

# PROGRESS ON SELECTED WORLD HEALTH ASSEMBLY NUTRITION TARGETS IN 12 COUNTRIES



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## **SUMMARY**

Stunting and overweight in children under five years of age remain major malnutrition challenges in the 12 countries in Africa and Asia where GAIN operates: Bangladesh, Benin, Ethiopia, India, Indonesia, Kenya, Mozambique, Nigeria, Pakistan, Rwanda, Tanzania, and Uganda. These forms of malnutrition appear in two of the six Global Nutrition Targets of the World Health Assembly (WHA), which are meant to be achieved by 2025. This paper evaluates progress towards these two WHA goals in these 12 countries, identifies lessons learned, and offers actionable insights for evidence-based policymaking.

While some countries have successfully reduced stunting and overweight, overall progress, particularly on stunting, remains slow. Using globally accepted methodologies, we find that of the 12 countries studied only Kenya is on track to meet the WHA stunting target by 2025, while the other 11 countries are classified as off track, having made some progress. For child overweight, nine countries, namely Ethiopia, Indonesia, Kenya, Mozambique, Nigeria, Pakistan, Rwanda, Tanzania, and Uganda are on track, while the remaining three are off track.

Through deep dives into selected cases, this paper emphasises the need for multi-sectoral approaches, strong political commitment, and targeted interventions. A shift towards integrated, data-driven, and context-specific solutions is crucial.

Accelerated, evidence-based action must be taken. This includes highlighting where efforts need to concentrate, guiding policy and programme adjustments, and enabling more targeted interventions to help countries achieve and surpass the reductions in child stunting and the limitations on the rates of child overweight embodied in the WHA 2025 nutrition targets.

### **KEY MESSAGES**

- Stunting and overweight among children under five are two of the six Global Nutrition Targets set by the World Health Assembly (WHA) for achievement by 2025.
- Approaching the end of the 2025 WHA target year, this paper highlights the progress made between 2012-2022 in both nutrition outcomes in 12 focus countries.
- Of the 12 countries analysed, only one (Kenya) is currently on track to meet the stunting reduction target by 2025. In contrast, progress on reducing child overweight is more promising, with nine out of the 12 countries on track to achieve this target by 2025.
- Deep dives into likely drivers of progress highlight the need for multi-sectoral approaches, strong political commitment, and targeted interventions. A shift towards integrated, data-driven, and context-specific solutions is crucial.

## BACKGROUND AND OBJECTIVE

Malnutrition remains a global challenge, significantly affecting children under five years of age. In 2012, the World Health Organization (WHO) Member States at the 65th World Health Assembly (WHA) endorsed Resolution 65.6, a Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition (1,2). The WHA identified six global nutrition targets to be achieved by 2025. These global nutrition targets were based on, among other criteria, epidemiological evidence, technical and operational feasibility, surveillance and implementation capacity, and coherence with global policy frameworks (3). The targets aimed to motivate countries to focus on priority nutrition challenges during the 13-year period starting in 2012 and to set themselves realistic national goals. Table 1 summarises the Global Nutrition Targets for 2025.

**Table 1. WHA Global Nutrition Targets 2025 (3)**

| WHA Global Nutrition Target                                           | Target Year 2025                                                                        |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <b>1. Stunting in children under five years of age</b>                | 40% reduction in the number of children under-five who are stunted                      |
| <b>2. Anaemia in women of reproductive age</b>                        | 50% reduction of anaemia in women of reproductive age                                   |
| <b>3. Low birthweight</b>                                             | 30% reduction in low birthweight                                                        |
| <b>4. Overweight in children under five years of age</b>              | No increase in childhood overweight                                                     |
| <b>5. Exclusive breastfeeding during the first six months of life</b> | Increase the rate of exclusive breastfeeding in the first six months up to at least 50% |
| <b>6. Wasting in children under five years of age</b>                 | Reduce and maintain childhood wasting to less than 5%                                   |

In 2015, the United Nations General Assembly reaffirmed its commitment to sustainable development by endorsing the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals (SDGs). Goal 2, 'Zero Hunger,' includes Target 2.2 with Indicators 2.2.1 (stunting), 2.2.2 (childhood wasting / overweight), and 2.2.3 (anaemia among women of reproductive age), thus encompassing four of the six 2025 Global Nutrition Targets.

Stunting, or being too short for one's age, is defined as a height-for-age that is more than two standard deviations below the WHO child growth standards median. Linear growth in early childhood is a strong marker of healthy growth given its association with morbidity and mortality risk, non-communicable diseases in later life, and learning capacity and productivity (4). While there has been significant progress made towards stunting reduction, the global WHA target will not be achieved by 2025. In 2012, the baseline global stunting burden was 177.9 million children, making the 2025 target 106.7 million children (40% reduction). The latest estimates from 2022 suggest a reduction of only 16.7% achieved, with global stunting burden reducing to 148.1 million (5). The current rate of reduction is far from adequate to achieve the target of 40% reduction in absolute burden of under-five child stunting.

Child overweight is defined as weight-for-height greater than two standard deviations above the WHO child growth standards median. Childhood obesity also increases the risk

of obesity, non-communicable diseases, premature death, and disability in adulthood (6). For the WHA child overweight goal, the target is likely to be achieved at a global level. With a 2012 child overweight prevalence of 5.5%, the current (2022) prevalence stands at 5.6%, putting the world on-track to achieve the global nutrition target on child overweight (5). However, significant variations exist across regions and countries in terms of their performance on this target. Table 2 below provides the definitions of key terms used in this paper.

**Table 2. Definition of Key Terms**

| Key Term                                            | Definition                                                                                                                                                                                      |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Baseline Year                                       | The baseline reference year for the WHA Global Nutrition Targets is 2012.                                                                                                                       |
| Current Average Annual Rate of Reduction (AARR)     | Average relative percent decrease per year in prevalence or rate from 2012 to 2022. A positive sign indicates reduction or downward trend; a negative sign indicates increase, or upward trend. |
| Under-five Population Percentage Change (2012-2022) | The under-five population percentage change (2012-2022) is the percentage increase or decrease in population over a 10-year period, providing an overview of population growth.                 |
| Required Average Annual Rate of Reduction (AARR)    | Average relative percent decrease per year in prevalence or rate from 2012 to 2025 that is required to achieve the global target by 2025.                                                       |
| Target Year                                         | The target year for the WHA Global Nutrition Targets is 2025.                                                                                                                                   |

All forms of malnutrition share common drivers that can be leveraged for double impact. These drivers include early life nutrition, dietary diversity, food environments, and socioeconomic factors (7). Enabling access to healthy diets for all is key to address malnutrition in all its forms and to achieve the SDG nutrition targets. However, healthy diets remain elusive in most world populations, and for an estimated 2.8 billion, they are unaffordable (8).

The Global Alliance for Improved Nutrition (GAIN) operates in 12 countries across Africa and Asia (Bangladesh, Benin, Ethiopia, India, Indonesia, Kenya, Mozambique, Nigeria, Pakistan, Rwanda, Tanzania, and Uganda) (9). Child stunting and child overweight remain major malnutrition challenges of political interest in several countries in which GAIN operates. Despite ongoing efforts, progress made on child stunting and child overweight varies across these countries, with critical gaps in understanding the trends, underlying factors, and policy responses. To support the global nutrition agenda, GAIN is committed to deepening this understanding across its 12 focus countries.

This paper provides an analysis of child stunting and overweight trends among children under five across 12 countries where GAIN operates. It evaluates progress toward WHA goals, identifies lessons learned, and offers actionable insights for evidence-based policies.

By examining these trends and their underlying factors, the paper also discusses future policy implications, aiming to inform GAIN's work and contribute to the broader dialogue on ending child malnutrition.

## **METHODOLOGY**

The methodology broadly consists of two phases. Initially, publicly available data pertaining to child stunting and child overweight for children under-five over a period of two decades were mapped across the 12 countries from nationally representative population-based household surveys and model-based estimates available through Joint Malnutrition Estimates (JME). This was followed by data analysis to assess the progress of these 12 countries towards achieving Global Nutrition Targets 2025 over the last decade (2012-2022) (10). As a second step, a literature review was conducted for eight countries: Bangladesh, India, Indonesia, Kenya, Nigeria, Pakistan, Rwanda, and Uganda to further identify the potential factors contributing to the progress made on stunting in six countries and overweight in four countries.

### **Phase 1: Data Mapping and Analysis**

#### ***Prevalence of Child Stunting and Child Overweight***

Stunting and overweight prevalence among children below five years was mapped using freely available data for the 12 countries. As per the monitoring rules for the WHA nutrition targets, model-based estimates are to be used for assessing progress on child stunting and overweight (11). Accordingly, this working paper used the JME model-based estimates<sup>1</sup> to analyse the progress of the 12 country cases in relation to the targets of child stunting and overweight, since it is an external facing document intended to inform the WHA 2025.

