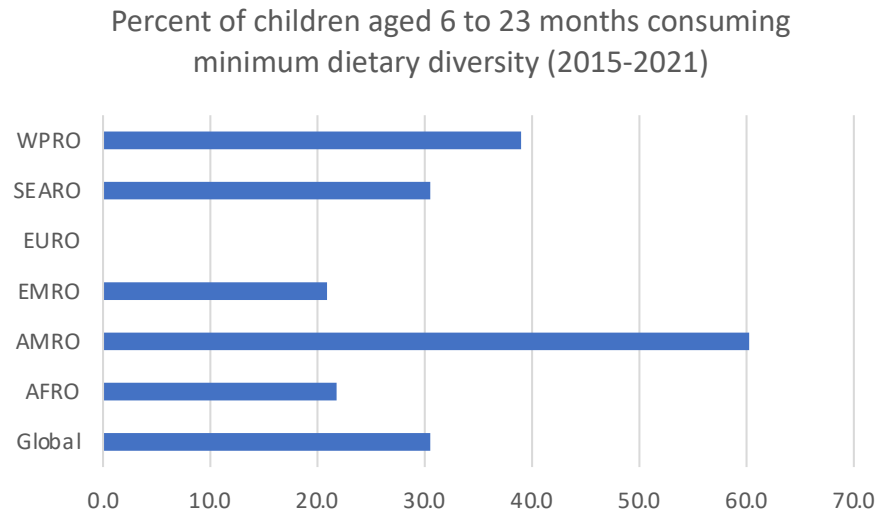
The percent of children consuming a diet with MDD can be calculated from data in the standard Demographic and Health Surveys (DHS) or the Multiple Indicator Cluster Surveys (MICS) as well as other national surveys. Data are available in the UNICEF Infant and young child feeding database for 107 countries *(21).* Based on a weighted average of data collected in 2015-2021, 30.5% of children aged 6 to 23 months consume a diet with MDD (Table 18). The prevalence is higher in the Americas than in other regions, although data are insufficient in Europe to calculate a regional average (Fig. 13). The 80th percentile (top quintile) of prevalence across countries is 58.2%.

Table 18. Minimum dietary diversity (6-23 months) – global average prevalence (%) and highest quintile of country prevalence, 2015-2021.

Minimum dietary diversity (6 to 23 months)	Prevalence (%)
Global average (2015-2021)	30.5
Highest quintile of country prevalence (top 20%)	58.2

Source: UNICEF *(21)*

Fig.13. Minimum dietary diversity (6-23 months) – average prevalence (%) in WHO regions and globally, 2015-2021.



Source: UNICEF *(21)*

3.1.1.2 Proposed 2030 Target: 40%

Progress on improving this indicator has been stagnant, with a median annual rate of reduction in the percent not achieving MDD being 0.01% per year among the 62 countries with trend data. However, some countries have been able to achieve a faster rate of improvement, with the cutoff for the upper quintile being 2.11% per year. Applying this rate of improvement to the 30.5% baseline prevalence suggests that an increase to 38.8% (rounded up to 40%) by 2030 should be achievable (Table 19).

While a subset of countries has been able to achieve a level of MDD above 58%, it seems unrealistic to expect the global average to almost double in just five years. We suggest that setting a target based on progress (40%) is ambitious and yet achievable.

Table 19. Minimum dietary diversity (6-23 months) – global baseline prevalence (%), 2015-2021, and proposed global target for 2030.

Minimum dietary diversity (6-23 months)	Prevalence (%)
Global baseline (2015-2021)	30.5
Global target (2030) Based on progress of exemplars	40.0
Limitations: Data are collected using a mix of datasets, with open recall and list-based dietary recall of foods consumed, and so estimates may not be comparable over time within countries or across countries. The MDD indicator does not differentiate between lower and higher quality foods within each food group and does not account for quantities consumed.	

Source: UNICEF *(21)*

3.2 Anaemia in women of reproductive age

3.2.1 Option 1: Percentage of women consuming any iron-containing supplements during pregnancy.

Anaemia is a complex condition with multiple causes, including nutritional deficiencies, infections, inflammation, gynaecological and obstetric conditions and inherited red blood cell disorders. As such, a comprehensive approach to making progress on anaemia reduction is critical *(17).* Iron deficiency is the most common and widely recognized cause of anaemia, particularly during pregnancy due to an increase in maternal red cell mass, the growth of the fetus and placenta,

increased maternal basal requirements and preparation for blood loss at delivery. Therefore, ensuring adequate iron intake during pregnancy should be a key component of intervention packages for the prevention of anaemia. WHO recommends that all pregnant women take a daily oral supplement containing 30 mg to 60 mg of elemental iron *(26).*

The GNMF includes an indicator on antenatal iron supplementation *(27).* Although the original GNMF recommended a more specific indicator on "the proportion of women with a birth in the last 2 years who received or bought iron and folic acid supplements for at least 6 months during their last pregnancy, in amounts that were in accordance with recommended protocols," the operational guidance for the framework recommended a simpler indicator "any antenatal iron supplementation" due to concerns about the ability of mothers to accurately recall the specific type of supplement, number of tablets consumed, or duration of use *(3).*

The percentage of women taking antenatal iron supplements is an important process indicator for informing progress towards meeting the global nutrition target on anaemia in women of reproductive age, as it is one of the only interventions recommended for all pregnant women aimed at addressing the main cause of anaemia in this population group. It assumes that quality iron supplements are available and that there are policies and programmes in place for their delivery. If coverage of the intervention is poor, more work will be needed to assess where along the path from policy to consumption of oral iron the intervention is failing *(28).* If coverage is high and the prevalence of anaemia in pregnant women also remains high, further work on assessing the quality of the supplement and verification of the underlying cause of anaemia would be warranted.

