Global nutrition targets 2030

Stunting brief

Target: By 2030, achieve a **40% reduction** in the number of children under five years of age who are **stunted**, compared to the 2012 baseline.

Based on current trends, it is estimated that child stunting was reduced globally from 26.4% in 2012 to 23.2% in 2024 *(1)*. This is far short of the original 2025 target to achieve a 40 % reduction. During the 78th World Health Assembly, the World Health Organization's (WHO) Member States passed a resolution to extend the target for five more years to 2030, during which time actors can intensify attention to, investment in, and actions for reducing the prevalence of child stunting *(2)*. The purpose of this brief is to raise awareness of the impact of child stunting and highlight the interventions and policies needed to achieve the extended target by 2030.

Stunting hinders development

Childhood stunting, defined in Box 1, is one of the most significant impediments to physical and cognitive development. A child who is stunted is up to four times more likely to die than non-stunted children. Those who survive may have poor cognition and reduced educational performance: a study from 2021 found a 5.2 times chance of lower average IQ compared to children who are not stunted *(3)*. Adults who were stunted may have lower productivity and less earning power: GDP loss due to undernutrition is up to 12% annually in low- and middle-income countries *(4)*. If stunting is followed by excessive weight gain later in childhood, there is an increased risk of nutrition-related chronic diseases as an adult *(5, 6)*.

Maternal stunting is consistently associated with an increased risk of perinatal deaths *(6)*.

According to the latest World Bank investment framework, scaling up nutrition interventions is estimated to generate US$ 2.4 trillion in economic benefits (based on 2023 USD currency over a ten year period from 2025-2034). Every dollar invested in reducing undernutrition will generate US$ 23 in economic returns *(7)*. These economic benefits far outweigh the costs of inaction, which run at around US$ 21 trillion in economic productivity losses because of undernutrition over a ten-year period (2025-2034) *(4)*. Thus, it is clearly a good investment in the longer term for governments and partners to accelerate actions to prevent stunting.

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Underscoring the significance of this issue, the prevalence of childhood stunting is a core indicator of progress towards the Sustainable Development Goal (SDG) target 2.2, end malnutrition in all its forms *(8)*.

Stunting has many causes

Numerous factors can lead to stunting. These include inadequate infant and young child feeding, chronic infections and inflammation during childhood, and poor nutritional status during pregnancy *(9)*. The underlying causes are complex, spanning limited access to health services; poor dietary diversity; chronic food insecurity; poor water, sanitation, and hygiene (WASH); prolonged poverty; urban-rural variations; and gender inequalities *(9)*.

Inadequate infant and young child feeding consists mainly of a lack of breastfeeding – especially a lack of exclusive breastfeeding during the first six months of life – and complementary feeding that is limited in quantity, quality and variety. Chronic infections can bring about reduced appetite, malabsorption of nutrients, a reduced ability of the gut to function as a barrier against disease-causing organisms, and increased nutrient demands *(10)*. Systemic inflammation and clinically nonapparent infections are associated with reduced concentrations of insulin-like growth factor 1 (IGF-1), the most important hormonal promoter of linear growth in infants and young children *(11)*.

Factors related to the mother include insufficient nutrition during pregnancy, maternal short stature, closely spaced births, and adolescent pregnancies. Intrauterine growth restriction due to maternal undernutrition alone accounts for 20% of childhood stunting *(12)*.

The 2025 target has not been met

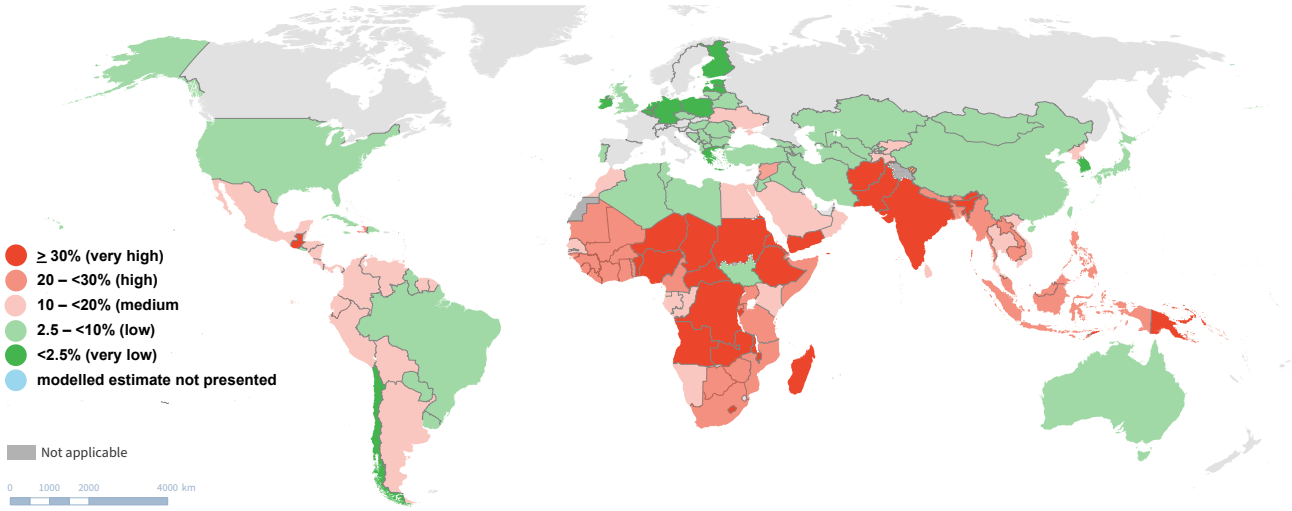
The number of stunted children under 5 years of age dropped from 177.9 million in 2012 to 150.2 million in 2024 *(1)*. The majority of these children are in low- and middle-income countries (See Fig. 1), with Asia having 51% of the global share and Africa 43% *(1)*.