The data sources included model-based estimates provided by JME and other nationally representative household surveys including Demographic and Health Surveys (DHS) (12), Multiple Indicator Cluster Surveys (MICS), and other country-specific surveys. JME estimates on both stunting and overweight were used to assess country progress towards attainment of Global Nutrition Targets on stunting and overweight. Survey estimates on stunting and overweight from the latest available DHS were used for data mapping and further disaggregated analysis by sex and residence in these 12 countries (Annex 1).

In cases of surveys conducted over multiple years, the median year was established considering, whenever available, the months when the surveys were carried out. If information on months was unavailable, and surveys were conducted over two or more years, the median year was the statistical mean when odd or the nearest year above the mean, when even. The mapped data were also verified for completeness, accuracy, and consistency; data preparation steps are documented to support reproducibility. Completeness was ensured by looking into all available data points for each of the indicators studied. To ensure accuracy, data were cross-checked and validated against

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<sup>1</sup> JME group used uniform methodology to derive the model-based estimates; the prevalence estimates are standardised considering the data quality and are comparable over time and across these countries.

original sources, while consistency was maintained by adhering to standardised formats and classification available across all the datasets. Table 3 below provides the data preparation steps followed.

**Table 3. Data preparation steps**

| Steps                                     | Activity                                                                                                                                                                                                   |
|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Data Source Documentation                 | All datasets (JME estimates, DHS, MICS, WPP) were sourced from freely available platforms. URLs, publication years, and access dates were recorded for transparency and traceability.                      |
| Version Control                           | The version of each dataset (e.g., JME 2023 release, WPP 2024) was explicitly documented to ensure consistency in replication.                                                                             |
| Data Extraction Protocol                  | A standardised protocol was followed for extracting prevalence estimates both for stunting and overweight, population estimates, and disaggregation variables (e.g., sex, residence).                      |
| Data analysis                             | All cleaning steps (e.g., renaming variables, assigning value labels, recoding missing values and analysis) were performed using STATA 15. The syntaxes were stored with explanations for reproducibility. |
| Date Handling and Median Year Calculation | For surveys spanning multiple years, median year estimation rules were clearly applied and coded to ensure consistent year assignment across countries.                                                    |
| Cross-Validation and Quality Checks       | Data were cross-checked with original reports and compared across sources to verify consistency.                                                                                                           |
| Data Transformation Logs                  | A log file of all transformations (e.g., burden calculations and AARR calculation) was maintained, including formulas and intermediary steps used in STATA 15.                                             |

### ***Under-five Population Estimates***

Under-five child population was mapped for these 12 countries over a decade (2012-2022) using the World Population Prospects (WPP) 2024, published by the Department of Economic and Social Affairs, Population Division of the United Nations (13). Similarly, the prevalence data for child stunting and overweight were mapped over a decade (2012-2022) for these 12 countries, with absolute burden of stunting estimated by considering the under-five population available from the WPP 2024.

### ***Descriptive Analysis***

For the overall analysis, absolute burdens of stunting and overweight were estimated for each of the 12 countries, followed by a comparison with the global burden for each indicator. Subsequently, detailed country-level analyses were performed to assess the progress of these 12 countries towards attainment of Global Nutrition Targets on stunting and overweight. The trend analysis also included distributions of these two indicators by UN sub-region corresponding to these countries (14).

For each of the countries, trend graphs were developed to show the progress made from 2005 to 2012, in terms of prevalence (for child stunting and overweight), projected prevalence by 2025 following the current Average Annual Rate of Reduction (AARR) and a comparison to the individual country target for 2025. In addition, scatterplots showing current prevalence and absolute burden of stunting and overweight among the 12 countries were prepared for both 2012 and 2022.

For calculating the current AARR (2012-2022), all data points with longer time series from 2012-2022 were used for stunting and overweight (15). A log-linear regression approach was adopted, where  $AARR = 1 - \exp(\beta)$  (slope) to incorporate all available data points to account for year-to-year variability. Data analysis was conducted using Stata, version 15.

For calculating stunting and overweight targets for 2025, the following approach was followed:

1. The absolute number of stunted children in 2012 (using the model-based estimate from JME for 2012 and considering the under-five population from WPP 2024)
2. For stunting, a 40% reduction as per Global Nutrition Targets 2025 is applied to the baseline absolute stunting burden. For overweight, since the target is no increase in the prevalence of overweight, the target prevalence for 2025 equals the 2012 prevalence.
3. Stunting target prevalence 2025 was calculated by dividing the target number of stunted children for 2025 by the estimated 2025 population of children under 5.

For 2025 under-five population estimates, data were mapped using the projected population available under the medium-term variant from WPP 2024. To calculate stunting/overweight projected prevalence for 2025, the formula:  $Y_{t+n} = Y_t \times (1-b)^n$  was used to project prevalence trends based on the current AARR. This model uses a trend-based extrapolation from recent data and assumes a constant rate of change. It does not account for potential changes in intervention coverage, policy, or external shocks, and should be interpreted as indicative rather than predictive. These projections were used to identify a country's likely progress under current trends. This was also helpful to identify country cases for the deep dives.

### ***Country Indicator Profiles***

Brief country data profiles for stunting and overweight were prepared for each of the 12 countries, collating the information listed in Table 4.

**Table 4. Country Profiles for Child Stunting and Child Overweight**

| Child Stunting                                                                                                                                                                                                                                                                                                                                                                                                                         | Child Overweight                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Baseline prevalence 2012 (%)</li> <li>• Baseline under-five population 2012 ('000)</li> <li>• Baseline stunting burden 2012 ('000)</li> <li>• Current prevalence 2022 (%)</li> <li>• Current under-five population 2022 ('000).</li> <li>• Under-five population percentage change (2012-2022) (%).</li> <li>• Current AARR (2012-2022).</li> <li>• Projected Prevalence 2025 (%).</li> </ul> | <ul style="list-style-type: none"> <li>• Baseline Prevalence 2012 (%)</li> <li>• Current Prevalence 2022 (%)</li> <li>• Current AARR (2012-2022).</li> <li>• Projected Prevalence 2025 (%)</li> <li>• Target Prevalence 2025(%).</li> <li>• Required AARR (2012-25).</li> <li>• Classification of country's progress</li> </ul> |

|                                                                                                                                                                                                                                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>• Target stunting burden 2025 ('000).</li> <li>• Projected under-five population 2025 ('000).</li> <li>• Target Prevalence 2025 (%)</li> <li>• Required AARR (2012-25)</li> <li>• Classification of country's progress</li> </ul> |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

## Phase 2: Literature Review

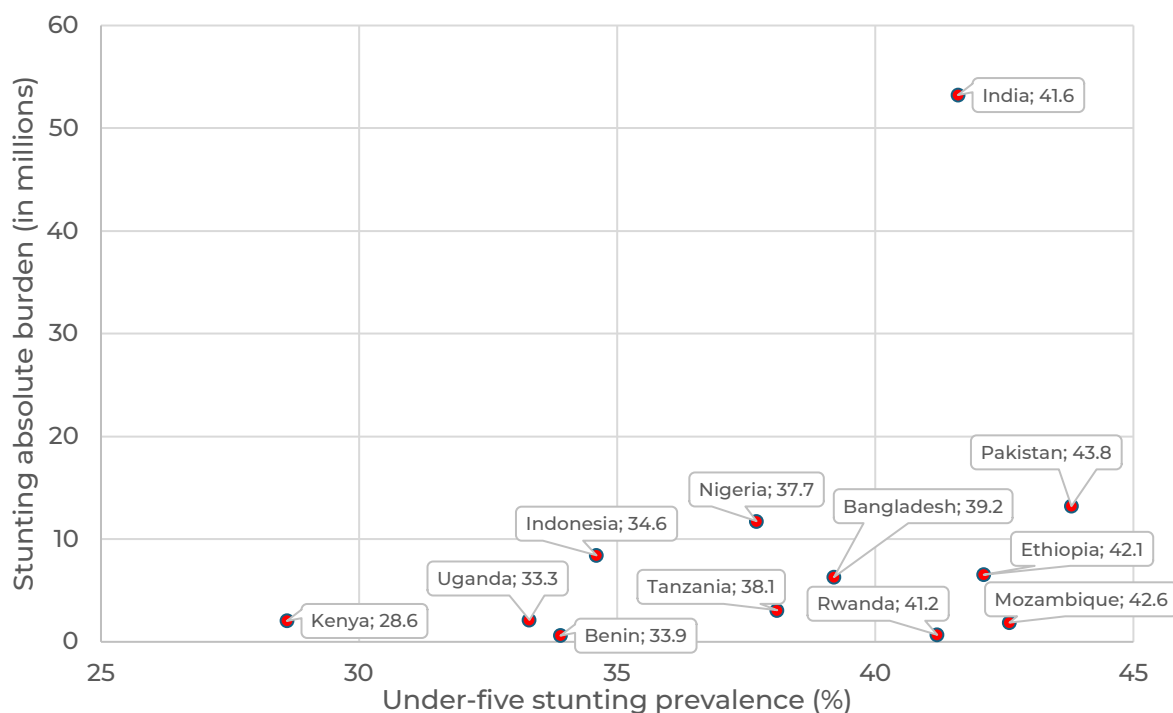
In the second phase, in-depth studies were conducted for eight countries. Stunting was the focus in six countries: Bangladesh, India, Kenya, Nigeria, Rwanda, and Uganda. Overweight was examined in four countries: Indonesia, Nigeria, Pakistan, and Rwanda. Nigeria and Rwanda were included in both focus areas. For child stunting, countries were selected based on exemplary progress in reducing stunting, as well as those where progress has been limited. The selection was also informed by GAIN advocacy requirements relating to political traction to address stunting in each of these 12 countries. For overweight, the country selection was guided by the pace of overweight decline and GAIN's perceptions of advocacy needs related to addressing overweight burdens among children in each of these 12 countries.

