



PROGRESS FOR CHILDREN

A REPORT CARD ON NUTRITION
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CHILD NUTRITION

Eradicating extreme poverty and hunger, reducing child mortality and achieving all the Millennium Development Goals (MDGs) related to health and education are largely dependent on progress in nutrition. If undernutrition is not successfully addressed, it will be difficult to reach the other MDGs.

Every year, it is estimated that undernutrition contributes to the deaths of about 5.6 million children under the age of five. One out of every four children under five – or 146 million children in the developing world – is underweight for his or her age, and at increased risk of an early death.

When nutrition falls short, damage is done to individuals and to society. When pregnant women are not adequately nourished, their babies are born at low weights, putting their survival at risk. When girls are undernourished, their future ability to bear healthy children is threatened. Undernutrition and micronutrient deficiencies can lead to developmental delays throughout childhood and adolescence, making individuals less productive as adults.

This report card – the fourth in a UNICEF series that monitors progress for children towards the MDGs – measures the world's performance on nutrition, taking the prevalence of underweight among children under five as its primary indicator. The global community promised to cut the proportion of underweight children by half between 1990 and 2015, but we are still not on track to reach that target.

We can make swift advances in a short time. The world has seen great progress with proven strategies, such as the promotion of breastfeeding, vitamin A supplementation and the global campaign to iodize salt, all of which are critical interventions.

NUTRITION AND THE MDGs

This report card shows clearly that the world must alter its priorities in order to reach the MDG target of reducing child undernutrition by half. But it shows just as clearly that reducing undernutrition is attainable if the lessons of the past 15 years are applied. The goal could not be more important: a world in which children live free from poverty and hunger.



Ann M. Veneman
Executive Director, UNICEF



In the developing world, 146 million children under five are underweight – and more than half of them live in South Asia. South Asia has by far the largest prevalence of underweight in children under five in the developing world, proportionally and in numbers.

Indicator: Percentage of children under five who are underweight (moderate and severe).

Source: UNICEF analysis based on latest available estimates of underweight prevalence in 110 developing countries (1996–2005).

NUTRITION: THE FOUNDATION OF SURVIVAL AND DEVELOPMENT

Improving nutrition, particularly in the early years, is crucial towards meeting the Millennium Development Goals (MDGs).

Undernutrition, particularly in children, is a vice locked around humanity, preventing individuals and even whole societies from achieving their full potential. Children who are undernourished have lowered resistance to infection and are more likely to die from such common childhood ailments as diarrhoeal diseases and respiratory infections. Those who survive may be locked into a vicious cycle of recurring sickness and faltering growth, often with irreversible damage to their cognitive and social development.

For current and succeeding generations, good nutrition is the cornerstone for survival, health and development. Well-nourished women face fewer risks during pregnancy and childbirth, and their children set off on a firmer developmental path, both physically and mentally. Well-nourished children perform better in school, grow into

healthier adults and are able to give their own children a better start in life.

Good nutrition has strong economic implications too. When populations are well nourished, higher individual productivity, lower health care costs and greater economic output will ensue.

MDG 1 is to eradicate extreme poverty and hunger, affirming the fundamental interrelation between the two – hunger is often both a consequence and a cause of poverty. In all regions of the world, in the absence of determined public policies, people who live on low incomes tend to have worse diets than those who are better off. And people who lack adequate nutrition have to struggle harder to avoid or extricate themselves from poverty than healthier, well-nourished people.

Tackling the global nutrition problem is essential to attaining any of the other MDGs. Undernutrition is an underlying cause of an estimated 53 per cent of all under-five deaths¹, which means that MDG 4 and its associated target – reduce by two thirds the mortality rate of children under five – cannot possibly be achieved without action to improve the nutrition of young children and mothers.

The other health-related goals – MDG 5 on maternal health and MDG 6 on combating key diseases – are also intimately linked to nutrition, given that an undernourished body is in every way more vulnerable. Undernutrition affects children's school attendance and performance and reflects biases in access to food and health services, areas in which women play a key role for their families – thus the goals on education (MDG 2) and gender equality (MDG 3) are unlikely to be achieved if the problem of undernutrition is not addressed.

What is undernutrition?

This report card primarily uses the term **undernutrition**, defined as the outcome of insufficient food intake (hunger) and repeated infectious diseases. Undernutrition includes being underweight for one's age, too short for one's age (stunted), dangerously thin (wasted), and deficient in vitamins and minerals (micronutrient malnutrition).

When individuals are undernourished, they can no longer maintain natural bodily capacities, such as growth, resisting infections and recovering from disease, learning and physical work, and pregnancy and lactation in women. Poor feeding of infants and young children, especially the lack of optimal breastfeeding and responsive complementary feeding, along with such illnesses as diarrhoea, pneumonia, malaria and HIV/AIDS, often exacerbated by helminths, are major causes of undernutrition.²

The second target of MDG 1 is to reduce the proportion of people who suffer from hunger by half between 1990 and 2015. The indicator by which progress is measured – and the focus of this report card – is the prevalence of underweight in children under five, specifically, the percentage of children aged 0–59 months who fall below minus two standard deviations from the median weight for age of the standard reference population.

Estimates for underweight prevalence are based on the most recent data available to UNICEF for years between 1996 and 2005 from 110 countries, covering 98 per cent of the developing world's under-five population. Trend analysis is based on a subset of 73 countries with available trend data for 1990–2004, covering 86 per cent of children in developing countries.

How many children are underweight?

In the developing world, one out of every four children under five years old – 27 per cent – is underweight, around 146 million children, based on the most recent estimates. Of these children, nearly three quarters live in 10 countries.

Of the 146 million children under five who are underweight in the developing world, 106 million – 73 per cent – live in just 10 countries.