3.2.1.1 Latest coverage levels

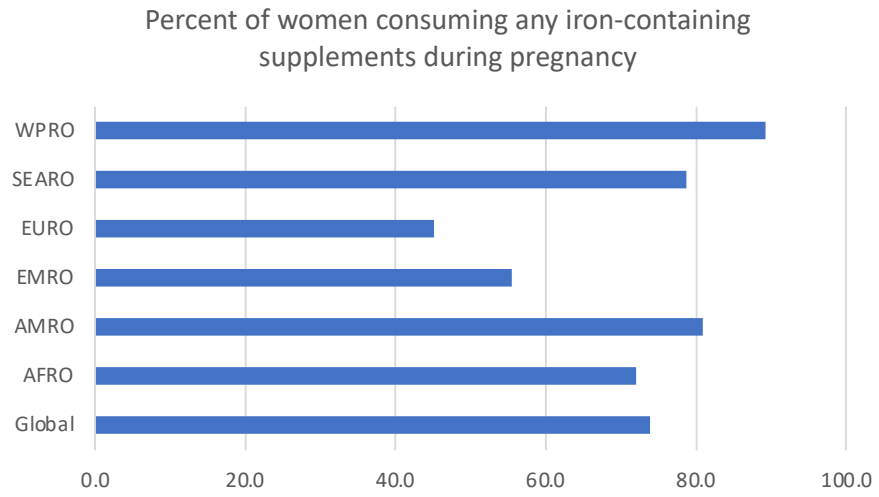
The DHS asks mothers who gave birth in the past five years about consumption of iron-containing supplements during their last pregnancy. Data on this indicator are available for 65 countries, 41 of which collected data during the period 2015-2022 *29*. Based on a weighted average of data collected between 2015 and 2022, 73.8% of mothers took at least one iron supplement during her last pregnancy (Table 20). Coverage is lowest in Europe and highest in the Western Pacific (Fig. 14). The 80th percentile of coverage across all 65 countries is 89.3% (rounded to 90%).

Table 20. Consumption of iron-containing supplements during pregnancy – global average (%) and highest quintile of country coverage, 2015-2021.

Women consuming any iron-containing supplements during pregnancy	Coverage (%)
Global average (2015-2022)	73.8
Highest quintile of country coverage (top 20%)	89.3

Source: ICF *(29)*

Fig. 14. Percentage (%) of women consuming any iron-containing supplements during pregnancy - average prevalence in WHO regions and globally, 2015-2021.



Source: ICF *(29).*

3.2.1.2 Proposed 2030 Target: 90%

At the median across the 62 countries with trend data, the percent of women reporting no use of iron-containing supplements has shown an annual rate of reduction of 6.1%. The 80th percentile of progress is 10.5% per year. Applying this rate of improvement to the 73.8% coverage (26% consuming no supplement) suggests that an increase to 86.6% (rounded to 90%) by 2030 should be achievable (Table 21).

Table 21. Percentage (%) of women consuming any iron-containing supplements during pregnancy – global baseline coverage, 2015-2021, and proposed global target for 2030.

Women consuming any iron-containing supplements during pregnancy	Coverage (%)
Global baseline (2015-2022)	73.8
Global target (2030) Based on both progress of exemplars and current 80th percentile	90.0
Limitations: Data are self-reported. Consumption of iron supplements for only a short time is unlikely to have substantial nutritional benefits. The intervention only targets pregnant women, whereas the global nutrition target is for all women of reproductive age. Iron deficiency is only one of many causes of anaemia and this intervention will only address iron deficiency anaemia.	

Source: ICF *(29).*

3.2.2 Option 2: Percent of women consuming at least 90 iron-containing supplements during pregnancy.

To be effective, consumption of iron supplements would need to be sustained over several months, suggesting that a target of consuming supplements for at least three months would be more meaningful. The DHS question on supplement use asks about the number of iron-containing supplements a mother took during pregnancy and reports on any use, <60, 60-89 and 90+ days of supplementation *(30)*.

3.2.2.1 Latest coverage levels

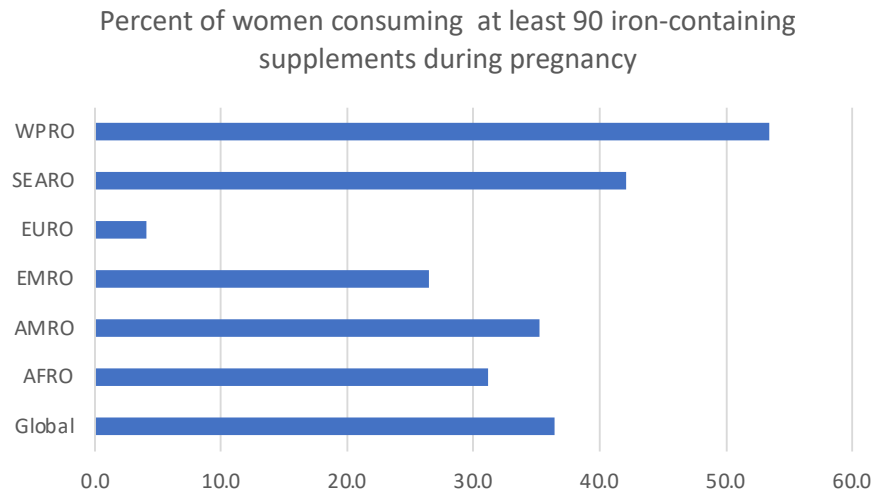
On average, 36.4% of women took at least 90 tablets during their last pregnancy, based on data collected between 2015 and 2022 (Table 22). Regional patterns are similar to those for any supplement use (Fig. 15). The 80th percentile of coverage with at least 90 supplements across all 65 countries is 55.0%.

Table 22. Percentage (%) of women consuming at least 90 iron-containing supplements during pregnancy – global average and highest quintile of country coverage, 2015-2022.

Women consuming at least 90 iron-containing supplements during pregnancy	Coverage (%)
Global average (2015-2022)	36.4
Highest quintile of country coverage (top 20%)	55.0

Source: ICF *(29).*

Fig.15. Percentage (%) of women consuming at least 90 iron-containing supplements during pregnancy – average prevalence in WHO regions and globally, 2015-2021.



Source: ICF *(29).*

3.2.2.2 Proposed 2030 Target: 55%

On average, the percentage of women not taking at least 90 tablets during pregnancy has decreased by 2.3% per year among the 43 countries with trend data, with the 80th percentile being 5.2% per year. Applying this rate of improvement to the 35.8% baseline (64.2% not taking at least 90 tablets) suggests that an increase to 54.0% (rounded to 55%) by 2030 should be achievable (Table 23).