For each deep-dive, detailed literature review was conducted, primarily focusing on identifying the potential factors contributing to the malnutrition trends over the last decade and the performance against the WHA targets on stunting and overweight. The literature review complemented the descriptive and trend analysis of child stunting and overweight. Relevant sources were identified using keyword-based searches focused on child malnutrition trends, policies, and interventions across these countries. Inclusion criteria prioritised documents that provided empirical evidence, policy insights, or programmatic evaluations related to under-five stunting and overweight. Publications not available in English or those focused solely on adult populations or unrelated nutrition issues were excluded. Findings from the literature were triangulated with quantitative data and country-level trends to contextualise observed progress. In addition to this, relevant policy materials received through GAIN country policy advisors were also used as source material for parts of the deep dives.

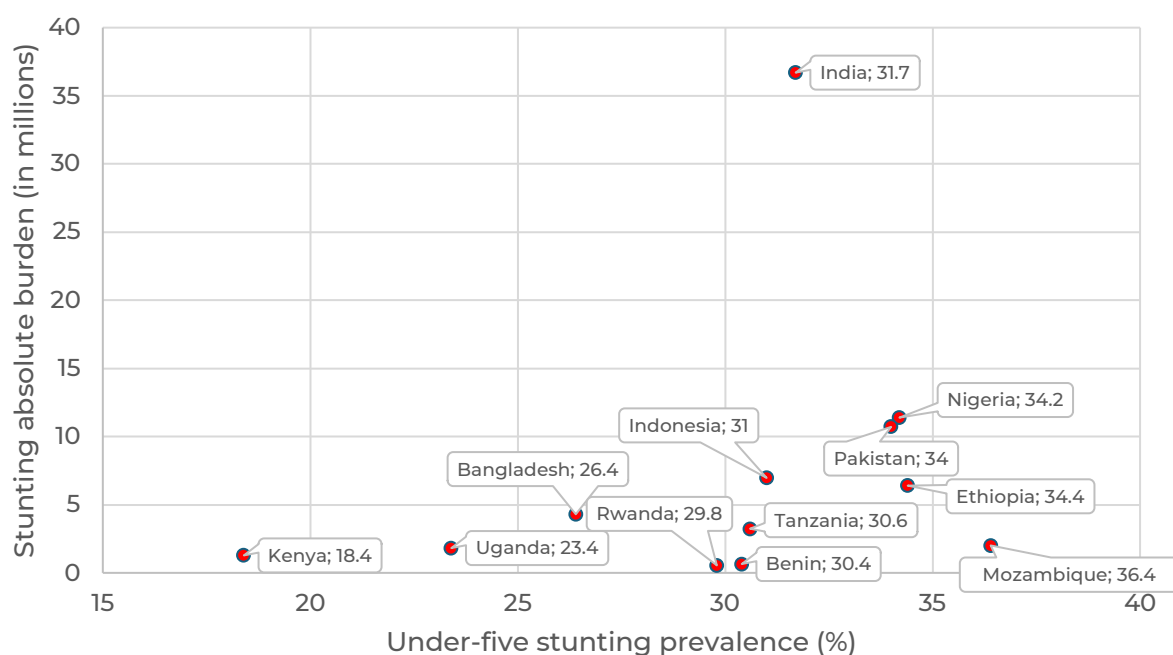
## FINDINGS

### Stunting in children under five years of age

In 2012, when the WHA Global Nutrition Targets were adopted, the prevalence of child stunting in the 12 countries was relatively higher compared to the global prevalence. While these 12 countries were home to almost 40% of under-five children in the world, they accounted for 61% of global burden of stunted children. Based on the child malnutrition prevalence thresholds for stunting severity suggested by WHO, 11 out of 12 countries had very high prevalence ( $\geq 30\%$ ) of stunting and one country had high ( $20\% - <30\%$ ) prevalence of stunting in the year 2012 (16) (Figure 1). In terms of absolute burden of stunted children, India had the highest burden of more than 50 million, while Pakistan and Nigeria both had stunting burdens exceeding ten million.



**Figure 1. Child stunting – prevalence and absolute burden for 12 countries in 2012<sup>2</sup>**

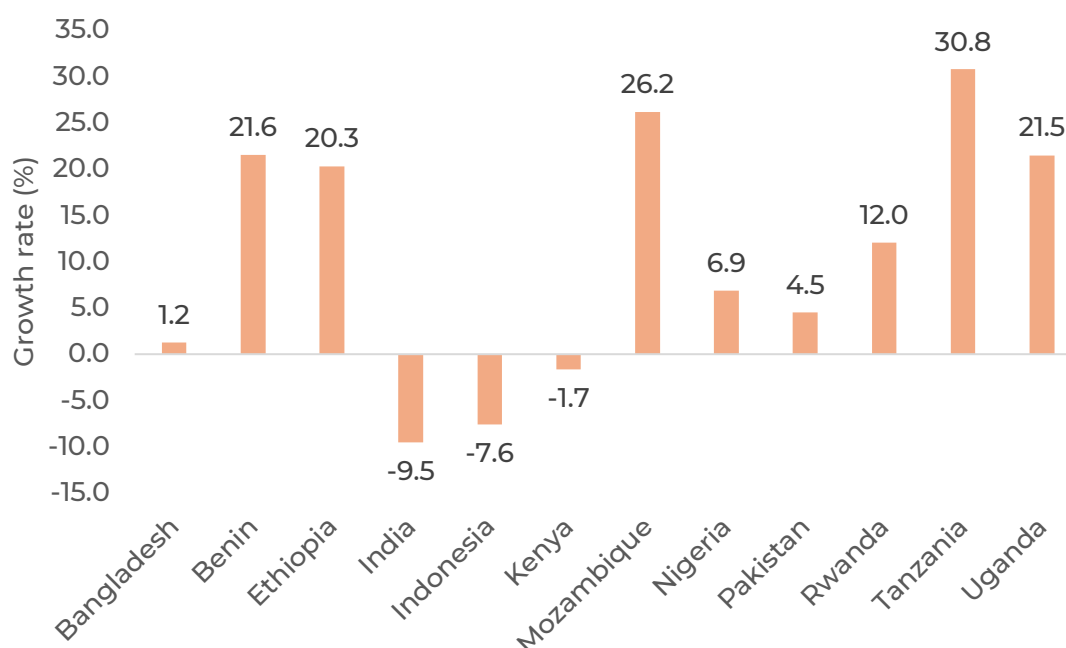


**Figure 2. Child stunting – prevalence and absolute burden for 12 countries in 2022<sup>2</sup>**

<sup>2</sup> In Figures 1 and 2, country names are followed by the stunting prevalence in %.

The latest country-level JME estimates for 2022 show a decline in stunting prevalence across all 12 countries. Despite the progress made, these countries still account for 58% of the global burden of stunted children. Stunting levels remain very high in eight countries, high in three, and medium (10% - <20%) in one (Figure 2). Between 2012 and 2022, the absolute number of stunted children decreased in nine countries but increased in Benin, Mozambique, and Tanzania due to a combination of modest decline in stunting prevalence and high under-five population growth. As in the baseline year, India, Nigeria, and Pakistan continue to bear the highest burden of stunted children among the 12 countries.

To assess a country's progress towards achieving the WHA stunting target, a comparison between required AARR (2012-2025) and the current AARR (2012-2022) serves as a relevant metric. It is worth noting that the child stunting target is the only global target that is compounded by population growth and hence countries undergoing an increase in their under-five populations from 2012 to 2025 need to achieve a relatively higher AARR (2012-2025) to meet the WHA target on child stunting, compared to countries where under-five populations are declining between 2012 and 2025. Figure 3 shows the rate of under-five population growth from 2012 to 2022 in the 12 countries. Nine out of 12 countries have witnessed increases in under-five population between 2012 and 2022, while three countries (India, Indonesia, and Kenya) have seen a decline.