India, 57 million

Bangladesh, 8 million

Pakistan, 8 million

China, 7 million

Nigeria, 6 million

Ethiopia, 6 million

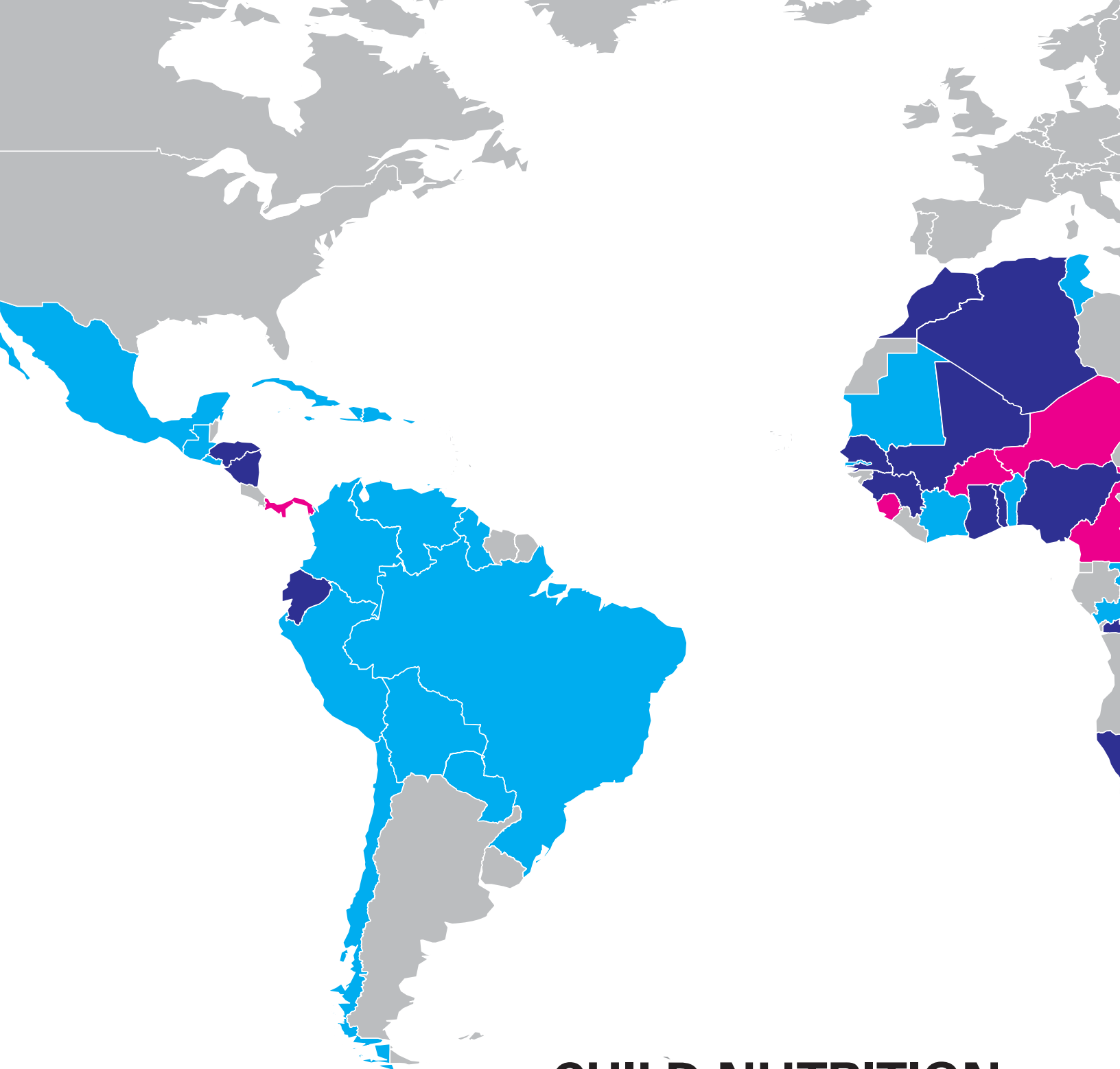
Indonesia, 6 million

Democratic Republic of the Congo, 3 million

Philippines, 3 million

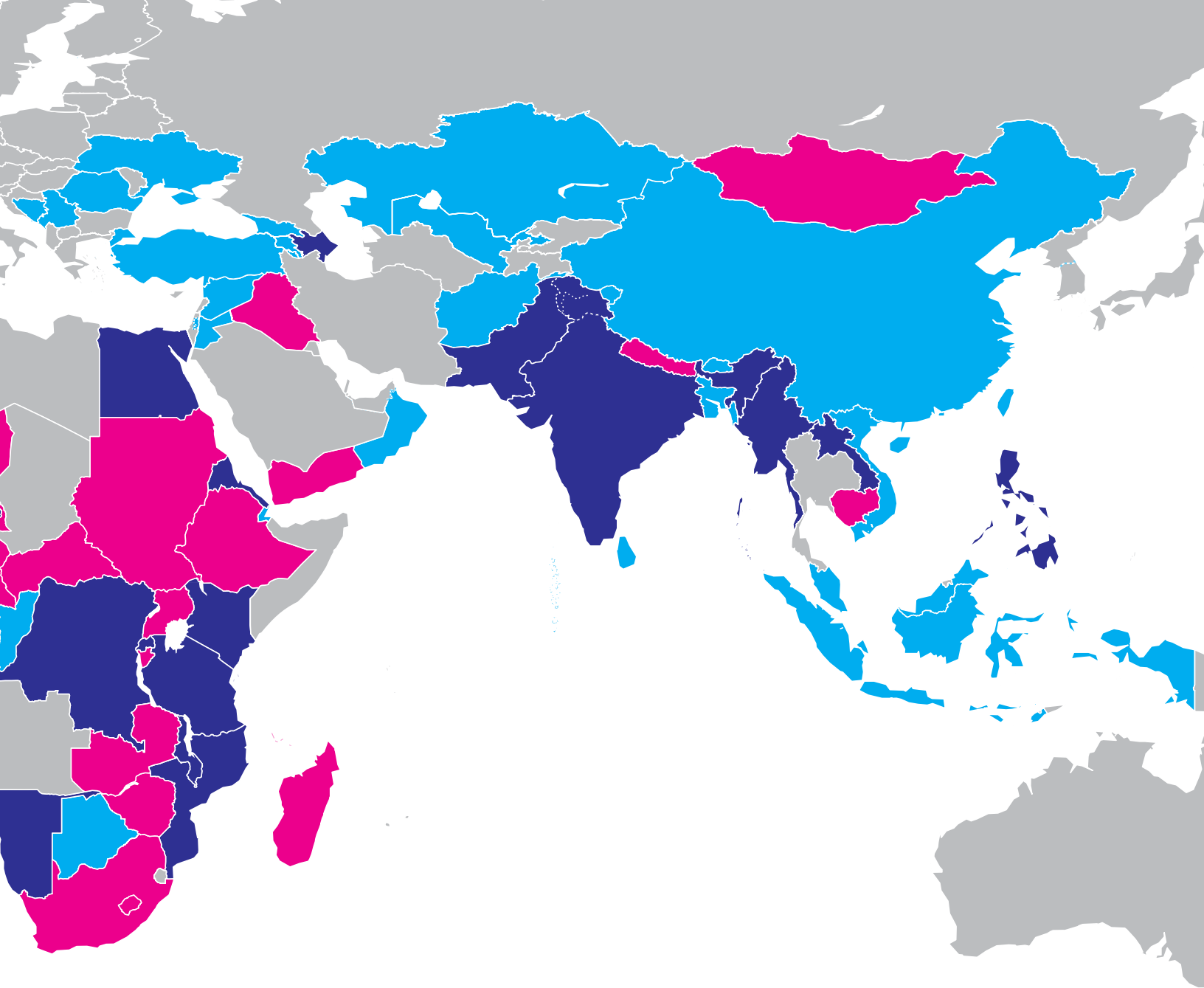
Viet Nam, 2 million

Other developing countries, 40 million



CHILD NUTRITION

Unless progress is accelerated, the MDG target will not be met. Underweight prevalence among children under five is the indicator used to measure progress towards the MDG target: reduce by half the proportion of people who suffer from hunger. Progress is calculated by comparing the average annual rate of reduction (AARR) based on available trend data for around the period of 1990–2004 with the AARR needed to achieve a 50 per cent reduction over a 25-year period (1990–2015). The rate of change required to achieve the goal is a constant of 2.8 per cent per year for all countries.



MDG 1: Eradicate extreme poverty and hunger

Target: Reduce by half the proportion of people who suffer from hunger between 1990 and 2015

Indicator: Percentage of children under five who are underweight (moderate and severe)

Countries and territories are classified according to the following thresholds:

- **On track to reach the MDG target:** AARR is 2.6 per cent or more **or** latest available estimate of underweight prevalence (from 1999 or later) is 5 per cent or less, - regardless of AARR.
- **Making progress, but insufficient:** AARR is between 0.6 per cent and 2.5 per cent, inclusive.
- **No change or getting worse:** AARR is 0.5 per cent or less.
- **Insufficient data:** No trend data available.