Although the global prevalence of stunting has declined, this decline is not fast enough to reach the 2025 target of 40% reduction. Alarmingly, recent data show a worrying halt in progress and a potential reversal in the trend among low and middle income countries who have previously seen significant progress. The number of stunted children in the African region is moving in the wrong direction (from 61,7 million in 2012 to 64.8 million in 2024) *(1)*. Despite the lack of global progress to reach the goal, a number of countries have managed to reduce their prevalence. Nepal (see Box 2) and Peru (see Box 3) have achieved significant prevalence reductions through concrete policy actions.

Box 1. World Health Organization definition of stunting in children under 5 years of age

Stunting, or being too short for one's age, is defined as a height/length-for-age that is below -2 standard deviations of the WHO child growth standards median *(13)*.

Fig. 1. Stunting prevalence among children under 5 years of age per country in 2024



The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Source: adapted from (1, 14).

Box 2. Nepal is leading the way in tackling stunting

In 2012, close to half (39.7%) of the children under five years of age in Nepal were stunted. Recognizing this as a major political and health concern, Nepal reduced the prevalence of stunting to 26% by 2024 *(1)* through concerted efforts and investments by the government.

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Nepal has long been a champion in addressing undernutrition. In 1995, it recorded the highest stunting prevalence in the world (68%) *(15)*. Since then, Nepal has managed to be among the leading countries globally in building governmental efforts to tackle undernutrition. It did this by improving the economic situation and making significant increases in healthcare spending. This in turn led to the construction of health facilities, the development of a nationwide community health worker cadre, and training of health workers. In addition, Nepal has implemented multisectoral interventions that have led to the increased education of mothers and fathers, better maternal nutrition, increased access to antenatal, maternal and newborn care, a greater proportion of households with access to toilets, and higher household income, driven largely by remittances and national pro-poor policies and investments. All this was made possible by the development of the Multisector Nutrition Overarching National Plan, a collaboration among five ministries (Health, Agriculture, Education, Urban Development, Federal Affairs and Local Development) *(15).* To further continue the political commitments, Nepal has recently developed an evidence-based, gender-responsive, resilient and inclusive multisectoral nutrition plan (MSNP III) 2023-2030 targeted at federal, provincial and local government (753 municipalities).

What has happened since 2012

Since the launch of the *Comprehensive implementation plan on maternal, infant and young child nutrition (16)*, global efforts to reduce stunting have been instrumental in shaping strategies and mobilizing resources.

- **The Scaling Up Nutrition Movement (SUN)** *(17)*. This collaborative movement of civil society, donors, UN agencies, businesses and researchers aims to support country-led, multisectoral strategies to address all forms of malnutrition, including stunting.
- **Nutrition for Growth (N4G)** *(18)*. National governments stepped up to mobilize nutrition commitments at the N4G summits, held against the backdrop of the Olympic games. The first N4G summit, conducted in 2012 in London, resulted in the joint Global Nutrition for Growth Compact, signed by world leaders, which pledged to prevent at least 20 million children from being stunted. That Summit mobilized more than US$ 4 billion in new funding for nutrition-specific projects and US$ 19 billion for nutrition-sensitive projects, largely directed at preventing stunting. Additional funds were mobilized at subsequent summits held in Milan in 2017 (US$ 3.4 billion) and Tokyo in 2021 (US$ 27 billion). The 2025 N4G summit was organized by France and held in Paris. It advocated for ambitious financial and political commitments, and fostered dialogue among diverse actors from around the world. The summit gathered over 400 commitments and mobilized US$ 28 billion in nutrition funding.
- **The Global Complementary Feeding Collective** *(19)*. Formed in 2024 and led by UNICEF and WHO, the Collective calls on governments, policymakers and civil society to take concrete, coordinated and synergistic actions to accelerate access to nutritious, safe and diverse diets during the complementary feeding period. It provides tools, resources and support for advocates of complementary feeding; it helps policy makers and nongovernmental organizations implement solutions; and it harnesses the possibilities for coordinated action to create measurable, sustainable improvements in the diets of young children.