**Figure 3. Under-five Population Percentage Change (2012-2022) in the 12 countries**

Kenya is the only country where the current AARR is more than the required AARR, indicating that the country is on track to achieve the WHA stunting target by 2025 (Table 5). The other 11 countries are classified as 'off track- some progress' as per the

methodology for monitoring progress towards the Global Nutrition Targets for 2025<sup>3</sup> by WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring (11).

For Bangladesh and India, the current AARR is close to required AARR, indicating that these countries have a high chance of achieving the stunting target by 2025 if they can accelerate progress between 2022 and 2025. Even though Pakistan, Rwanda, and Uganda have experienced a significant decline in stunting prevalence from 2012 to 2022, the AARR needed to achieve the 2025 stunting target remains substantially higher. For the remaining six countries, the substantial gap between the current AARR and the required AARR suggests a very low likelihood of achieving the stunting target by 2025.

**Table 5. Stunting: Country Snapshots**

| Country    | Required AARR (2012-2025) | Current AARR (2012-2022) | Classification of Country's Progress |
|------------|---------------------------|--------------------------|--------------------------------------|
| Bangladesh | 4.3                       | 3.9                      | Off track -some progress             |
| Benin      | 5.7                       | 1.0                      | Off track - some progress            |
| Ethiopia   | 5.7                       | 2.0                      | Off track - some progress            |
| India      | 3.0                       | 2.7                      | Off track - some progress            |
| Indonesia  | 3.2                       | 1.0                      | Off track - some progress            |
| Kenya      | 4.0                       | 4.3                      | On track                             |
| Mozambique | 6.2                       | 1.6                      | Off track - some progress            |
| Nigeria    | 4.6                       | 0.9                      | Off track - some progress            |
| Pakistan   | 4.4                       | 2.6                      | Off track - some progress            |
| Rwanda     | 5.0                       | 3.1                      | Off track - some progress            |
| Tanzania   | 6.4                       | 2.1                      | Off track - some progress            |
| Uganda     | 5.8                       | 3.5                      | Off track - some progress            |

### Summary of Country Deep Dives on Child Stunting

Out of the 12 countries, an in-depth analysis of stunting was conducted for six: Bangladesh, India, Kenya, Nigeria, Rwanda, and Uganda. These countries were selected to represent both ends of the spectrum, those with exemplary progress in reducing stunting as well as those where progress has been limited. The selection was also informed by GAIN advocacy requirements relating to political traction to address stunting in each country. Table 6 presents the stunting profiles for the six selected countries while the

<sup>3</sup> The methodology for monitoring progress on the stunting target classifies a country as on track if the current AARR  $\geq$  required AARR; off track- some progress if the current AARR  $<$  required AARR but  $\geq 0.5$ ; and off track- no progress or worsening if current AARR  $<$  required AARR and  $< 0.5$ .

following text presents the key highlights from the six country deep dives on stunting. Stunting country profiles for all the 12 countries are at Annex 2.

**Table 6. Selected Country Profiles: Child Stunting WHA Target**

| Key Indicator                                           | Bangladesh | India     | Kenya   | Nigeria  | Rwanda  | Uganda  |
|---------------------------------------------------------|------------|-----------|---------|----------|---------|---------|
| Baseline Prevalence 2012 (%)                            | 39.2       | 41.6      | 28.6    | 37.7     | 41.2    | 33.3    |
| Baseline Under-five Population 2012 ('000)              | 16,091.6   | 127,971.6 | 7,099.0 | 31,188.2 | 1,662.7 | 6,410.1 |
| Baseline Stunting Burden 2012 ('000)                    | 6,307.9    | 53,236.2  | 2,030.3 | 11,757.9 | 685.0   | 2,134.6 |
| Current Prevalence 2022 (%)                             | 26.4       | 31.7      | 18.4    | 34.2     | 29.8    | 23.4    |
| Current Under-five Population 2022 ('000)               | 16,290.9   | 115,769.5 | 6,982.0 | 33,327.2 | 1,862.5 | 7,786.4 |
| Under-five Population Percentage Change (2012-2022) (%) | 1.2        | -9.5      | -1.7    | 6.9      | 12.0    | 21.5    |
| Current AARR (2012-2022)                                | 3.9        | 2.7       | 4.3     | 0.9      | 3.1     | 3.5     |
| Projected Prevalence 2025 (%)                           | 23.4       | 29.2      | 16.1    | 33.2     | 27.1    | 21.0    |
| Target Stunting Burden 2025 ('000)                      | 3,784.7    | 31,941.7  | 1,218.2 | 7,054.8  | 411.0   | 1,280.7 |
| Projected Under-five Population 2025 ('000)             | 16,831.4   | 113,100.7 | 7,201.1 | 34,221.1 | 1,912.4 | 8,173.1 |
| Target Prevalence 2025 (%)                              | 22.5       | 28.2      | 16.9    | 20.6     | 21.5    | 15.7    |
| Required AARR (2012-25)                                 | 4.3        | 3.0       | 4.0     | 4.6      | 5.0     | 5.8     |

### ***Bangladesh***

With a population of approximately 171 million, of which 17 million were children under five in 2023, Bangladesh has made remarkable progress in reducing child stunting since 2012 (13). The national stunting prevalence declined from 39.2% in 2012 to 26.4% in 2022. To achieve the WHA 2025 stunting targets, Bangladesh requires an AARR of 4.3 between 2012 and 2025. With an AARR of 3.9, the country will further lower the stunting prevalence to 23.4% by 2025, which closely aligns with the WHA target of 22.5% for Bangladesh.

### ***India***

With a population of approximately 1.4 billion (2023) and a historically high prevalence of child stunting, India has consistently accounted for the largest share of the global stunting burden (13). However, significant progress has been made over the past decade. In 2012, when the WHA nutrition targets were adopted, India's child stunting prevalence stood at 41.6%, contributing to nearly 29.5% of the global burden. By 2022, this prevalence had declined to 31.7%, with India's share of the global stunting burden reducing to 24.4%. To meet the WHA 2025 stunting target, India requires an AARR of 3.0 between 2012 and 2025. However, the country's AARR from 2012 to 2022 has been 2.7. At this rate, the projected child stunting prevalence in India for 2025 is 29.2%, slightly above the target of 28.2%.

### ***Kenya***

Kenya, home to 55 million (2023) people, has made significant strides in reducing child stunting (13). From a prevalence of 28.6% in 2012, stunting declined to 18.4% in 2022, positioning Kenya on track to meet the WHA 2025 global target. With an AARR of 4.3, projections indicate a stunting prevalence of 16.1% in 2025, well within the WHA target of 16.9%.

### ***Nigeria***

Nigeria, Africa's most populous nation, had an estimated population of 227 million in 2023, growing at an annual rate of 2.1% (13). Nigeria bears the second-highest absolute burden of stunted children globally. In 2012, Nigeria's child stunting prevalence stood at 37.7%. Over the past decade, progress has been slow, with prevalence declining modestly to 34.2% in 2022, reflecting an AARR of 0.9. If this trend continues, Nigeria's projected stunting prevalence in 2025 would be 33.2%, far above the WHA 2025 target of 20.6%.

### ***Rwanda***

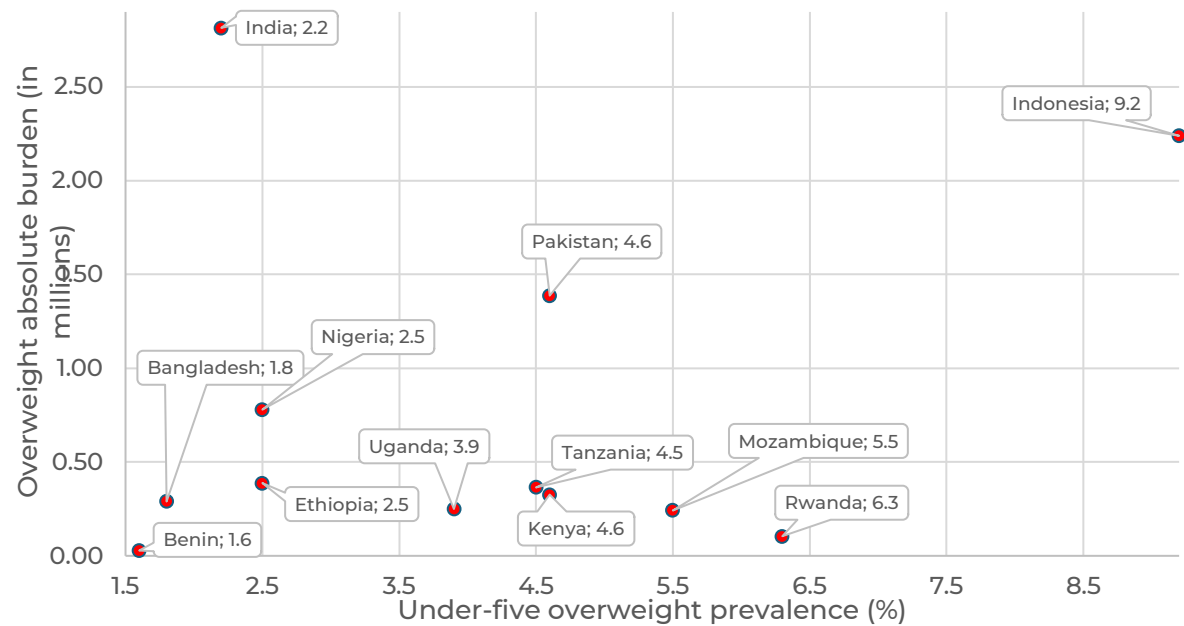
Rwanda has a population of approximately 14 million, of which 2 million were children under five in 2023 (13). Despite progress in other areas of development and public health, malnutrition, particularly stunting, remains a critical challenge. From a baseline stunting prevalence of 41.2% in 2012, the country managed to reduce it to 29.8% in 2022. To achieve the WHA 2025 stunting target, the country requires an AARR of 5.0 between 2012 and 2025. With an AARR of 3.1, the country is on its way to further lower the stunting prevalence to 27.1% by 2025, which is higher than the WHA global nutrition target of 21.5%.