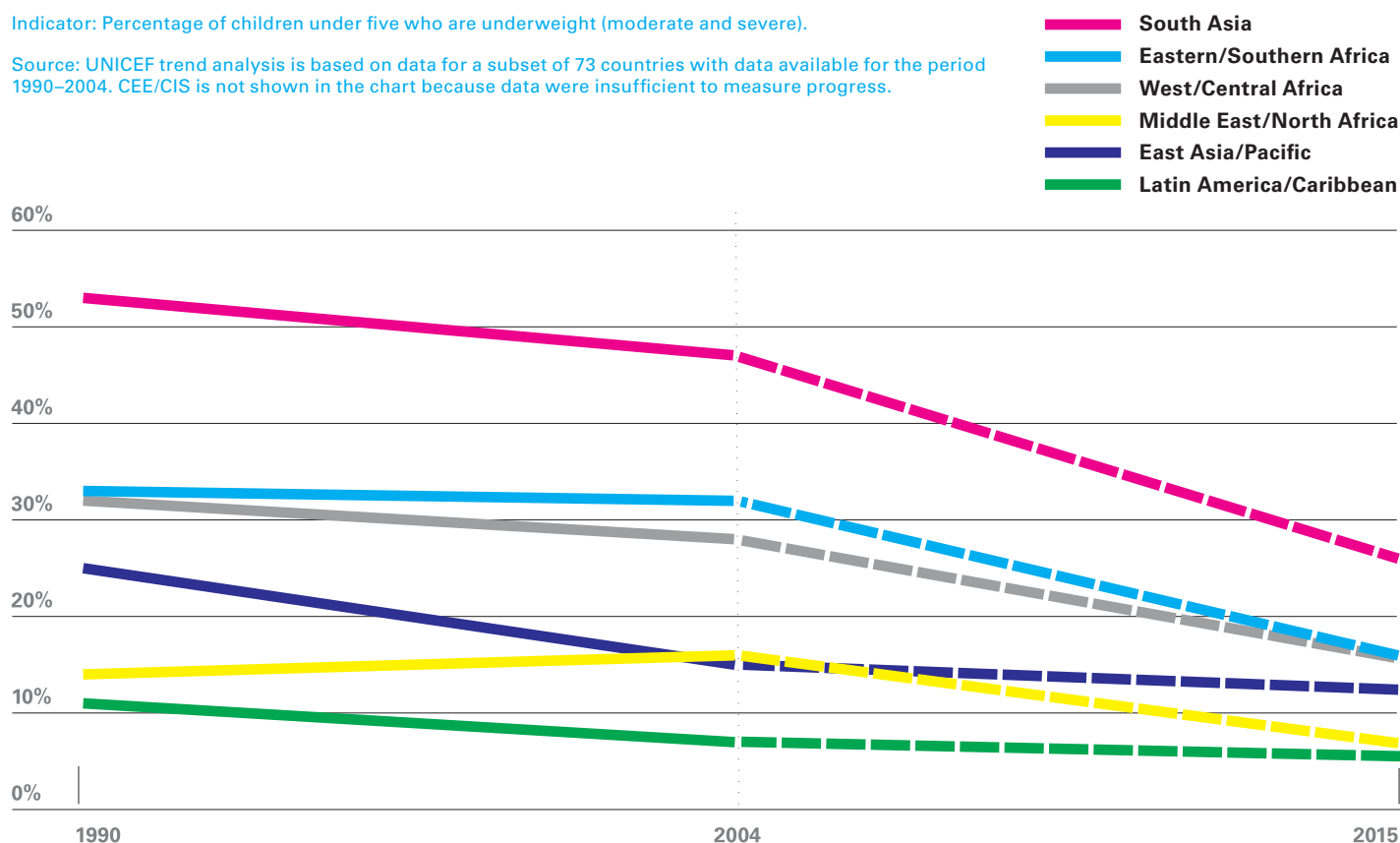
This map is stylized and is not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

Progress towards reaching the MDG target needs to accelerate. The prevalence of underweight in children under five has decreased since 1990 in the developing world, but the rate of reduction needs to accelerate if undernutrition is to be reduced by half by 2015. The solid lines show the regional proportions of underweight children in 1990 and 2004. The dotted lines show progress that will need to be made in order to reach the target.

Indicator: Percentage of children under five who are underweight (moderate and severe).

Source: UNICEF trend analysis is based on data for a subset of 73 countries with data available for the period 1990–2004. CEE/CIS is not shown in the chart because data were insufficient to measure progress.



South Asia has by far the highest levels of underweight, affecting 46 per cent of all under-five children in the region. In sub-Saharan Africa, 28 per cent of children are underweight; the lowest prevalences are in Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS, with 5 per cent) and Latin America/Caribbean (7 per cent).

Similar patterns are seen in the prevalence of stunting – where children’s height is low for their age, a telling indicator of chronic undernutrition – and wasting, where children’s weight is low for their height, a measure of acute undernutrition that often appears in emergency situations. South Asia has the highest levels in the world, with 44 per cent of its children stunted and 15 per cent wasted, considerably in excess of rates in most other regions.

Sub-Saharan Africa has the next highest proportion of stunted children, with 41 per cent in Eastern/Southern Africa and 35 per cent in West/Central Africa; the proportion of children wasted is next highest in West/Central Africa (10 per cent), the Middle East/North Africa (8 per cent) and Eastern/Southern Africa (7 per cent). As with

underweight, the CEE/CIS and Latin America/Caribbean regions show the lowest prevalences of stunting, 14 per cent and 16 per cent, respectively, and wasting, at 3 per cent and 2 per cent.

Some progress has been made, and the proportion of underweight children in developing countries declined from 33 per cent to 28 per cent between 1990 and 2004.³ During this time, the sharpest decline occurred in the East Asia/Pacific region, where prevalence decreased from 25 per cent to 15 per cent. This improvement was primarily driven by gains in China, where underweight prevalence was reduced by more than half; China contributes 59 per cent of the region’s under-five population. South Asia has also made progress, although the current levels clearly remain high. Latin America/Caribbean, too, reduced the prevalence of underweight.

But little improvement has been seen in sub-Saharan Africa, where underweight prevalence remained roughly the same over the 1990–2004 period. In fact, given this lack of progress and due to population growth, the total number of underweight children actually increased in sub-Saharan Africa.

Will the target for MDG 1 be met?

Despite an overall improvement between 1990 and 2004, the present rate of decline in the proportion of underweight children in the developing world is not sufficient to reach the MDG target of reducing hunger by half between 1990 and 2015. The average annual rate of reduction (AARR) stands at 1.7 per cent – and unless that rate improves, 50 million children who could have benefited from adequate nutrition by 2015 will miss out, their very lives at stake.⁴

Latin America/Caribbean, with an AARR of 3.8 per cent, is on track to reach the target, and East Asia/Pacific, with an AARR of 3.6 per cent, has practically already achieved it. Again, the region's progress is primarily driven by China, where underweight prevalence declined from 19 per cent in 1990 to 8 per cent in 2002. Taken without China, however, East Asia/Pacific is not on track to achieve the target.

Both West/Central Africa (1.6 per cent AARR) and South Asia (1.7 per cent AARR) have made progress, although not sufficient to reach the target.

There has been no change in Eastern/Southern Africa, while the situation in the Middle East/North Africa has deteriorated (its AARR is -1.6 per cent). The deterioration in this region is mainly attributable to conditions in three countries – Iraq, Sudan and Yemen – with large populations that have been affected by conflict or natural disasters.