Box 3. Over 12 years, Peru has managed to halve the stunting prevalence for children under five

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In the space of twelve years (2012-2024), Peru managed to reduce the prevalence of stunting in children under five years of age from 18.1% to 10.6% *(1).* This progress was made possible by investments targeting disadvantaged groups. The key investments and policies were i) building political support to fight stunting; ii) improving the health system infrastructure and creating demand for maternal and child health services; and iii) developing an evidence-based strategy for nutrition-related interventions.

Political support included effective advocacy by civil society, implementing interventions to reduce stunting that targeted the poorest, financing, monitoring, and multilateral collaboration. It also involved providing incentives to individuals to seek care (for example, free health care for poor children and pregnant women, and conditional cash transfers) and to state and local governments to deliver care according to national government policy. The Government of Peru invested in its health infrastructure and adopted data-driven budgeting and accountability mechanisms to improve the quality of health and nutrition services and outreach. Peru revisited its health and nutrition spending and reprioritized its resources according to scientific evidence, including making cuts to feeding programmes for older children and putting a greater and more holistic focus on the first 1000 days *(20)*.

Through Supreme Decree 002-2024-SA, the Executive Branch approved the Multisectoral Plan for the Prevention and Reduction of Maternal and Child Anemia in Peru for the period 2024-2030, aiming to reduce the prevalence of anemia to 37.2% in children, with an emphasis on children under 36 months of age and pregnant women.

Actions to drive progress by 2030

The complexity of what causes and underlies stunting means that no single intervention can eliminate the condition. Furthermore, the combination of interventions required to make noteworthy progress differs in every country. The simultaneous delivery of two or more interventions has a greater impact on stunting than any one intervention alone *(21).* This calls for strong coordination across key sectors, including health, WASH, agriculture, social protection, education, and gender equality.

Stunting is linked with other global nutrition targets and can be substantially reduced with an intervention package delivered during preconception, pregnancy, and early childhood *(22).* Interventions include improving the nutrition of adolescent girls, ensuring that pregnant and lactating women are adequately nourished, that infants are exclusively breastfed during the first six months of life and that children aged 6–23 months consume adequate complementary foods in addition to breastmilk.

Stronger food systems, including food fortification and biofortification, will increase the accessibility and affordability of sustainable, healthy and nutritious diets. Food assistance programmes can be designed to meet the specific nutritional needs of adolescents, pregnant and breastfeeding women, and young children. Along the same lines, nutrition and social protection policies, strategies and programmes can be reviewed to ensure that they address the needs of vulnerable adolescent girls and women. School feeding programmes that reach adolescent girls will serve as a platform/ entry point for instilling healthy behaviours.

Policies and interventions are needed to protect, promote and support exclusive breastfeeding for the first six months of life and continued breastfeeding up to two years of age. Labour policies, including maternity protection, as well as laws curtailing the marketing of breast-milk substitutes, can improve the health of the mother and her children.

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Children aged 6-23 months need the opportunity to consume healthy, safe and diversified diets, including high-quality, nutrient-rich foods *(23).* The Global Complementary Feeding Collective calls for governments to enact seven priority actions to improve complementary feeding *(19)*:

1. Establish national complementary feeding guidelines promoting the use of nutritious foods and ensure they are aligned with global standards and address local drivers of poor diets.
2. Stimulate the production of and access to nutritious foods that can be included in young children's diets, including locally-produced foods, particularly for vulnerable children and in fragile and food-insecure contexts.
3. Deliver quality counselling and nutrition services, investing in community health and nutrition workers, particularly in underserved areas.
4. Provide appropriate food supplements, home fortificants and micronutrients for vulnerable children through national programmes, especially in food-insecure and humanitarian contexts.
5. Set and enforce standards for the safety, quality and labelling of all commercially-produced complementary foods.
6. Implement and enforce WHO guidance on ending the inappropriate marketing and promotion of foods for young children.
7. Leverage the social protection system to make appropriate complementary foods accessible for vulnerable families, including in fragile contexts.
8. Enhance accountability through robust data systems that collect, analyse and monitor progress on complementary feeding.

Safe water supply systems in rural and urban communities, as well as latrines and toilets, are needed to discourage open defecation and reduce the transmission of diarrhoeal diseases.

The interventions listed in this brief were gathered through a comprehensive review of guidelines and recommendations from WHO and UNICEF, including consultations from the respective regional offices (see annex). This process involved reviewing official publications, policy frameworks, and expert recommendations to ensure alignment with global best practices and region-specific considerations. The priority interventions are presented in Box 4.