Table 23. Percentage (%) of women consuming at least 90 iron-containing supplements during pregnancy – global baseline, 2015-2022, and proposed global target for 2030.

Women consuming at least 90 iron-containing supplements during pregnancy	Coverage (%)
Global baseline (2015-2022)	36.4
Global target (2030) Based on both progress of exemplars and current 80th percentile	55.0
Limitations: Data are self-reported. Recall of actual days of consumption may be poor. The intervention only targets pregnant women, whereas the global nutrition target is for all women of reproductive age.	

Source: ICF *(29).*

3.2.3 Option 3: Percentage of wheat or maize flour that is fortified with iron

Iron intake for all women of reproductive age could be enhanced through fortification of staple foods. WHO has recommended that wheat flour be fortified with highly bioavailable iron to improve

haemoglobin concentrations and iron status and to prevent anaemia and iron deficiency in populations *(31).* Fortification of maize flour and corn meal is likewise recommended *(32).* Iron deficiency is one of the main causes of anaemia in pregnant and non-pregnant women.

The percentage of flour that is fortified with iron gives an indication of populations having access to additional iron in the diet. If coverage is poor, more work will be needed to assess where along the path from policy to consumption of iron fortified maize and wheat flour the intervention is failing. If coverage is high and the prevalence of anaemia also remains high, further work on assessing the quality and amounts of fortified flours being consumed, and verification of the underlying cause of anaemia would be warranted.

3.2.3.1 Latest coverage levels

The Global Fortification Data Exchange aggregates data on national policies and practices on fortifying staple foods *(33).* Data are available from 74 countries on the proportion of wheat flour that is fortified, of which 16 also have data on maize flour. Where data are available for both, the data on wheat and maize flour fortification were combined as a weighted average using the domestic supply of these flours. To calculate a regional and global total, national estimates were weighted by domestic supply estimates from balance sheets published by the United Nations Food and Agriculture Organization (FAO), providing data for 72 countries, representing 48% of the global production of wheat and maize flour *34* .

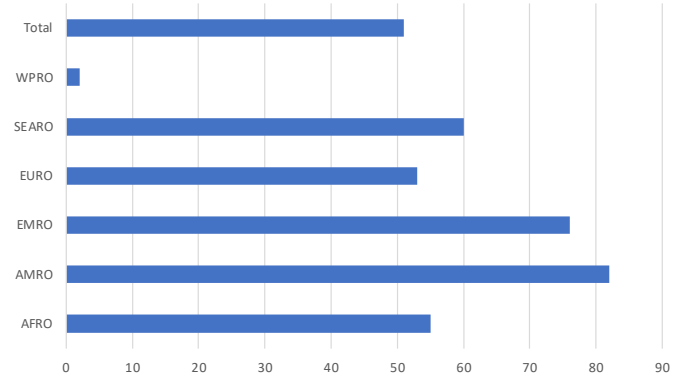
On average, 43.5% of wheat or maize flour is currently fortified with iron (Table 24). Fortification coverage is higher in the Americas, Eastern Mediterranean and Africa, although data are insufficient in Europe and Southeast Asia to present regional estimates (Fig. 16). The 80th percentile of coverage of fortification across all 74 countries is 100%.

Table 24. Proportion (%) of wheat or maize flour that is fortified with iron – global average and highest quintile of country coverage.

Percent of wheat or maize flour that is fortified with iron	Coverage (%)
Global average (2011-2022)	43.5
Highest quintile of country coverage (top 20%)	100

Source: Global Fortification Data Exchange *(33)*

Fig. 16. Proportion (%) of wheat or maize flour that is fortified with iron – average percentage coverage in WHO regions and globally, 2011-2022.



Source: Global Fortification Data Exchange *(33).*

3.2.3.2 Proposed 2030 Target: 75%

The fact that the 80th percentile of coverage of fortification across all 74 countries is 100%, demonstrates that universal fortification is possible in some countries. However, it is unrealistic to expect that the global average could reach such a high level in five years. A more achievable goal of 75% – halfway between the current level and universality – is proposed (Table 25).

Table 25. Proportion (%) of wheat or maize flour that is fortified with iron – global baseline and proposed global target for 2030.

Percent of wheat or maize flour that is fortified with iron	Coverage (%)
Global baseline (2011-2022)	43.5
Global target (2030) Based on average of current coverage and the 80th percentile	75.0
Limitations: The majority of countries with information on this indicator utilize expert opinion rather than testing at the market or household level. The number of countries with coverage data based on actual testing is quite small.	

Source: Global Fortification Data Exchange *(33).*

3.3 Low birth weight

3.3.1 Option 1: Percentage of pregnant women attending at least four antenatal care visits

A healthy, full-term birth is the result of a healthy pregnancy. The WHO recommendations on antenatal care for a positive pregnancy experience include a number of nutritional interventions to reduce the risks of adverse birth outcomes, including counselling on optimal nutrition, vitamin and mineral supplements, and provision of protein and energy supplements in high-risk contexts *(26).* Thus, provision of adequate antenatal care is a key intervention for prevention of low birth weight.

The percentage of women attending at least four antenatal care visits is a critical indicator for prevention of low birth weight. Receiving antenatal care at least four times increases the likelihood of receiving effective maternal health interventions and reduces the risk of low birth weight. Regular antenatal care visits also enable antenatal care providers to closely monitor maternal health and fetal development, facilitating early detection and management of potential risk factors for low birth weight. These visits also offer opportunities for healthcare providers to offer nutritional counselling and support, promote healthy lifestyle behaviours and screen for pregnancy complications that can adversely affect fetal growth and birth weight if left untreated. This is also one of the indicators in the *Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030) Monitoring Framework (35),* and one of the tracer indicators of health services for the universal health coverage (SDG indicator 3.8.1).

3.3.1.1 Latest coverage levels

Data on adequate antenatal care from the DHS, MICS, and other surveys in 2015-2022 are available for 112 countries, representing 72% of the global population *(36).* Overall, 65.2% of pregnant women attended a minimum of four visits (Table 26). This coverage is higher in the Americas, Europe and the Western Pacific regions (Fig. 16). The 80th percentile of coverage across the countries is 94.3%. This rate is significantly above current coverage and is not likely to be attainable globally in five years.