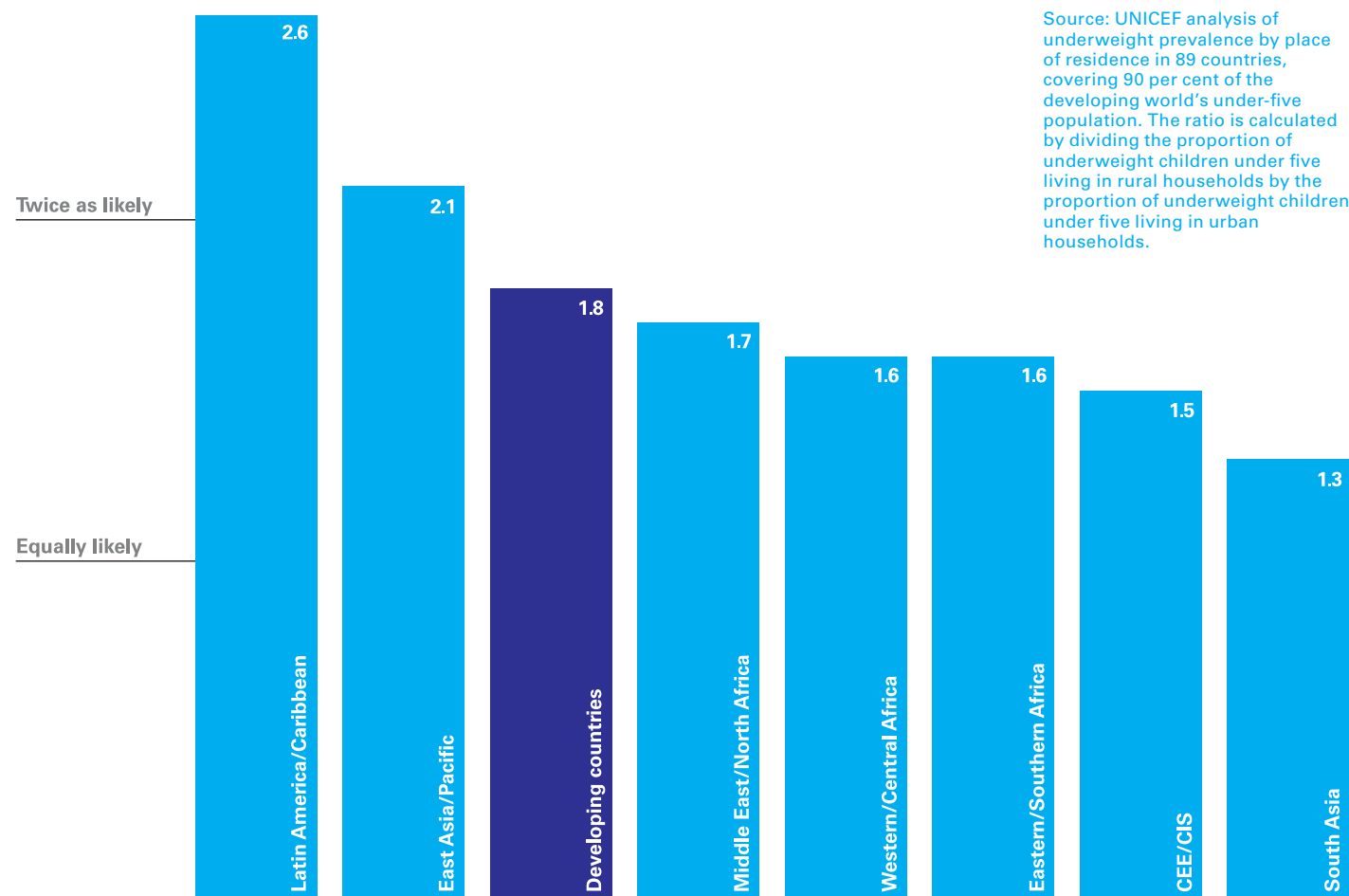
Data are insufficient to track progress for the CEE/CIS region, where levels of undernutrition are generally already low.

It is important to note that tracking progress towards this goal, which has a 1990 baseline, is limited by the fact that many countries did not have data for underweight prevalence in the early 1990s. (Data for this indicator became more widely available in the mid-1990s.) Countries with insufficient data are those with no data or those with only one estimate of underweight prevalence but no trend data. More details on trends within each region, including data on individual countries, are presented on the following pages.

Children in rural areas are nearly twice as likely to be underweight as children in urban areas.

Rural-urban disparities are highest in the Latin America/Caribbean and East Asia/Pacific regions, where children living in rural areas are, respectively, 2.6 times and 2.1 times as likely to be underweight as children living in urban areas.

Indicator: Percentage of children under five who are underweight (moderate and severe); ratio of underweight prevalence among children under five living in rural areas compared to urban areas.



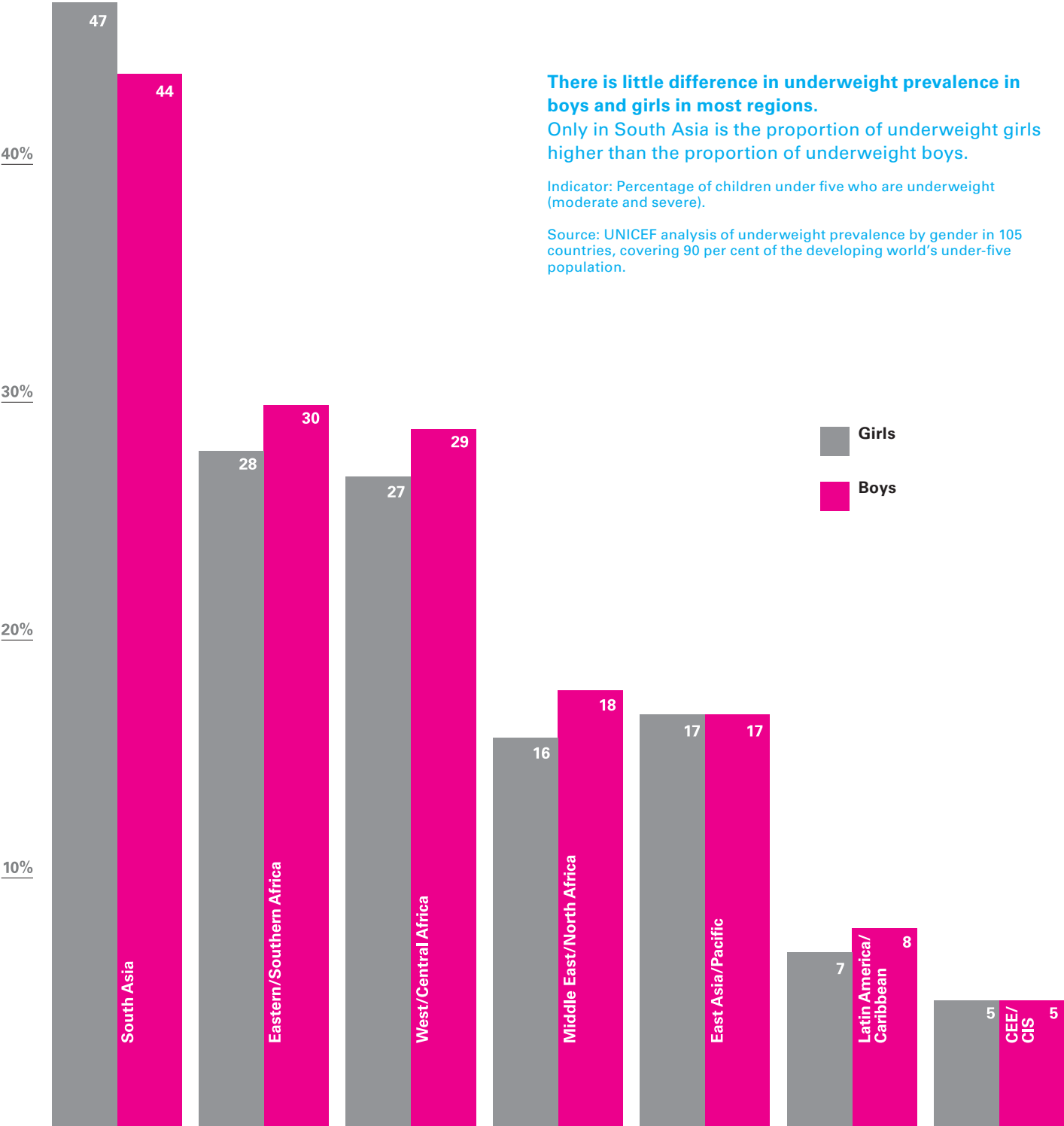
Disparities

Broad overall averages for regions or even for individual countries tend to hide disparities. A country with a low average prevalence of underweight children can have significant pockets of undernutrition in a particular geographical area or among certain population subgroups.

Disaggregated statistics indicate large disparities between children living in rural areas and children living in urban areas (see chart on page 7). On average, children’s underweight prevalence in rural areas is almost double that for their urban counterparts.⁵ But high underweight prevalence in urban slums in many developing countries still gives cause for concern.