Box 4. Priority interventions

1. **Provide nutrition counselling and supplementation for pregnant women**
   - Distribute nutritional supplements, such as balanced energy and protein supplements, to women living in food-insecure contexts.
   - Provide cash transfers or food vouchers to pregnant women in food insecure households to improve dietary intake during pregnancy and lactation.
2. **Ensure access to healthy, diversified diets, including high-quality, nutrient-rich foods during the period of complementary feeding (6–23 months of age)**
   - Invest in agriculture and food policies and innovations designed to improve household food security, food diversity and food safety.
   - Provide food assistance programmes, food vouchers, or targeted food distribution to vulnerable families.
   - Counsel all caregivers of young children on appropriate breastfeeding and complementary feeding practices.
3. **Scale up supplementation and food fortification programmes**
   - Deliver Vitamin A supplements to children aged 6-59 months.
   - Provide zinc supplements during and after diarrhoeal episodes in children.
   - Implement targeted or blanket fortification of staple foods with vitamins and minerals based on the country data on prevalence of deficiencies.
4. **Strengthen community-based interventions, including improved water, sanitation and hygiene, to protect children from diarrhoeal diseases, malaria, intestinal worms and environmental causes of subclinical infection**
   - Install and maintain safe water supply systems in rural and urban communities.
   - Build and promote the use of latrines and toilets to reduce open defecation.
   - Establish effective vector control measures for malaria (e.g. indoor residual spraying, insecticide-treated nets).
5. **Ensure universal access to primary health care services**
   - Build the capacity of healthcare workers to provide Integrated management of childhood illness (IMCI), including oral rehydration therapy for diarrhoea, antibiotics for pneumonia, malaria treatment, immunization, and nutrition services.

Growth monitoring, as a component of routine child health visits and community nutrition programmes, will capture deficits early for both child growth and development outcomes. The data from monitoring, in conjunction with representative survey data, can help district and provincial officials to evaluate programme effectiveness over time. In addition to growth status, it is important to collect data on key behaviours that contribute to poor growth and development, particularly concerning what young children eat. Minimum dietary diversity in children is a basic marker of healthy and nutritious diets and should be assessed regularly. Data on the coverage of policies and programmes to prevent undernutrition can serve to identify gaps and assess programme needs. Counselling on infant and young child feeding, and measuring minimum diet diversity have been recommended by the World Health Assembly as fundamental operational targets for routine assessment and improvement over time (Box 5).

Box 5. Operational 2030 targets for stunting prevention

- **Increase the proportion of children aged 6 to 23 months who consume minimum dietary diversity by 20%* (from the 2016-2024 average baseline of 34.3%) *(2, 24)*.** WHO recommends that children 6-23 months of age consume a diverse diet, including meat, poultry, fish, eggs, dairy, fruits and vegetables. Inadequate food intake is one of the main causes of stunting in children.
- **Increase the proportion of caregivers who are counselled on infant and young child feeding by 65%** (from the 2022 baseline of 39.3%[a]) *(2, 24)*.** WHO recommends that counselling on infant and young child feeding be provided to all pregnant women and mothers with young children. This counselling aims to shape behaviours on breastfeeding and complementary feeding, which can prevent wasting, stunting and overweight.

* Based on projected coverage at the best performing quintile of past progress
** Based on best performing quintile of coverage
[a] Not a global estimate (i.e. population coverage is below 50%)

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Annex: Development of this brief

The methodology for developing this brief involved an initial literature review to gather selected previously published WHO guidelines and WHO and UNICEF recommendations, technical documents, and training modules. Such documents were selected from the WHO and UNICEF websites based on their applicability, importance and impact to stunting. Key references include: Comprehensive implementation plan on maternal, infant and young child nutrition *(1)*; 2025-2030 World Health Assembly global maternal, infant and young child nutrition targets and proposal for process indicators. Results of the online consultation and way forward *(2);* Essential nutrition actions: mainstreaming nutrition through the life-course *(3);* The UNICEF Nutrition Strategy 2020–2030: Nutrition, for Every Child *(4)*; Global nutrition targets 2025: stunting policy brief *(5)*; WHO Guideline for complementary feeding of infants and young children 6–23 months of age *(6)*; Global action plan on child wasting: a framework for action to accelerate progress in preventing and managing child wasting and the achievement of the Sustainable Development Goals *(7);* and WHO guideline on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under 5 years *(8).*

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We used the WHO Global Nutrition Target tracking database to identify countries that had made the most progress on stunting. We then reached out to these countries through the respective country offices to understand what policy and programme actions had been undertaken that contributed to country success. The selection of the country examples was then based on clarity of the lessons learned from the country, as well as the need to maintain geographic balance across all of the Global Nutrition Target briefs. Final reviews and inputs were made by the relevant regional and country offices.

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