### ***Uganda***

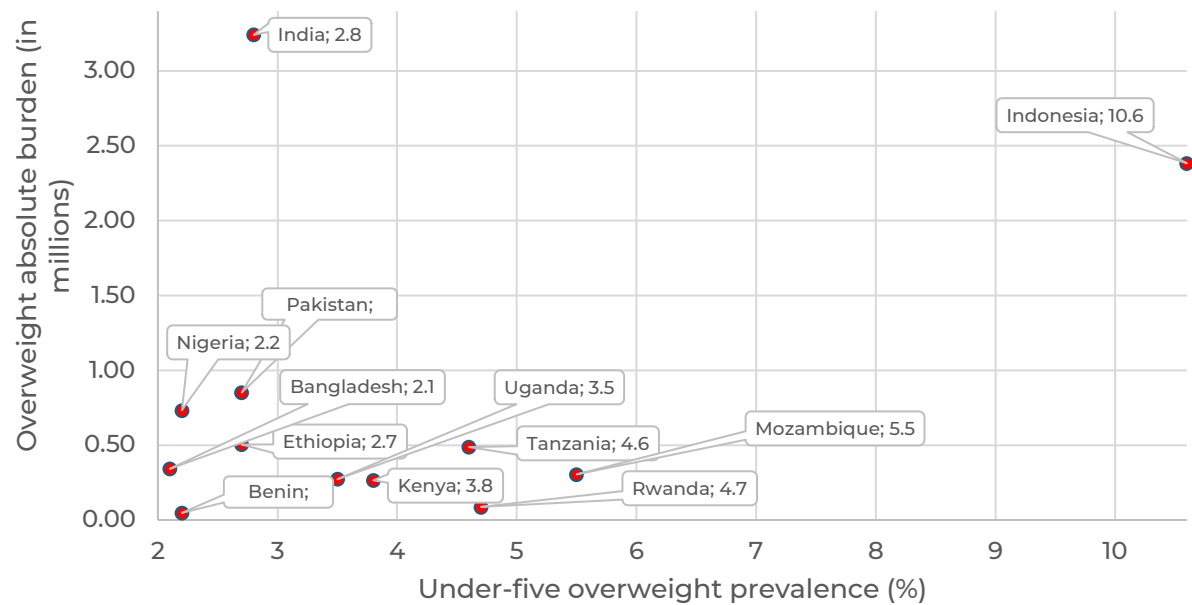
With a population of approximately 49 million, of which 8 million are children under five in 2025 (13), Uganda has made good progress in reduction in child stunting. From a national prevalence of 33.3% in 2012, the prevalence declined to 23.4% in 2022. To meet the WHA 2025 stunting target, the country requires an AARR of 5.8 between 2012 and 2025. With current AARR of 3.5, Uganda will attain stunting prevalence of 21.0% by 2025 which is more than the WHA target of 15.7 %.

## **Overweight in children under five years of age**

In 2012, when the WHA global nutrition targets were adopted, the prevalence of child overweight in Indonesia was highest amongst the 12 countries. These 12 countries accounted for 25% of the global number of overweight children. Based on WHO thresholds for overweight prevalence suggested, three of 12 countries had **very low** prevalence (>2.5%) of overweight and six had **low** (2.5% - <5%) prevalence of overweight in 2012 (Figure 4). In terms of absolute burden of overweight children under 5, India had the highest burden (3 million), followed by Indonesia (over 2 million), and Pakistan (over 1 million). The remaining countries all had fewer than 1 million overweight children.



**Figure 4. Child Overweight – prevalence and absolute burden in 12 countries in 2012<sup>4</sup>**



**Figure 5. Child overweight – prevalence and absolute burden in 12 countries in 2022<sup>4</sup>**

<sup>4</sup> For figures 4 and 5, country names are followed by the overweight prevalence in %

The latest country-level JME prevalence estimates for the year 2022 indicate that the overweight prevalence has declined in five countries (Kenya, Nigeria, Pakistan, Uganda, and Rwanda). These five countries account for 6% of the global burden of overweight among children under five. The levels of overweight remain very low (<2.5%) in three countries, medium (5–10%) in one country, low (2.5–5%) in seven countries, and high for Indonesia (10–15%) (Figure 5). Between 2012 and 2022, the absolute burden of overweight children declined in four countries (Rwanda, Kenya, Nigeria, and Pakistan), while it increased for Uganda, Bangladesh, Benin, Ethiopia, India, Indonesia, Tanzania, and Mozambique. As in 2012, India, Indonesia, and Pakistan continue to account for the highest burden of overweight children among the 12 countries. In all twelve countries in this sample, the prevalence of stunting among children under-five is greater than that of overweight, though the challenges are interconnected (7).

Of the 12 countries, nine (Ethiopia, Indonesia, Kenya, Mozambique, Nigeria, Pakistan, Rwanda, Tanzania, and Uganda) are on track to achieve the WHA target on child overweight by 2025 as per the methodology for monitoring progress towards the Global Nutrition Targets for 2025<sup>5</sup> by WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring (11). The remaining three countries (Bangladesh, Benin, and India) are off track to achieve the WHA target on child overweight by 2025 (Table 7).

**Table 7. Overweight: Country Snapshots**

| Country    | Required AARR (2012-2025) | Current AARR (2012-2022) | Classification of Country's Progress |
|------------|---------------------------|--------------------------|--------------------------------------|
| Bangladesh | 0.0                       | -1.7                     | Off track                            |
| Benin      | 0.0                       | -3.1                     | Off track                            |
| Ethiopia   | 0.0                       | -0.8                     | On track                             |
| India      | 0.0                       | -2.4                     | Off track                            |
| Indonesia  | 0.0                       | -1.5                     | On track                             |
| Kenya      | 0.0                       | 1.9                      | On track                             |
| Mozambique | 0.0                       | -0.2                     | On track                             |
| Nigeria    | 0.0                       | 1.5                      | On track                             |
| Pakistan   | 0.0                       | 5.1                      | On track                             |
| Rwanda     | 0.0                       | 2.9                      | On track                             |
| Tanzania   | 0.0                       | -0.2                     | On track                             |
| Uganda     | 0.0                       | 1.0                      | On track                             |

<sup>5</sup> The methodology for monitoring progress on overweight target classifies country as on track if current AARR  $\geq$  -1.5; and off track if current AARR < -1.5.

## Summary of Country Deep Dives on Child Overweight

For a more detailed understanding, deep dive analyses were undertaken for four countries: Indonesia, Nigeria, Pakistan, and Rwanda. Table 8 presents the overweight country profiles for the four countries, while the subsequent section presents the key highlights from the four country deep dives on overweight. The overweight country profiles for all the 12 countries are presented in Annex 3.

**Table 8. Progress towards Child Overweight WHA Target**

| Key Indicator                        | Indonesia | Nigeria | Pakistan | Rwanda |
|--------------------------------------|-----------|---------|----------|--------|
| <b>Baseline Prevalence 2012 (%)</b>  | 9.2       | 2.5     | 4.6      | 6.3    |
| <b>Current Prevalence 2022 (%)</b>   | 10.6      | 2.2     | 2.7      | 4.7    |
| <b>Current AARR (2012-2022)</b>      | -1.5      | 1.5     | 5.1      | 2.9    |
| <b>Projected Prevalence 2025 (%)</b> | 11.1      | 2.1     | 2.3      | 4.3    |
| <b>Target Prevalence 2025(%)</b>     | 9.2       | 2.5     | 4.6      | 6.3    |
| <b>Required AARR (2012-2025)</b>     | 0.0       | 0.0     | 0.0      | 0.0    |

### *Indonesia*

Indonesia showed an increase in child overweight prevalence from 9.2% in 2012 to 10.6% in 2022, though it has been in decline since 2019. With the current AARR of -1.5, Indonesia will attain a level of overweight prevalence of 11.1% by 2025. The country is making efforts to reduce it further to align with its WHA target (9.2% by 2025).