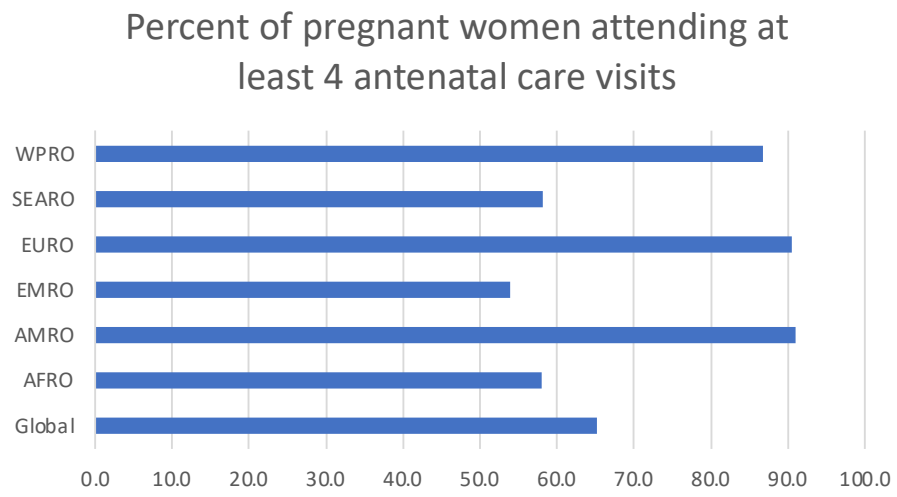
Table 26. Percentage (%) of pregnant women attending at least four antenatal care visits – global average and highest quintile, 2015-2022.

Pregnant women attending at least four antenatal care visits	Coverage (%)

Global average (2015-2022)	65.2
Highest quintile of country coverage (top 20%)	94.3

Source: WHO Global Health Observatory *(36).*

Fig. 17. Percentage (%) of pregnant women attending at least four antenatal care visits – average in WHO regions and globally, 2015-2022.



Source: WHO Global Health Observatory *(36).*

3.3.1.2 Proposed 2030 Target: 80%

Trend data are available for 148 countries. At the median, the percentage **not** receiving at least four antenatal care visits has decreased by 2.27% per year. At the 80th percentile, this percentage decreased by 6.03% per year. Applying this rate of improvement to the 65.2% baseline (34.8% not receiving four visits) suggests that an increase to 76.0% (rounded to 80%), representing a 16.7% relative increase, by 2030 should be achievable (Table 27).

Table 27. Percentage (%) of pregnant women attending at least four antenatal care visits – global baseline, 2015-2022, and proposed global target for 2030.

Pregnant women attending at least four antenatal care visits	Coverage (%)
Global baseline (2015-2022)	65.2
Global target (2030) Based on progress of exemplars	80.0
Limitations: Quality of care in antenatal visits is highly variable. Attendance at antenatal care visits does not necessarily mean that the recommended interventions that might prevent low birth weight are actually delivered.	

Source: WHO Global Health Observatory *(36).*

3.3.2 Option 2: Percentage of women consuming minimum dietary diversity

A healthy pregnancy is supported by a healthy diet before and during pregnancy. Studies have shown that pregnant women who consume a diverse range of foods from various food groups are more likely to consume essential nutrients necessary for optimal foetal growth and development, thereby lowering the risk of low birth weight. As with dietary diversity in children, improving the diversity of women's diets will depend on numerous upstream actions ranging from economic

advancement of women and availability of diverse foods to social protection policies and education for women.

3.3.2.1 Latest prevalence levels

One key indicator of a healthy diet is minimum dietary diversity in women (MDD-W). MDD-W is defined as consuming at least five out of 10 food groups on the previous day. MDD-W can be calculated from quantitative 24-hour recall dietary intake surveys, but also from simple diet quality questionnaires on food groups. The Global Diet Quality Project collected comparable dietary intake data in 56 countries during 2021-2023, providing a potential baseline for MDD-W *(37).* These 56 countries represent 72% of the global population.

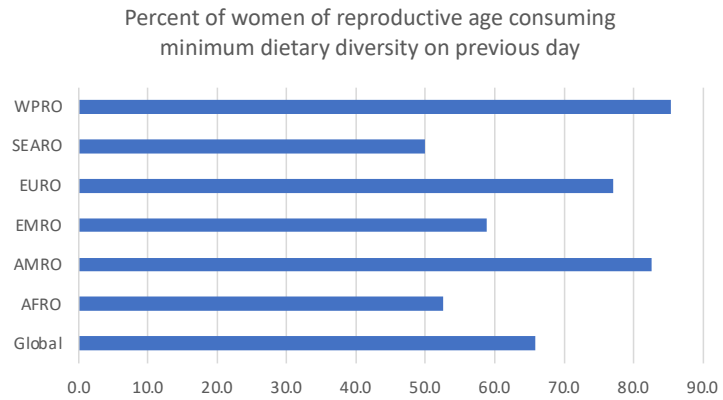
Overall, 65.8% of women consumed a minimum of five of the ten food groups on the previous day (Table 28). Consumption of a diverse diet was highest in the Western Pacific, the Americas, and Europe (Fig.18). Trend data are not available for this indicator. Consumption of minimum dietary diversity reached 86.0% in the best 20% of countries.

Table 28. Minimum dietary diversity in women – global average and highest quintile of country prevalence (%), 2021-2023.

Women consuming minimum dietary diversity	Prevalence (%)
Global average (2021-2023)	65.8
Highest quintile of country prevalence (top 20%)	86.0

Source: Global Diet Quality Project *(37).*

Fig. 18. Minimum dietary diversity in women – average in WHO regions and globally, 2021-2023



Source: Global Diet Quality Project *(37).*

3.3.2.2 Proposed 2030 Target: 85%

A new global target for 2030 is proposed on the basis of the current top 20% of countries – 86% rounded down to rounded to 85% (Table 29).

Table 29. Minimum dietary diversity in women – global baseline, 2021-2023, and proposed global target for 2030.