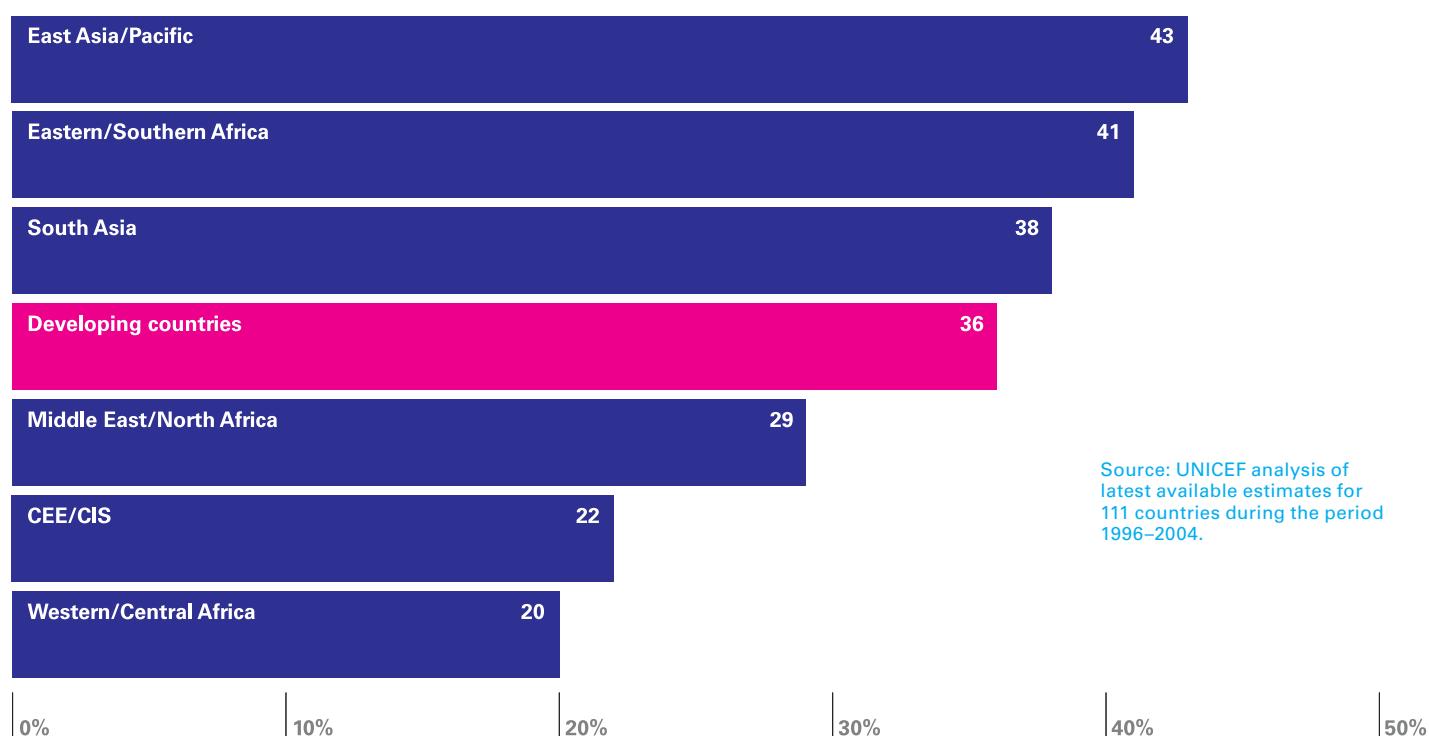
Significant disparities also exist between household asset quintiles, and on average, children living in the poorest households are twice as likely to be underweight as children living in the richest households.⁶ The greatest disparities between rich and poor are found in Latin America/Caribbean, where children living in the poorest households are 3.6 times more likely to be underweight than children from the richest households. The lowest disparities are found in East Asia/Pacific, followed by CEE/CIS and sub-Saharan Africa.

In terms of gender disparities, boys and girls have a similar underweight prevalence in every region except South Asia.⁷ In South Asia, 47 per cent of girls are underweight compared to 44 per cent of boys.



One out of every three children is exclusively breastfed for the first six months of life in the developing world. East Asia/Pacific and Eastern/Southern Africa are the regions with the highest levels of exclusive breastfeeding in the first six months of life, while CEE/CIS and West/Central Africa have the lowest levels.

Indicator: Percentage of infants exclusively breastfed for the first six months of life.



OTHER NUTRITION INDICATORS

Low birthweight

More than 20 million infants are born each year weighing less than 2,500 grams (5.5 pounds), accounting for 17 per cent of all births in the developing world – a rate more than double the level in industrialized countries (7 per cent).⁸ Infants with low birthweight are at higher risk of dying during their early months and years. Those who survive are liable to have an impaired immune system and may suffer a higher incidence of such chronic illnesses as diabetes and heart disease in later life.

More than 96 per cent of low birthweight occurs in the developing world, reflecting the higher likelihood of these babies being born in poor socio-economic conditions, where women are more susceptible to poor diet and infection and more likely to undertake physically demanding work during pregnancy.⁹ It reflects, further, a generational cycle of undernutrition, the consequences of which are passed along to children by mothers who are themselves in poor health or undernourished.

There is significant variation in the incidence of low birthweight across regions. South Asia has the highest incidence, with 31 per cent of all infants with low birthweight, while East Asia/Pacific has the lowest, at 7 per cent. India is home to nearly 40 per cent of all low-birthweight babies in the developing world. In sub-Saharan

Africa 14 per cent and in the Middle East/North Africa 15 per cent of infants are born with low weight.

Reliable monitoring of this vital indicator is difficult, however, given that 58 per cent of all infants in the developing world are not weighed at birth. This proportion is highest in South Asia (74 per cent) and sub-Saharan Africa (65 per cent).¹⁰

Trend analysis is also difficult due to the lack of comparable estimates over time, both within and between countries. However, an analysis of limited trend data indicates that the incidence of low birthweight remained roughly constant between 1990 and 2000 in both sub-Saharan Africa and Asia.¹¹

Exclusive breastfeeding

Human milk is the ideal nourishment for infants' survival, growth and development. Exclusive breastfeeding in the first six months of life stimulates babies' immune systems and protects them from diarrhoea and acute respiratory infections – two of the major causes of infant mortality in the developing world – and improves their responses to vaccination. Particularly in unhygienic conditions, breastmilk substitutes carry a high risk of infection and can be fatal in infants. Yet only slightly more than one third of all infants in developing countries are exclusively breastfed for the first six months of life.

Considerable variation exists across regions. The highest rates are currently found in East Asia/Pacific (43 per cent) and Eastern/Southern Africa (41 per cent), and the lowest in West/Central Africa (20 per cent) and CEE/CIS (22 per cent).¹²

But although percentages continue to be low across the developing world, trend data indicate that exclusive breastfeeding rates have improved: Between 1990 and 2004 this figure rose from 34 per cent to 41 per cent.¹³ In sub-Saharan Africa, the rate over the same period doubled, from 15 per cent to 32 per cent. West/Central Africa made noteworthy progress as the exclusive breastfeeding rate rose more than fivefold. African countries that have made major strides in exclusive breastfeeding since 1990 include Burkina Faso, Cameroon, Ghana, Madagascar, Mali, Nigeria, Senegal, the United Republic of Tanzania, Zambia and Zimbabwe.

Exclusive breastfeeding rates in South Asia and the Middle East/North Africa also improved between 1990 and 2004, from 43 per cent to 47 per cent and from 30 per cent to 38 per cent, respectively. Rates remained roughly constant in East Asia/Pacific during this time. There were insufficient data to calculate trends for CEE/CIS and Latin America/Caribbean (regional trend estimates are provided only if the available data cover 50 per cent or more of births).

Iodized salt consumption

An iodine-deficient diet results in insufficient thyroid hormone production, which can prevent normal growth in the brain and nervous system and lead to poor school performance, reduced intellectual ability and impaired work capacity. Iodine deficiency is particularly damaging during early pregnancy and childhood, yet it is easily preventable through the iodization of salt.

In 1990, few developing countries had large-scale salt-iodization programmes, and fewer than one in five households were estimated to consume adequately iodized salt. As a result, about 1.7 billion people, or 32 per cent of the developing-world population, lived at risk of iodine deficiency disorders (IDD).¹⁴

The campaign to eliminate iodine deficiency through universal salt iodization has succeeded in boosting the proportion of developing-world households that consume iodized salt to 69 per cent – and 82 million newborns are now being protected every year from IDD-caused learning disabilities.

Yet large differences in levels of iodized salt consumption exist among regions. The highest levels are recorded in Latin America/Caribbean (86 per cent) and East Asia/Pacific (85 per cent); in sub-Saharan Africa 64 per cent of households consume iodized salt. The lowest level (47 per cent) is recorded in CEE/CIS. The current round of Multiple Indicator Cluster Surveys (MICS) will update information on iodized salt consumption and is expected to document significant improvements, particularly in CEE/CIS.