### *Nigeria*

Nigeria has successfully curbed the rise in child overweight prevalence. From a baseline of 2.5% in 2012, the country has successfully prevented an increase, with the latest 2022 data showing a prevalence of 2.2%. Nigeria remains on track to meet the WHA 2025 child overweight target, with projected prevalence of 2.1% in 2025. Notably, Nigeria DHS 2024 reports further improvement, with prevalence dropping to 1.4% (17).

### *Pakistan*

According to JME data, the prevalence of child overweight in Pakistan was 4.6% in 2012. Unlike the Southern Asia sub-region, where overweight prevalence has remained almost stagnant (2.7% in 2012 to 2.8% in 2022), Pakistan has seen a steady decline, with prevalence reaching 2.7% in 2022, well below its WHA 2025 target of 4.6%.

### *Rwanda*

Rwanda has managed to reduce child overweight prevalence from 6.3% in 2012 to 4.7% in 2022. With the current AARR of 2.9, the country will attain a level of overweight prevalence of 4.3% by 2025, much lower than the WHA 2025 target of 6.3%.

## Likely Drivers of Progress in Child Stunting and Overweight

The literature reviewed as part of the deep dives revealed several factors likely contributing to meaningful reductions in child malnutrition. Multi- or cross-sectoral approaches, strong political commitment, and targeted interventions to address both immediate and underlying determinants have driven meaningful reductions in stunting across several of the studied countries (18–20). Having national plans that include targets aligned to global targets may also boost accountability and political buy-in (21,22).

Socioeconomic advances as well as policy reforms to make services more inclusive have been noted as contributing, for instance in Bangladesh and India; the slower progress in Nigeria could imply more care needs to be taken to ensure advances are equitable and social spending reaches vulnerable groups (23–26). Indeed, economic growth alone did not guarantee better outcomes on stunting: inequality, affordability of healthy diets and diet quality remained barriers in selected cases, particularly Nigeria (8,27). Decentralised and localised actions, for instance in Bangladesh, India, and Kenya, have helped tailor interventions to regional needs (28,29). The strong progress in Kenya highlights how continued investments in nutrition-sensitive programs, data-driven decision-making, and strengthened social protection systems will be needed to continue reaping nutrition gains.

Considering overweight, national policies and programmes, such as those promoting healthy diets, increased physical activity, and reduction of risk factors including excessive sugar and fat intake, can help effectively control rising trends of childhood overweight (30–32). Community-driven and multisectoral approaches are also highlighted. The case of Indonesia is of particular interest, given it is the only studied country where a once-increasing trend of childhood overweight has reversed. It is also a challenging context of easily available ultra-processed food and high urbanisation. Recent success has been attributed to policy and governance reforms, including public health campaigns (30,33). Emphasis has also been placed on the need for greater government intervention in the future, for instance through taxes and labelling on unhealthy options, and in implementing school-based interventions (34). Across all cases and impacting both stunting and overweight, the challenge of good dietary diversity persists. High proportions of young children across the sample countries lack a minimum acceptable diet (35,36). These findings highlight the need for continued investments in food systems transformation, behaviour change communication, and policy enforcement.

## **CONCLUSION**

This working paper has analysed trends in child stunting and overweight in 12 countries, assessing progress toward the 2025 WHA Global Nutrition Targets. It highlights mixed results across countries and potential drivers of them. The analysis has provided a good understanding of how child stunting and overweight have evolved over the last decade, with the use of standardised model-based estimates from JME ensuring comparability across countries, strengthening the validity of the conclusions. The country case studies – particularly those highlighting successes in Kenya, India, Bangladesh, Uganda, and Rwanda – have illustrated how multi-sectoral approaches, strong political commitment, and targeted interventions have driven meaningful reductions in child stunting. Similarly, the case studies on Rwanda, Nigeria, and Pakistan provided deeper insights into how national policies or programmes can effectively control rising trends of childhood overweight.

However, despite the charted progress towards targets for child stunting and overweight, the paper also highlights persistent challenges. Only Kenya is on track to meet the WHA stunting targets, while the remaining 11 countries are off-track with some progress. For child overweight, nine countries are on track to achieve the WHA overweight target while the remaining three countries – Bangladesh, Benin, and India – are off-track. The country deep dives suggest that addressing stunting and overweight requires not only sustained policy implementation but also adaptive strategies that consider prevailing socio-economic and demographic contexts.

This paper contributes to the existing evidence base by comparing progress on stunting and overweight across 12 diverse countries in Africa and Asia. It has calculated projected stunting and overweight prevalence estimates for 2025 based on current AARR from 2012 to 2022 to provide a forward-looking perspective on the attainment of Global Nutrition Targets. Additionally, it highlights the role of food system transformation in tackling both forms of malnutrition. Case studies illustrate how integrated policies – such as Kenya’s multisectoral coordination, India’s POSHAN Abhiyaan, and Bangladesh’s food fortification initiatives – offer valuable insights for other countries facing similar issues. The emphasis on sub-national variation, particularly in countries like India, Bangladesh, and Nigeria, underscores the importance of localised intervention strategies to achieve national nutrition targets.

While the country deep dives identified successful national programmes, a deeper exploration of these is required to understand their impact on stunting and overweight and further implications for refining policies to accelerate progress in reducing child malnutrition. Evaluations of multi-year national initiatives, such as Kenya’s Nutrition Action Plans and India’s POSHAN Abhiyaan, would provide valuable lessons for other countries.

This paper underscores the urgency of accelerating progress toward the 2025 WHA Global Nutrition Targets. While some countries have demonstrated effective strategies for reducing child stunting and overweight, the overall pace of improvement remains too slow in most contexts. A shift towards more integrated, data-driven, and context-specific interventions is recommended. Strengthening multi-sectoral coordination, investing in food systems transformation, and ensuring policy accountability will be key to effectively addressing child malnutrition.

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## ANNEX 1: DATA TABLES

Table A1.1. Prevalence of under-five stunting (%) in 12 countries from 2012 to 2022 (10)

| Country              | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|----------------------|------|------|------|------|------|------|------|------|------|------|------|
| Bangladesh           | 39.2 | 37.8 | 36.4 | 35.1 | 33.9 | 32.5 | 31.2 | 29.9 | 28.6 | 27.5 | 26.4 |
| Benin                | 33.9 | 33.5 | 33.1 | 32.9 | 32.7 | 32.5 | 32.3 | 31.9 | 31.4 | 30.9 | 30.4 |
| Ethiopia             | 42.1 | 41.1 | 40.3 | 39.5 | 38.8 | 38.1 | 37.4 | 36.6 | 35.8 | 35.1 | 34.4 |
| Indonesia            | 34.6 | 34.1 | 33.6 | 33.3 | 33.0 | 32.7 | 32.5 | 32.2 | 31.9 | 31.4 | 31.0 |
| India                | 41.6 | 40.4 | 39.3 | 38.3 | 37.3 | 36.3 | 35.4 | 34.4 | 33.5 | 32.5 | 31.7 |
| Kenya                | 28.6 | 27.2 | 26.0 | 24.9 | 23.9 | 23.0 | 22.0 | 21.1 | 20.1 | 19.2 | 18.4 |
| Mozambique           | 42.6 | 42.2 | 41.8 | 41.4 | 40.8 | 40.1 | 39.3 | 38.5 | 37.7 | 37.0 | 36.4 |
| Pakistan             | 43.8 | 43.0 | 42.2 | 41.4 | 40.5 | 39.4 | 38.3 | 37.1 | 36.0 | 34.9 | 34.0 |
| Nigeria              | 37.7 | 37.3 | 36.9 | 36.7 | 36.4 | 36.2 | 35.8 | 35.4 | 35.0 | 34.5 | 34.2 |
| Rwanda               | 41.2 | 39.6 | 38.1 | 36.7 | 35.6 | 34.6 | 33.6 | 32.6 | 31.6 | 30.7 | 29.8 |
| Tanzania             | 38.1 | 37.1 | 36.2 | 35.4 | 34.7 | 34.1 | 33.5 | 32.9 | 32.1 | 31.4 | 30.6 |
| Uganda               | 33.3 | 32.1 | 30.8 | 29.6 | 28.4 | 27.3 | 26.3 | 25.5 | 24.7 | 24.0 | 23.4 |
| <b>UN Sub-Region</b> |      |      |      |      |      |      |      |      |      |      |      |
| Eastern Africa       | 34.4 | 33.7 | 33.1 | 32.7 | 32.3 | 31.9 | 31.5 | 31.1 | 30.8 | 30.3 | 30.0 |
| South-Eastern Asia   | 30.4 | 29.8 | 29.4 | 29.0 | 28.7 | 28.3 | 27.9 | 27.6 | 27.3 | 26.8 | 26.4 |
| Southern Asia        | 40.3 | 39.1 | 38.0 | 37.0 | 36.0 | 35.1 | 34.1 | 33.1 | 32.2 | 31.3 | 30.5 |
| Western Africa       | 34.5 | 33.9 | 33.4 | 32.9 | 32.5 | 32.1 | 31.7 | 31.2 | 30.8 | 30.3 | 30.0 |
| World                | 26.3 | 25.7 | 25.1 | 24.6 | 24.1 | 23.7 | 23.3 | 23.0 | 22.7 | 22.5 | 22.3 |