Women consuming minimum dietary diversity	Prevalence (%)
Global baseline (2021-2023)	65.8
Global target (2030)	85.0

Based on current 80th percentile	
Limitations: Data in the diet quality questionnaire are collected using a simple recall of food groups rather than full 24-hour dietary recall, so reporting may be inaccurate for some foods. The MDD indicator does not differentiate between lower and higher quality foods within each food group and does not account for quantities consumed.	

Source: Global Diet Quality Project *(37).*

3.4 Overweight in children

3.4.1 Option 1: Percent of adults consuming sugar-sweetened beverages on the previous day

Overweight and obesity are the result of a variety of metabolic and environmental causes, but generally develop when energy intake exceeds energy expenditure. Numerous dietary changes can reduce energy intake, but consumption of sugar-sweetened beverages is particularly important because satiety mechanisms are less affected by intake of liquids than solid foods. WHO recommends that young children consume no sugar-sweetened beverages and limit their consumption of fruit juices *(23).*

3.4.1.1 Latest prevalence levels

The DHS and MICS core questionnaires have added questions to report the indicator of sweet beverage consumption in young children, but to date, only a handful of countries have collected and published estimates using these data. However, the Global Diet Quality Project questionnaire described above collects data on consumption of sugar-sweetened beverages in the previous 24 hours among adults *(37).* Data are not available for children.

Data on consumption of sugar-sweetened beverages among adults does not necessarily reflect consumption among children, but dietary patterns within families are closely linked and children develop eating preferences based on behaviours they see in adults *(37).* Data are available for 56 countries.

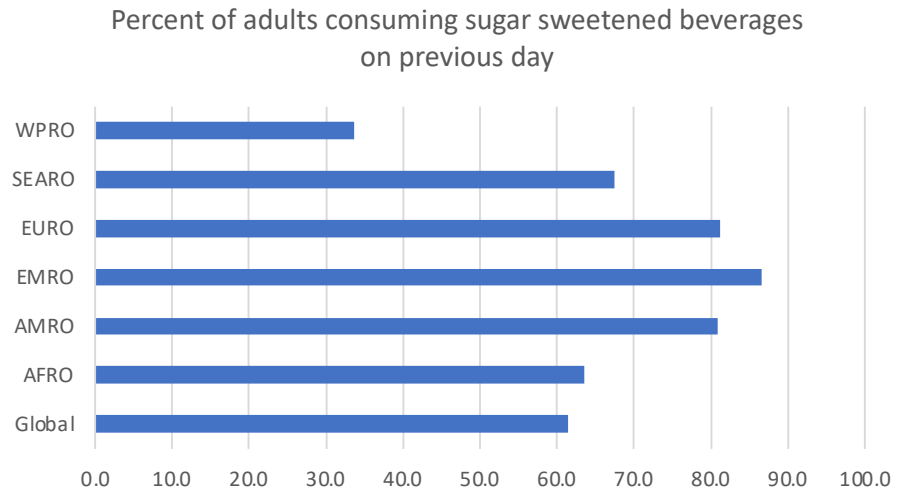
Based on a weighted average of data collected in 2021-2023, 61.5% of adults drank a sugar-sweetened beverage on the previous day (Table 30). The prevalence is highest in the Eastern Mediterranean, Europe and the Americas, and lowest in the Western Pacific (Fig. 19). Consumption of sugar-sweetened beverages was as low as 57.0% in the best 20% of countries.

Table 30. Percentage (%) of adults consuming sugar-sweetened beverages on the previous day – global average and highest quintile of country prevalence, 2021-2023.

Adults consuming sugar-sweetened beverages on the previous day	Prevalence (%)
Global average (2021-2023)	61.5
Lowest quintile of country prevalence (bottom 20%)	57.0

Source: Global Diet Quality Project *(37).*

Fig. 19. Percentage (%) of adults consuming sugar-sweetened beverages on the previous day – average in WHO regions and globally, 2021-2023.



Source: Global Diet Quality Project *(37).*

3.4.1.2 Proposed 2030 target: 55%

A new target for 2030 is proposed based on the current 20th percentile (57%), rounded to 55% (Table 31).

Table 31. Percentage (%) of adults consuming sugar-sweetened beverages on the previous day – global baseline, 2021-2023, and proposed global target for 2030.

Adults consuming sugar-sweetened beverages on the previous day	Prevalence (%)
Global baseline (2021-2023)	61.5
Global target (2030) Based on current 20th percentile (lowest quintile)	55.0
Limitations: Diet quality questionnaire data are collected using a simple recall of food groups rather than full 24-hour recall, so reporting may be inaccurate for some foods.	

Source: Global Diet Quality Project *(37).*

3.4.2 Option 2: Percent of population consuming no more than 10% of calories from free sugars

WHO recommends that intake of free sugars be limited to no more than 10% of total energy intake, preferably below 5% *(38).* The *WHO acceleration plan to stop obesity,* endorsed by the Seventy-fifth World Health Assembly in 2022, included a target of no more than 10% of calories coming from free sugars *(39).* Calculation of this statistic requires data on total caloric intake as well as free sugar intake. This requires data from 24-hour recall surveys. The FAO/WHO Global Individual Food consumption data Tool (GIFT) repository includes quantitative 24-hour recall data from 29 countries, but only 8 of these are nationally representative data collected within the past decade *(40).* As such, it is very difficult to estimate a baseline for this indicator.

3.5 Exclusive breastfeeding

3.5.1 Option 1: Percent of caregivers counselled on infant and young child feeding.

Interpersonal support is one of the most important interventions to help mothers exclusively breastfeed for six months. WHO recommends that breastfeeding counselling should be provided to all pregnant women and mothers with young children in both the antenatal period and postnatally *(41).* Breastfeeding counselling increases the likelihood of exclusive breastfeeding in the first six months of life *(42).*

3.5.1.1 Latest coverage Levels

The percentage of caregivers counselled on infant and young child feeding is one of the indicators in the Global Nutrition Monitoring Framework as well as the Global Breastfeeding Scorecard *(3,43).* The annual UNICEF Nutridash survey collects country-level data on the number of primary caregivers of children aged 0-23 months who received counselling on infant and young child feeding through facilities and community platforms in the previous year (*44*). By dividing this by the total population under 2 years of age in the country, it is possible to estimate the percent of caregivers who were counselled. These estimates are included in the Global Breastfeeding Scorecard, with data available for 66 countries in 2022 *(43).*