In 33 countries, less than half of households consume iodized salt, and each year 37 million newborns in the developing world are unprotected from the lifelong consequences of brain damage associated with IDD.

Vitamin A supplementation

Vitamin A is essential for immune system functions and the survival, growth and development of children. The provision of high-dose supplements every four to six months has a dramatic impact on the health of children aged 6–59 months, reducing the risk of mortality by up to 23 per cent.¹⁵

The overall coverage rate for vitamin A supplementation to children 6–59 months old in the developing world stood at 61 per cent in 2003. Coverage is higher than average (76 per cent) in the least-developed countries, where the need is inevitably greatest. South Asia has the lowest rate of supplementation, at 58 per cent, and East Asia/Pacific (excluding China) the highest, at 73 per cent. West/Central Africa has a coverage rate of 60 per cent, and Eastern/Southern Africa reaches 68 per cent of the children targeted. Data are insufficient to provide an overall coverage rate in CEE/CIS, Latin America/Caribbean and the Middle East/North Africa.¹⁶

Although many countries have not been able to assess the true level of vitamin A deficiency due to technical and financial constraints, an estimated 100 million to 140 million children are afflicted by this hidden hunger. Most of these children live in the least developed areas of South Asia and sub-Saharan Africa.¹⁷ Recent estimates show that more than 43 million children in sub-Saharan Africa are at risk of vitamin A deficiency.¹⁸

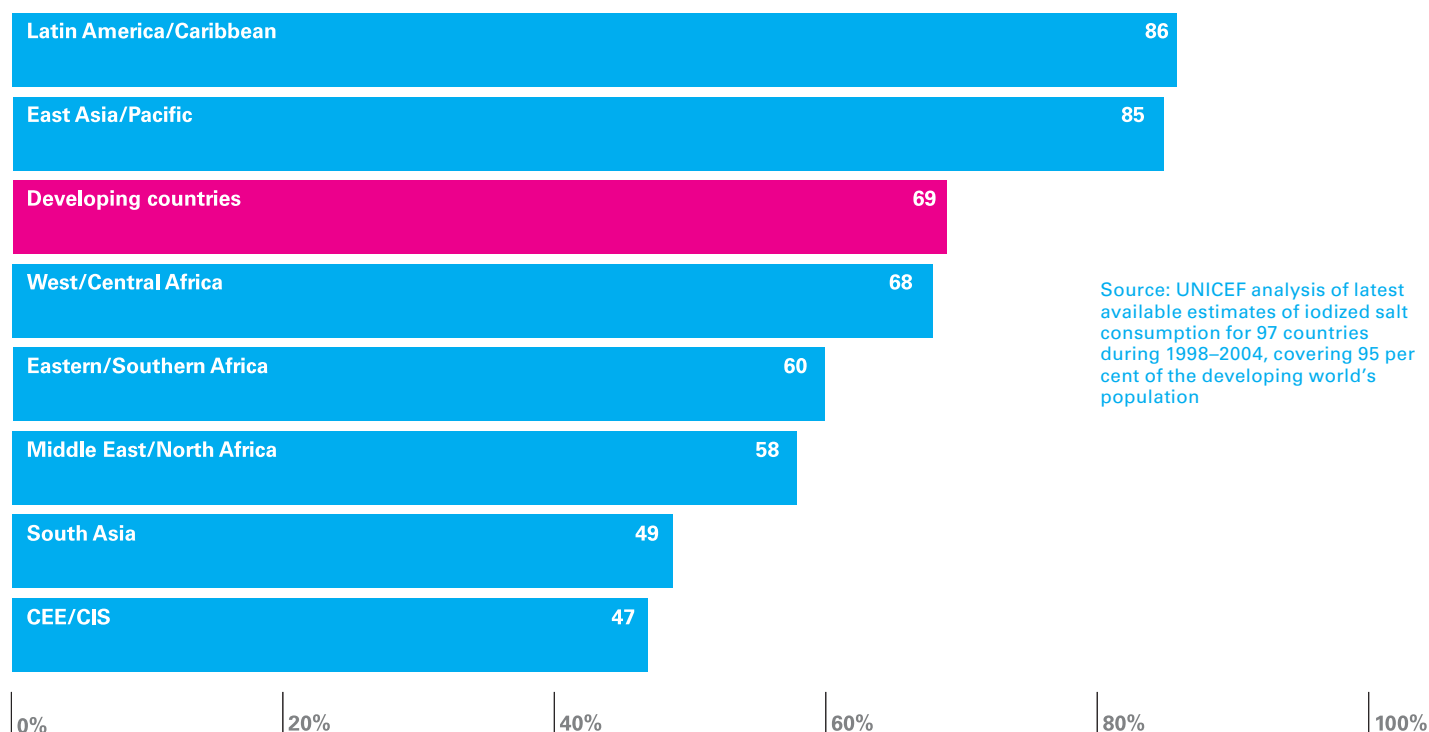
Iron deficiency and anaemia

Around two billion people worldwide suffer from anaemia,¹⁹ most commonly iron-deficiency anaemia, a major cause of maternal deaths and of cognitive deficits in young children; it can permanently affect later motor development and school performance. Anaemia also has a negative impact on the economic well-being of individuals, families and national economies. The UN Standing Committee on Nutrition (SCN) has estimated that the economic costs of anaemia in Bangladesh, for example, amount to 7.9 per cent of the country's gross domestic product.²⁰

Iron supplementation reduces iron-deficiency anaemia in pregnant and lactating women, but programmes have been largely unsuccessful so far, not least because they have tended to reach women too late in their pregnancy. Anaemia and iron deficiency are also very prevalent in young children, yet few countries have significant, large-scale programmes to address these conditions. As a result there has been no evidence of significant improvement in the global incidence of anaemia during the past 15 years.²¹ Flour fortification and iron supplementation programmes are being stepped up with partner support.

Two out of three households consume iodized salt in the developing world. The regions of Latin America/Caribbean and East Asia/Pacific have nearly achieved the goal of universal salt iodization. Yet only half of households in the CEE/CIS and South Asia regions consume iodized salt.

Indicator: Percentage of households consuming adequately iodized salt (15 parts or more per million).



NUTRITION IN EMERGENCIES

In the aftermath of all emergencies, undernutrition runs rampant, exponentially increasing children's risk of disease and death. In most situations, children's baseline nutrition is poor even before the crisis exacerbates such underlying factors as food insecurity, limited access to essential health services, unhealthy environments, and poor feeding and care practices. Consequently, the limited nutritional stores of young children are soon depleted after emergencies. Micronutrient deficiencies, particularly of iron, vitamin A and iodine, are frequently a major public health threat.

To promote access to essential, quality health and nutrition services in the immediate onset of acute emergencies and beyond, UNICEF has agreed on an essential set of interventions, the Core Commitments for Children. These include rapid nutrition assessments; measles immunization accompanied by vitamin A supplementation; fortified foods and micronutrient supplements; support for breastfeeding and complementary feeding for infants and young children; therapeutic and supplementary feeding in collaboration with the World Food Programme and non-governmental organizations; support for nutrition monitoring and surveillance; and provision of nutrition education and counselling, including messages on the importance of breastfeeding.

Major advances have been made during the past decade in the way the international community responds to the health and nutrition consequences of complex emergencies. The public health and clinical response to diseases of acute epidemic potential has improved, especially in camps, and fatality rates for severely undernourished children have plummeted.

A Humanitarian Response Review commissioned by the UN Office for the Coordination of Humanitarian Affairs in August 2005 recommended assigning responsibilities by sector to lead organizations and the clustering of partners for improved emergency preparedness and response. UNICEF has been asked to lead the nutrition cluster.

Amid the human drama of conflict and natural disasters, public attention and relief efforts tend to focus – rightly – on children. But the numbers of children who succumb in emergencies is small compared with the millions of undernourished children each year who fall ill and die in a 'silent' emergency of undernutrition, outside the focus of international concern.²²

South Asia has staggeringly high levels of underweight – 46 per cent of its children – and India, Bangladesh and Pakistan together account for half the world’s underweight children, despite being home to just 29 per cent of the developing world’s under-five population.