**Table A1.2. Prevalence of under-five overweight in 12 countries from 2012 to 2022 (10)**

| Country              | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|----------------------|------|------|------|------|------|------|------|------|------|------|------|
| Bangladesh           | 1.8  | 1.9  | 2.0  | 2.0  | 2.1  | 2.2  | 2.2  | 2.2  | 2.2  | 2.2  | 2.1  |
| Benin                | 1.6  | 1.6  | 1.7  | 1.7  | 1.8  | 1.8  | 1.8  | 1.9  | 2.0  | 2.1  | 2.2  |
| Ethiopia             | 2.5  | 2.5  | 2.5  | 2.5  | 2.5  | 2.6  | 2.6  | 2.6  | 2.6  | 2.7  | 2.7  |
| Indonesia            | 9.2  | 9.9  | 10.5 | 11.1 | 11.5 | 11.8 | 11.9 | 11.8 | 11.6 | 11.2 | 10.6 |
| India                | 2.2  | 2.2  | 2.2  | 2.2  | 2.3  | 2.3  | 2.4  | 2.4  | 2.5  | 2.7  | 2.8  |
| Kenya                | 4.6  | 4.4  | 4.3  | 4.2  | 4.1  | 4.0  | 3.9  | 3.8  | 3.8  | 3.8  | 3.8  |
| Mozambique           | 5.5  | 5.4  | 5.3  | 5.3  | 5.3  | 5.3  | 5.4  | 5.4  | 5.5  | 5.5  | 5.5  |
| Pakistan             | 4.6  | 4.4  | 4.2  | 4.0  | 3.8  | 3.7  | 3.5  | 3.3  | 3.1  | 2.9  | 2.7  |
| Nigeria              | 2.5  | 2.5  | 2.4  | 2.4  | 2.3  | 2.3  | 2.2  | 2.2  | 2.2  | 2.2  | 2.2  |
| Rwanda               | 6.3  | 6.2  | 6.1  | 6.0  | 5.8  | 5.6  | 5.5  | 5.3  | 5.1  | 4.9  | 4.7  |
| Tanzania             | 4.5  | 4.5  | 4.6  | 4.6  | 4.6  | 4.6  | 4.6  | 4.6  | 4.6  | 4.6  | 4.6  |
| Uganda               | 3.9  | 3.8  | 3.7  | 3.7  | 3.7  | 3.6  | 3.6  | 3.6  | 3.5  | 3.5  | 3.5  |
| <b>UN Sub-Region</b> |      |      |      |      |      |      |      |      |      |      |      |
| Eastern Africa       | 3.9  | 3.8  | 3.8  | 3.7  | 3.7  | 3.7  | 3.7  | 3.6  | 3.6  | 3.6  | 3.6  |
| South-Eastern Asia   | 6.4  | 6.7  | 7.0  | 7.3  | 7.5  | 7.7  | 7.8  | 7.8  | 7.7  | 7.6  | 7.4  |
| Southern Asia        | 2.7  | 2.6  | 2.6  | 2.6  | 2.6  | 2.6  | 2.6  | 2.6  | 2.7  | 2.7  | 2.8  |
| Western Africa       | 2.3  | 2.3  | 2.3  | 2.3  | 2.3  | 2.3  | 2.3  | 2.3  | 2.3  | 2.4  | 2.4  |
| World                | 5.5  | 5.5  | 5.5  | 5.5  | 5.5  | 5.6  | 5.6  | 5.6  | 5.6  | 5.6  | 5.6  |

**Table A1.3. Under-five population ('000) in 12 countries in 2012, 2022, and 2025 (13)**

| Country    | 2012    | 2022    | 2025 <sup>6</sup> |
|------------|---------|---------|-------------------|
| Bangladesh | 16,092  | 16,291  | 16,831            |
| Benin      | 1,773   | 2,155   | 2,228             |
| Ethiopia   | 15,522  | 18,673  | 19,654            |
| Indonesia  | 24,342  | 22,488  | 22,097            |
| India      | 127,972 | 115,770 | 113,101           |
| Kenya      | 7,099   | 6,982   | 7,201             |
| Mozambique | 4,397   | 5,547   | 5,896             |
| Pakistan   | 30,165  | 31,525  | 32,134            |
| Nigeria    | 31,188  | 33,327  | 34,221            |
| Rwanda     | 1,663   | 1,863   | 1,912             |
| Tanzania   | 8,103   | 10,596  | 11,226            |
| Uganda     | 6,410   | 7,786   | 8,173             |

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<sup>6</sup> For under-five population 2025, the projected population available under medium-term variant from World Population Prospects 2024 have been used.

**Table A1.4. Prevalence of Stunting in Children under five as per the latest survey-  
Disaggregated by Gender and Residence**

| Country                | Data Source                   | Total | Gender |        | Residence |       |
|------------------------|-------------------------------|-------|--------|--------|-----------|-------|
|                        |                               |       | Male   | Female | Urban     | Rural |
| Bangladesh             | 2022 DHS                      | 23.6  | 23.8   | 23.3   | 22        | 24.1  |
| Benin                  | 2017-18 DHS                   | 32.2  | 35.1   | 29.1   | 27.5      | 35.2  |
| Ethiopia               | 2019 DHS                      | 36.8  | 39.8   | 33.6   | 26.2      | 40.4  |
| India                  | 2019-21 DHS                   | 35.5  | 36.2   | 34.6   | 30.1      | 37.3  |
| Indonesia <sup>7</sup> | 2023 Indonesian Health Survey | 15.8  | 16.5   | 15.1   | 14.7      | 17.3  |
| Kenya                  | 2022 DHS                      | 17.6  | 19.6   | 15.6   | 12.1      | 20.3  |
| Mozambique             | 2022-23 DHS                   | 36.7  | 40.9   | 32.8   | 26.3      | 41    |
| Nigeria                | 2023-24 DHS                   | 39.5  | 42.6   | 36.4   | 27.8      | 48.1  |
| Pakistan               | 2017-18 DHS                   | 37.6  | 38.2   | 37.1   | 30.7      | 40.9  |
| Rwanda                 | 2019-20 DHS                   | 33.1  | 37     | 29.2   | 19.8      | 35.8  |
| Tanzania               | 2022 DHS                      | 30    | 33.3   | 26.6   | 20.5      | 33.4  |
| Uganda                 | 2016 DHS                      | 28.9  | 30.9   | 26.9   | 23.5      | 30.2  |

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<sup>7</sup> DHS Indonesia does not provide estimates on stunting and overweight.

**Table A1.5. Prevalence of Overweight in Children under five as per the latest survey:  
Disaggregated by Gender and Residence**