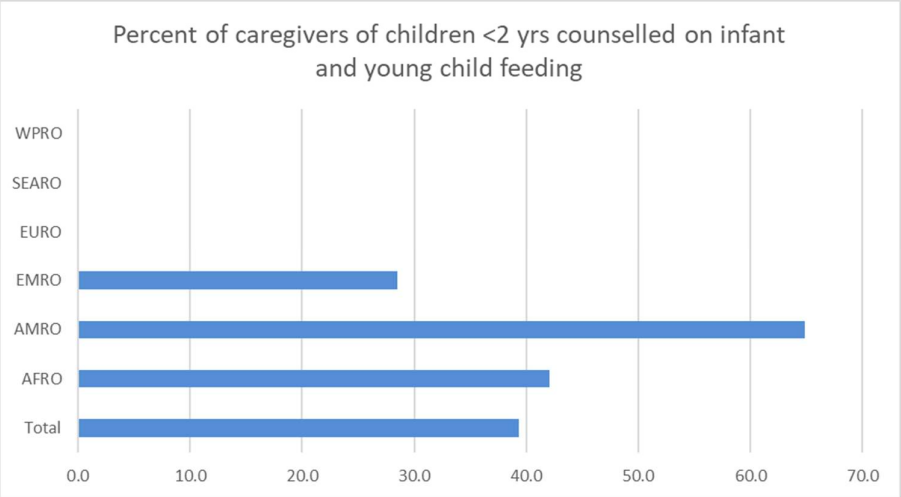
Overall, 39.3% of caregivers of children under 2 years old received counselling on infant and young child feeding (Table 32). The prevalence is highest in the Americas and Africa (Fig. 20). Too few countries in the European, Southeast Asian or Western Pacific regions reported data to calculate averages. Trend data are not available. The 80th percentile of coverage across the 66 countries is 100%, but this includes a number of countries that reported more caregivers counselled than there are children, indicating an overcount. If these countries are excluded, the 80th percentile would be 65.1 (rounded to 65%), which might reflect a more realistic target.

Table 32. Percentage (%) of caregivers counselled on infant and young child feeding – global average and highest quintile of country coverage, 2022.

Caregivers counselled on infant and young child feeding	Coverage (%)
Global average (2022)	39.3
Highest quintile of country coverage (top 20%)	65.1

Source: UNICEF *(44)*

Fig. 20. Percentage (%) of caregivers of children under 2 years counselled on infant and young child feeding – average in WHO regions and globally, 2022.



Source: UNICEF *(44)*

3.5.1.2 Proposed 2030 Target: 65%

If the countries that reported more caregivers counselled than there are children are excluded, the 80th percentile would be 65.1 (rounded to 65%), which might reflect a more realistic target (Table 33).

Table 33. Percentage (%) of caregivers of children under 2 years counselled on infant and young child feeding – global baseline, 2022, and proposed global target for 2030.

Caregivers counselled on infant and young child feeding	Coverage (%)
Global baseline (2022)	39.3
Global target (2030) Based on current 80th percentile	65.0
Limitations: The source of information on the number of caregivers counselled differs by country and thus the estimates are not necessarily comparable. There is no standard definition of the nature, duration or quality of counselling on infant and young child feeding provided. Data are likely collected from simple counts of mothers who receive minimal messages about breastfeeding without assessing the qualifications of the provider, the messages delivered, the time spent or the quality of the interaction. Depending on how the data are collected, mothers may be counted multiple times in some countries. As a result, the indicator is likely to overestimate the receipt of counselling.	

Source: UNICEF *(44)*

3.5.2 Option 2: Percentage of newborns being put to the breast in the first hour after birth

Support for breastfeeding in the hours after birth is a critical part of newborn care. In order to successfully initiate breastfeeding and prevent neonatal mortality, WHO recommends that all newborns be put to the breast immediately after birth *(*45*).* Early initiation of breastfeeding is closely linked to early skin-to-skin care of newborns, which is also recommended. Skin-to-skin contact between mother and infant shortly after birth helps to initiate early breastfeeding and increases the likelihood of exclusive breastfeeding for one to four months of life as well as the overall duration of breastfeeding. Early newborn care is largely directed by healthcare providers and institutional policies.

3.5.2.1 Latest prevalence Levels

Early initiation of breastfeeding, defined as the percentage of children born in the last 24 months who were put to the breast within one hour of birth, is a key indicator included in the WHO/UNICEF Indicators on Infant and Young Child Feeding *(25).* The UNICEF Infant and young child feeding database includes data from 133 countries based on data from the DHS and MICS *(21).* The indicator is also included in the *Global Breastfeeding Scorecard (43).*

On average, 45.8% of newborns are put to the breast within the first hour (Table 34). This figure is higher in the Americas and Africa but lower in the Eastern Mediterranean and Western Pacific regions (Fig. 21). The 80th percentile for latest prevalence among countries with data in the period 2016-2022 is 69.4%.

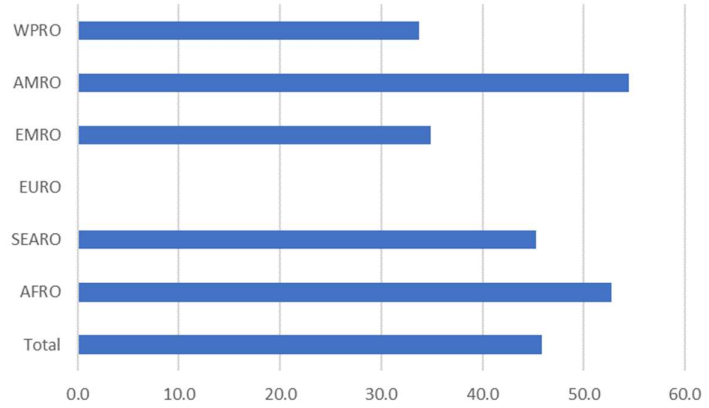
Table 34. Percentage (%) of newborns put to the breast in the first hour after birth – global average and highest quintile of country prevalence, 2016-2022.