In the region as a whole there has been some progress. Underweight prevalence has declined from 53 per cent in 1990 at an average annual rate of 1.7 per cent. Improvement at this modest level will be insufficient to meet the MDG target by 2015, although there is a wide divergence between the performance of individual countries in the region. Afghanistan, Bangladesh, Bhutan, Maldives and Sri Lanka are all on track to halve the proportion of under-fives who are underweight by 2015.

In Bangladesh, underweight prevalence declined from 66 per cent to 48 per cent between 1990 and 2004, though this still leaves the proportion of underweight children higher than in any other country in the region bar Nepal. Bhutan managed to reduce its underweight prevalence by half in about 10 years: from 38 per cent in 1988 to 19 per cent in 1999. Afghanistan and Maldives have also made significant

underweight²³ and therefore at risk of delivering babies with low birthweight.

While most infants in the region are initially breastfed, only 38 per cent are exclusively breastfed for the first six months of life. Again, there is wide variation between individual countries, ranging from 84 per cent of babies exclusively breastfed in Sri Lanka to just 10 per cent in the Maldives.

Iodine deficiency disorders remain a major problem, and in the region only half of households are consuming iodized salt. Examples of progress include Bhutan, which has become the first country in the region to attain the goal of universal salt iodization.²⁴ Significant efforts have also been made in Bangladesh, Nepal and Sri Lanka.

Considerable advances have been made during the past decade in reducing vitamin A deficiency through supplementation. Afghanistan, Bangladesh, Nepal and Pakistan, for example, have reached more than 85 per cent of their target population – children between the ages of 6 months and 5 years – with two doses of vitamin A supplements per year.

SOUTH ASIA: HALF THE WORLD'S UNDERWEIGHT CHILDREN

progress: Afghanistan from 49 per cent in 1997 to 39 per cent in 2003–2004; Maldives from 39 per cent in 1994 to 30 per cent in 2001.

Both India and Pakistan are making modest improvements, but this progress is currently insufficient to reach the target. Nepal, however, has not made much progress in reducing underweight prevalence during the 1990s.

Other forms of undernutrition in South Asia have persisted at high levels and have proved stubbornly resistant to improvement – 44 per cent of under-fives in the region are stunted and 15 per cent are wasted.

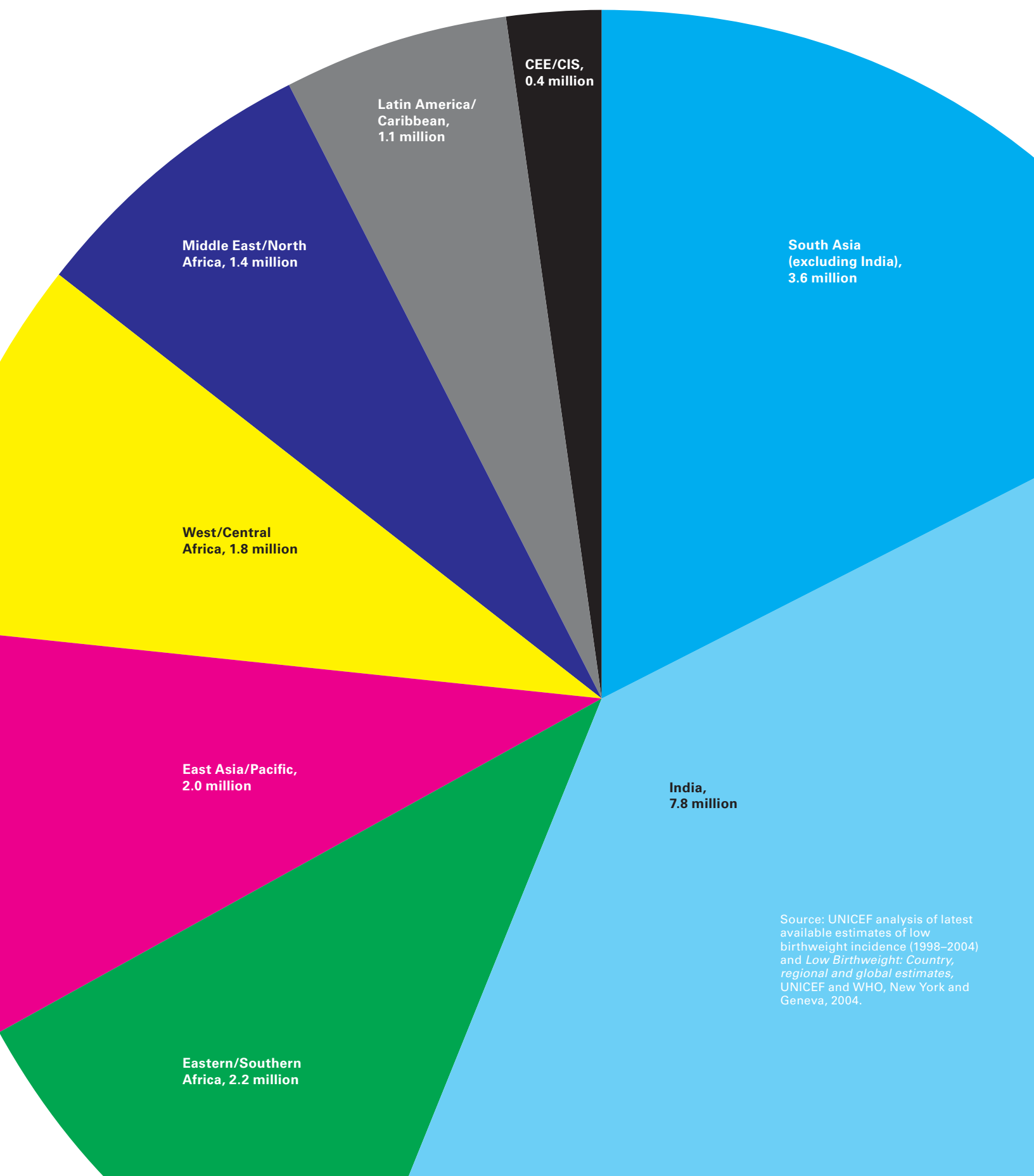
In many South Asian countries, chronic conditions of energy-deficient diets and lack of access to safe sanitation are compounded by the poor educational and social status of women. Girls, like women, also suffer from gender discrimination – South Asia is the only region in the world in which girls are more likely to be underweight than boys. In India, one out of every three adult women is

Outside Sri Lanka, in most countries of the region nearly half or more of women of reproductive age are anaemic,²⁵ and anaemia prevalence among preschool children throughout the region has not dropped to below 50 per cent for more than two decades.²⁶

In Pakistan, food security and nutrition surveys undertaken shortly after the October 2005 earthquake showed that the immediate nutritional status of children under five had not declined. Even the highest levels of wasting found in areas surveyed were below the national average of 13 per cent. Pakistan benefited from a new approach to humanitarian coordination involving the Government of Pakistan, non-governmental organizations and UN agencies, piloted under the UN Inter-Agency Standing Committee (IASC) mechanism.²⁷

Of the estimated more than 20 million low-weight births each year in the developing world, more than half occur in South Asia and more than one third in India. Contributing to the problem is that only one in four births is weighed in South Asia, making it the region with the largest proportion of unweighed births.

Indicator: Percentage of infants with low birthweight (less than 2,500 grams).



Source: UNICEF analysis of latest available estimates of low birthweight incidence (1998–2004) and *Low Birthweight: Country, regional and global estimates*, UNICEF and WHO, New York and Geneva, 2004.

The Eastern/Southern Africa region as a whole, far from making progress towards the MDG target of reducing hunger by half, has shown no improvement at all since 1990 in the proportion of children who are underweight. The absolute number of underweight children has actually increased in the region over the past 15 years.

This is due mainly to declines in agricultural productivity, recurring food crises associated with drought and conflict, and increasing levels of poverty. At the same time, HIV/AIDS, especially when coupled with drought-related food crises, has posed serious challenges to nutrition development, particularly in the southern African countries of Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe. Positive trends seen in the early 1990s have been slowed or reversed, with, for example, Lesotho and Zimbabwe showing increased levels of underweight and Zambia experiencing no change over the 1990–2004 period.