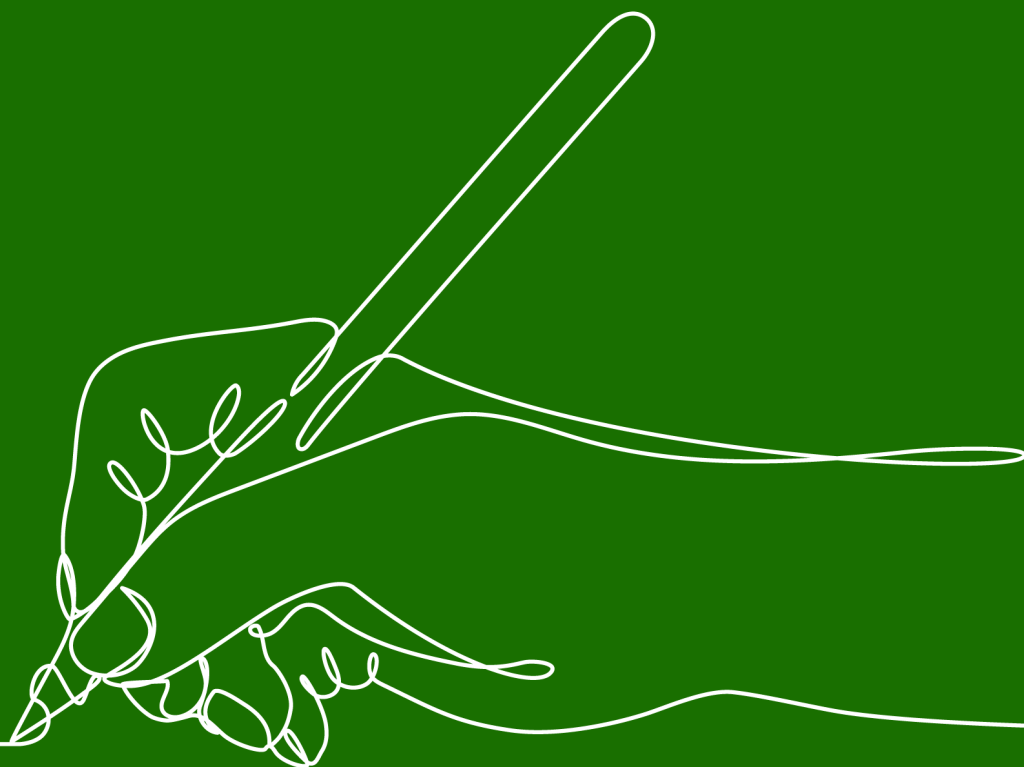
| Countries              | Data Source                   | Total | Gender |        | Residence |       |
|------------------------|-------------------------------|-------|--------|--------|-----------|-------|
|                        |                               |       | Male   | Female | Urban     | Rural |
| Bangladesh             | 2022 DHS                      | 1.5   | 1.3    | 1.7    | 1.5       | 1.5   |
| Benin                  | 2017-18 DHS                   | 1.9   | 1.8    | 1.9    | 1.8       | 1.9   |
| Ethiopia               | 2019 DHS                      | 2.3   | 2.3    | 2.2    | 2.4       | 2.2   |
| India                  | 2019-21 DHS                   | 3.4   | 3.5    | 3.3    | 4.2       | 3.1   |
| Indonesia <sup>7</sup> | 2023 Indonesian Health Survey | 4.2   | 4.5    | 4.0    | 4.5       | 3.9   |
| Kenya                  | 2022 DHS                      | 3.2   | 2.9    | 3.6    | 4.0       | 2.8   |
| Mozambique             | 2022-23 DHS                   | 3.2   | 3.2    | 3.1    | 3.0       | 3.3   |
| Nigeria                | 2023-24 DHS                   | 1.4   | 1.5    | 1.3    | 1.4       | 1.4   |
| Pakistan               | 2017-18 DHS                   | 2.5   | 2.3    | 2.6    | 3.0       | 2.2   |
| Rwanda                 | 2019-20 DHS                   | 5.6   | 5.8    | 5.4    | 6.7       | 5.4   |
| Tanzania               | 2022 DHS                      | 3.5   | 3.7    | 3.3    | 3.4       | 3.5   |
| Uganda                 | 2016 DHS                      | 3.7   | 4.9    | 2.6    | 2.8       | 3.9   |

## ANNEX 2. STUNTING COUNTRY PROFILES FOR 12 COUNTRIES

| Key Indicator                                  | Bangladesh                | Benin                     | Ethiopia                  | India                     | Indonesia                 | Kenya    | Mozambique                | Nigeria                   | Pakistan                  | Rwanda                    | Tanzania                  | Uganda                    |
|------------------------------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|----------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| Baseline Prevalence 2012 (%)                   | 39.2                      | 33.9                      | 42.1                      | 41.6                      | 34.6                      | 28.6     | 42.6                      | 37.7                      | 43.8                      | 41.2                      | 38.1                      | 33.3                      |
| Baseline U5 Population 2012 ('000)             | 16091.6                   | 1772.7                    | 15521.6                   | 127971.6                  | 24342.4                   | 7099.0   | 4397.2                    | 31188.2                   | 30165.3                   | 1662.7                    | 8103.0                    | 6410.1                    |
| Baseline Stunting Burden 2012 ('000)           | 6307.9                    | 600.9                     | 6534.6                    | 53236.2                   | 8422.5                    | 2030.3   | 1873.2                    | 11757.9                   | 13212.4                   | 685.0                     | 3087.2                    | 2134.6                    |
| Current Prevalence 2022 (%)                    | 26.4                      | 30.4                      | 34.4                      | 31.7                      | 31.0                      | 18.4     | 36.4                      | 34.2                      | 34.0                      | 29.8                      | 30.6                      | 23.4                      |
| Current U5 Population 2022 ('000)              | 16290.9                   | 2155.0                    | 18673.4                   | 115769.5                  | 22488.3                   | 6982.0   | 5547.1                    | 33327.2                   | 31524.9                   | 1862.5                    | 10595.9                   | 7786.4                    |
| U5 Population Percentage Change(2012-2022) (%) | 1.2                       | 21.6                      | 20.3                      | -9.5                      | -7.6                      | -1.7     | 26.2                      | 6.9                       | 4.5                       | 12.0                      | 30.8                      | 21.5                      |
| Current AARR (2012-2022)                       | 3.9                       | 1.0                       | 2.0                       | 2.7                       | 1.0                       | 4.3      | 1.6                       | 0.9                       | 2.6                       | 3.1                       | 2.1                       | 3.5                       |
| Projected Prevalence 2025 (%)                  | 23.4                      | 29.5                      | 32.4                      | 29.2                      | 30.1                      | 16.1     | 34.7                      | 33.2                      | 31.5                      | 27.1                      | 28.7                      | 21.0                      |
| Target Stunting Burden 2025 ('000)             | 3784.7                    | 360.6                     | 3920.8                    | 31941.7                   | 5053.5                    | 1218.2   | 1123.9                    | 7054.8                    | 7927.4                    | 411.0                     | 1852.3                    | 1280.7                    |
| Projected U5 Population 2025 ('000)            | 16831.4                   | 2227.9                    | 19653.6                   | 113100.7                  | 22097.1                   | 7201.1   | 5895.9                    | 34221.1                   | 32134.1                   | 1912.4                    | 11226.1                   | 8173.1                    |
| Target Prevalence 2025 (%)                     | 22.5                      | 16.2                      | 19.9                      | 28.2                      | 22.9                      | 16.9     | 19.1                      | 20.6                      | 24.7                      | 21.5                      | 16.5                      | 15.7                      |
| Required AARR (2012-2025)                      | 4.3                       | 5.7                       | 5.7                       | 3.0                       | 3.2                       | 4.0      | 6.2                       | 4.6                       | 4.4                       | 5.0                       | 6.4                       | 5.8                       |
| Classification of Country's Progress           | Off track - some progress | Off track - some progress | Off track - some progress | Off track - some progress | Off track - some progress | On track | Off track - some progress | Off track - some progress | Off track - some progress | Off track - some progress | Off track - some progress | Off track - some progress |

## ANNEX 3. OVERWEIGHT COUNTRY PROFILES FOR 12 COUNTRIES

| Key Indicator                        | Bangladesh | Benin     | Ethiopia | India     | Indonesia | Kenya    | Mozambique | Nigeria  | Pakistan | Rwanda   | Tanzania | Uganda   |
|--------------------------------------|------------|-----------|----------|-----------|-----------|----------|------------|----------|----------|----------|----------|----------|
| Baseline Prevalence 2012 (%)         | 1.8        | 1.6       | 2.5      | 2.2       | 9.2       | 4.6      | 5.5        | 2.5      | 4.6      | 6.3      | 4.5      | 3.9      |
| Current Prevalence 2022 (%)          | 2.1        | 2.2       | 2.7      | 2.8       | 10.6      | 3.8      | 5.5        | 2.2      | 2.7      | 4.7      | 4.6      | 3.5      |
| Current AARR (2012-2022)             | -1.7       | -3.1      | -0.8     | -2.4      | -1.5      | 1.9      | -0.2       | 1.5      | 5.1      | 2.9      | -0.2     | 1.0      |
| Projected Prevalence 2025 (%)        | 2.2        | 2.4       | 2.8      | 3.0       | 11.1      | 3.6      | 5.5        | 2.1      | 2.3      | 4.3      | 4.6      | 3.4      |
| Target Prevalence 2025 (%)           | 1.8        | 1.6       | 2.5      | 2.2       | 9.2       | 4.6      | 5.5        | 2.5      | 4.6      | 6.3      | 4.5      | 3.9      |
| Required AARR (2012-2025)            | 0.0        | 0.0       | 0.0      | 0.0       | 0.0       | 0.0      | 0.0        | 0.0      | 0.0      | 0.0      | 0.0      | 0.0      |
| Classification of Country's Progress | Off track  | Off track | On track | Off track | On track  | On track | On track   | On track | On track | On track | On track | On track |



## ABOUT GAIN

The Global Alliance for Improved Nutrition (GAIN) is a Swiss-based foundation launched at the UN in 2002 to tackle the human suffering caused by malnutrition. Working with governments, businesses and civil society, we aim to transform food systems so that they deliver more nutritious food for all people, especially the most vulnerable.

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