Newborns put to the breast in the first hour after birth	Prevalence (%)

Global average (2016-2022)	45.8
Highest quintile of country prevalence (top 20%)	69.4

Source: UNICEF *(21).*

Fig. 21. Percentage (%) of newborns put to the breast in the first hour after birth – average in WHO regions and globally, 2016-2022.



Source: UNICEF *(21).*

3.5.2.2 Proposed 2030 Target: 60%

Among the 117 countries with trend data, the percentage **not** put to the breast in the first hour decreased by 1.18% per year, with the 80th percentile having a rate of decrease of 4.0% per year. Applying the rate of improvement among top performers to the 45.8% baseline (54.2% not put to breast in first hour) suggests that an increase to 57.5% (rounded to 60%) – equivalent to a 25.5% relative increase – by 2030 should be achievable (Table 35).

Table 35. Percentage (%) of newborns put to the breast in the first hour after birth – global baseline, 2016-2022, and proposed global target for 2030.

Newborns put to the breast in the first hour after birth	Prevalence (%)
Global baseline (2016-2022)	45.8
Global target (2030) Based on progress of exemplars	60.0
Limitations: Maternal recall of the specific time of breastfeeding initiation may be inaccurate.	

Source: UNICEF *(21).*

3.6 Wasting in children

3.6.1 Option 1: Percent of children consuming minimum meal frequency

Insufficient consumption of protein, energy and micronutrients is a key cause of wasting in children. Feeding meals and/or snacks less frequently than recommended can compromise total energy and micronutrient intake. WHO recommends that breastfed infants consume complementary foods two- to three times per day at 6-8 months of age and three to four times per day at 9-23 months of age, with additional nutritious snacks offered once or twice per day *(46).* The WHO-UNICEF indicators on

infant and young child feeding define minimum meal frequency based on eating at least the recommended number of meals or snacks on the previous day *(25).*

3.6.1.1 Latest prevalence levels

The percentage of children consuming minimum meal frequency can be calculated from data in the standard DHS or MICS as well as other national surveys. Data are available in the UNICEF infant and young child feeding database for 106 countries *(21).*

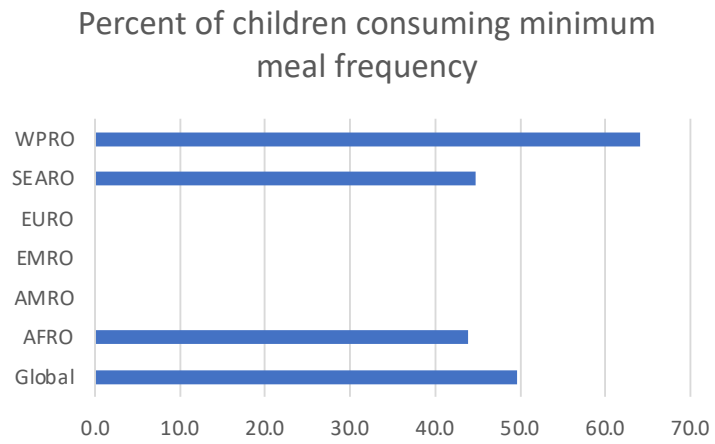
Based on a weighted average of data collected in 2015-2021, 49.7% of children aged 6 to 23 months consume a minimum meal frequency (Table 36). The prevalence is highest in the Western Pacific region although data are insufficient in the Americas, Eastern Mediterranean, or European regions to calculate regional averages (Fig. 22). The 80th percentile across countries is 68.1%.

Table 36. Children consuming minimum meal frequency – global average and highest quintile of country prevalence, 2015-2021.

Children consuming minimum meal frequency	Prevalence (%)
Global average (2015-2021)	49.7
Highest quintile of country prevalence (top 20%)	68.1

Source: UNICEF *(21).*

Fig. 22. Children consuming minimum meal frequency – average in WHO regions and globally, 2015-2021



Source: UNICEF *(21).*

3.6.1.2 Proposed 2030 Target: 70%

Progress on improving this practice has been slow, with an AARR in the percentage not meeting minimum meal frequency of 1.5% per year among the 62 countries with trend data. However, some countries have been able to achieve a much faster rate of improvement, with the 80th percentile showing a reduction of 9.7% per year. Applying this rate of improvement to the 49.7% baseline (50.3% not meeting the minimum) suggests that an increase to 72.7% (rounded to 70%) by 2030 should be achievable (Table 37).

Table 37. Children consuming minimum meal frequency – global baseline, 2015-2021, and proposed global target for 2030

Children consuming minimum meal frequency	Prevalence (%)
Global baseline (2015-2021)	49.7
Global target (2030)	70.0

Based on both progress of exemplars and current 80th percentile	
Limitations: Data are collected using a simple question about the number meals and snacks (also including milk feeds for non-breastfed children) consumed on the previous day. The definition of what counts as a meal or snack may not be clearly understood by the respondent.	

Source: UNICEF *(21).*

3.6.2 Option 2: Percentage of severely wasted children that have been treated

Addressing wasting is of critical importance because children with wasting are at increased risk of disease and death. Wasted children need timely and appropriate life-saving treatment to prevent mortality and re-establish normal growth. WHO guidelines on the management of wasting and nutritional oedema spell out key steps in treating children with either severe acute malnutrition (SAM) or moderate acute malnutrition (MAM) *(47).* Appropriate treatment of severe wasting will shorten its duration and reduce relapse, thus helping to drive down the prevalence.

3.6.2.1 Latest coverage levels

The UNICEF Nutridash survey collects country-level data on the number of severely wasted children who were admitted for treatment services (inpatient and outpatient) *(48)*. Dividing this by the number of severely wasted children generates a measure of the percent of severely wasted children who were treated. The number of severely wasted children can be estimated by multiplying the prevalence estimates in the WHO-UNICEF-World Bank Joint Malnutrition Estimates *(13)* by 2.6 as a standard factor to convert prevalence to incidence *(49).* Estimates of coverage are thus available for 64 countries representing 45% of the global population.

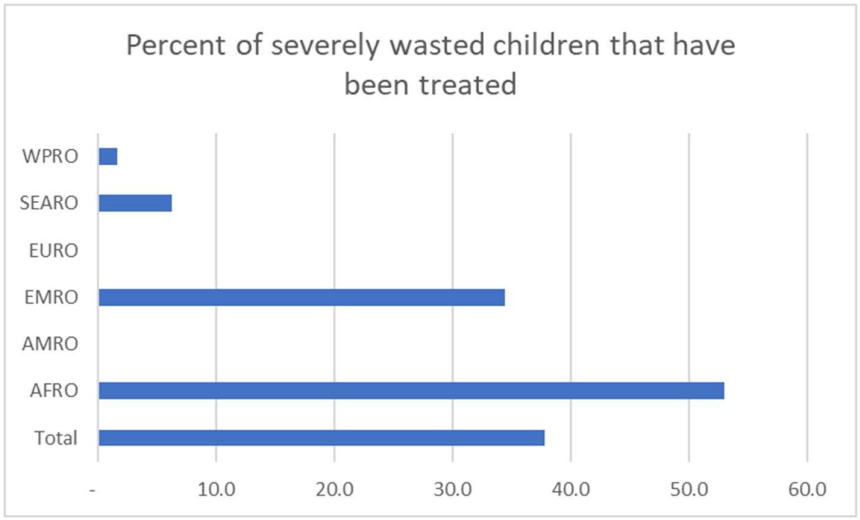
Based on a weighted average of data collected in 2021, 37.8% of severely wasted children were treated (Table 38). The prevalence is the highest in the African and the Eastern Mediterranean regions (Fig. 23). Data availability is insufficient in Europe and the Americas. Trend data are not available. The 80th percentile across countries is 72.7%.

Table 38. Percentage (%) of severely wasted children that have been treated – global average and highest quintile of country coverage, 2022.

Severely wasted children that have been treated	Coverage (%)
Global average (2022)	37.8
Highest quintile of country coverage (top 20%)	72.7

Source: Calculated using data from UNICEF *(48)* and UNICEF, WHO and the World Bank *(13)*.

Fig. 23. Percentage (%) of severely wasted children that have been treated – average in WHO regions and globally, 2022.



Source: Calculated using data from UNICEF *(48)* and UNICEF, WHO and the World Bank *(13)* .

3.6.2.2 Proposed 2030 Target: 70%

A new target for 2030 is proposed, based on the 80th percentile across countries of 72.7% (rounded to 70%) (Table 39).

Table 39. Percentage (%) of severely wasted children that have been treated – global baseline, 2022, and proposed target for 2030.

Children consuming minimum meal frequency	Coverage (%)
Global baseline (2022)	37.8
Global target (2030) Based on current 80th percentile	70.0
Limitations: The definition of treatment services as well as sources of data for this indicator vary by country and thus may not be comparable across countries. The number of wasted children is based on prevalence at a point in time during the year rather than the number of cases wasting occurring during the year. As a result, the number of children affected is likely to be underestimated. Although the greatest number of wasted children are moderately wasted, the prevention and management of moderate wasting is not reflected in this indicator.	

Source: Calculated using data from UNICEF *(48)* and UNICEF, WHO and the World Bank *(13)* .

3.7 Summary of proposed process indicators and targets

The potential process indicators, data sources and current levels of prevalence/coverage, as well as the proposed 2030 target for each indicator, are summarized in Table 40.

Table 40. Summary of the potential process indicators and proposed 2030 targets to drive progress towards the global nutrition targets

WHA global nutrition target	Potential process indicator	Data source	Number of countries with data	Current coverage/ prevalence	Best performing quintile of current prevalence/ coverage	Projected prevalence based on best performing quintile of past progress	Proposed 2030 Target
Stunting among children under 5	Percent of children aged 6 to 23 months consuming minimum dietary diversity	UNICEF IYCF database	107	30.5%	58.2%	38.8%	40%
Anaemia in women of reproductive age	Percent of women consuming any iron-containing supplements during pregnancy	DHS	65	73.8%	89.3%	86.6%	90%
	Percent of women consuming at least 90 iron-containing supplements during pregnancy	DHS	65	36.4%	55.0%	54.0%	55%
	Percent of wheat or maize flour that is fortified with iron	Global Fortification Data Exchange	72	43.5%	100%	n/a	75%
Low birthweight	Percent of pregnant women attending at least four antenatal care visits	WHO Global Health Observatory	112	65.2%	94.3%	76.0%	80%
	Percent of women consuming minimum dietary diversity	Global Diet Quality Project	56	65.8%	86.0%	n/a	85%
Overweight in children	Percent of adults consuming sugar-sweetened beverages on the previous day	Global Diet Quality Project	56	61.5%	57.0%	n/a	55%
	Percent of population consuming no more than 10% of calories from free sugars	FAO/WHO GIFT repository	8	n/a	n/a	n/a	n/a
Exclusive breastfeeding	Percent of caregivers counselled on infant and young child feeding	UNICEF Nutridash survey	66	39.3%	65.1%	n/a	65%
	Percent of newborns being put to the breast in the first hour after birth	UNICEF IYCF database	133	45.8%	69.4%	57.5%	60%
Wasting in children	Percent of children consuming minimum meal frequency	UNICEF IYCF database	106	49.7%	68.1%	72.7%	70%
	Percent of severely wasted children that have been treated	UNICEF Nutridash survey	64	37.8%	72.7%	n/a	70%

4. Conclusion

The UN is set to start discussions on the post-2030 agenda and this five-year period of 2025-2030 is the perfect opportunity to consult Member States, fellow international organizations, and global initiatives on setting the global nutrition priorities for this new agenda. This new global nutrition agenda will not only be focused on monitoring progress towards the targets but will empower Member States with the guidance on identifying bottlenecks to understand what context-specific actions are needed to drive change. The lessons learned from the global nutrition targets on maternal, infant, and young child nutrition and the Global Nutrition Monitoring Framework will contribute to these discussions.

A new global nutrition agenda will serve as a beacon, putting the spotlight on emerging priorities such as the diet quality and the larger food system. This new global nutrition agenda moving forward beyond 2030 will be developed alongside the UN's post-2030 agenda ensuring that all targets and milestones are aligned, and that the global community is focused on one consistent set of priorities. Member States will be invited to register their commitment towards this future global agenda through a World Health Assembly Resolution and this plan will be further enshrined in the UN's post-2030 agenda.

5. References

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