In regional terms, the main positive indicator is the increased rate of exclusive breastfeeding in the first six months of life. Eastern/Southern Africa has, at 41 per cent, a higher rate of exclusive breastfeeding than any other region except East Asia/Pacific.

surviving children, and undernutrition accelerates HIV disease progression – and therefore mortality rates.

In Eritrea, Kenya, Malawi, Mozambique, Namibia, Rwanda and the United Republic of Tanzania, steady progress is being made, but not sufficient to meet the MDG target. Of these countries, Eritrea has the highest proportion of underweight children: 40 per cent.

South Africa, the wealthiest country in the region, has a lower proportion of underweight children than any other nation except Swaziland – 12 per cent. Far from there being any room for complacency, however, South Africa has been going backwards, with its proportion of underweight children rising by an average of 5.6 per cent a year since 1994–1995. South Africa also has by far the region's lowest prevalence of exclusive breastfeeding, with only 7 per cent of children benefiting from this life-saving practice during their first six months of life.

In Ethiopia, almost half of children are underweight, and along with Nigeria (from the West/Central Africa region) it accounts for more than a third of all underweight children in sub-Saharan Africa. Like the region as a whole, Ethiopia is standing still – its proportion of underweight children

EASTERN/SOUTHERN AFRICA: AT AN IMPASSE

Of the 17 countries in this region with sufficient trend data to assess progress towards the MDG target, only Botswana is on track to reach the target, and 9 countries are either showing no change or getting worse.

Botswana's achievement is remarkable given the dire effects of the AIDS pandemic on the country – after Swaziland, it has the highest adult HIV prevalence rate in the world, at 37 per cent (39 per cent in Swaziland).²⁸ In these circumstances, Botswana's progress in reducing underweight prevalence is significant – it dropped from 17 per cent in 1996 to 13 per cent in 2000.

There are insufficient data to estimate whether Swaziland will achieve the MDG target, but it is noteworthy that it not only has a lower proportion of underweight children (10 per cent) than any other country in the region but has also reduced the proportion of under-fives who suffer from wasting to just 1 per cent.

Given the synergies between undernutrition and HIV in children, however, such results need to be interpreted with caution. Underweight prevalence is measured among

has remained more or less static since 1990 – so without an extraordinary push it is unlikely to achieve the MDG target. Ethiopia also has the lowest coverage of iodized salt, with only 28 per cent of households benefiting.

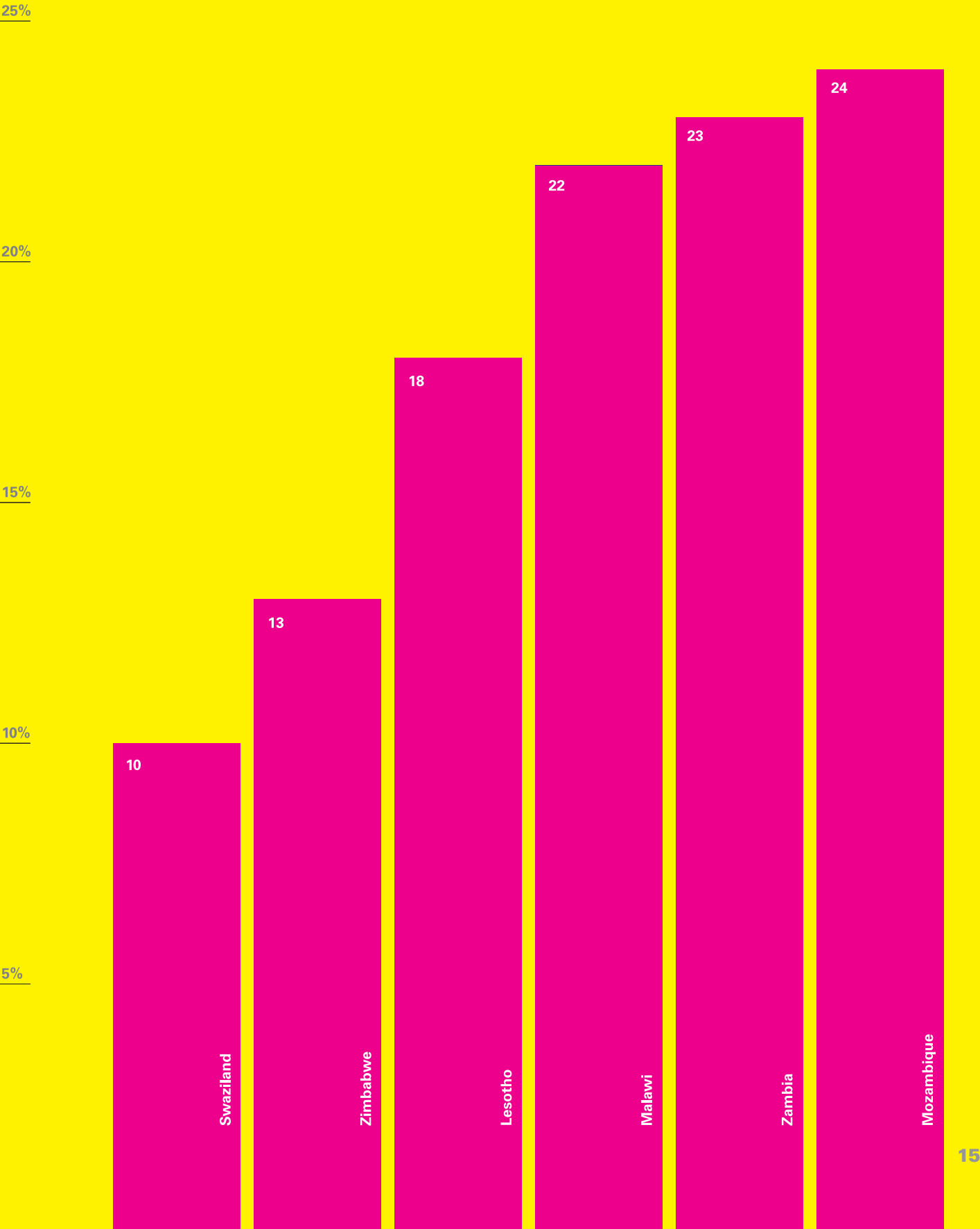
Underweight in Burundi and Madagascar exceeds 40 per cent of under-fives, with no sign of improvement. Burundi has, at 57 per cent, a much higher rate of stunting than any other country in the region. Somalia, meanwhile, has the highest rate of wasting in Eastern/Southern Africa: 17 per cent.

The profound impact of HIV/AIDS in the region inevitably affects its nutritional position, although the pandemic's relationship to undernutrition is complex. A 2003 study in six southern African countries affected by drought, for example, found that levels of underweight in children increased more rapidly in relatively prosperous communities close to urban centres than in other areas due to the high prevalence of HIV/AIDS; it suggests a new vulnerability in areas once thought to be better off.²⁹

Underweight prevalence in six southern African countries, where drought and HIV/AIDS have combined to the detriment of children's nutritional status. One out of five children in Malawi, Mozambique and Zambia is underweight, and the proportion of underweight children in Lesotho and Zimbabwe was higher in 2004 than in 1990. Swaziland has a child underweight prevalence rate of 10 per cent and the highest rate of adult HIV prevalence in the world.

Indicator: Percentage of children under five who are underweight (moderate and severe).

Source: UNICEF analysis of latest available estimates of underweight prevalence (1999–2003).



West/Central Africa – the region with the highest under-five mortality rate in the world – has managed to make some progress since 1990 in reducing the prevalence of underweight among its children. Its AARR is 1.6 per cent. But this progress is insufficient for the region as a whole to reach the MDG target.

As in all regions, there is wide variation in the position of individual countries, with five countries – Benin, Congo, Côte d'Ivoire, the Gambia and Mauritania – on track to meet the MDG target, a further seven that are improving, though not fast enough to meet the goal, and five that are either unchanged or in decline. There were insufficient data to measure progress in seven other countries.

Of the five countries on track, Congo has the lowest proportion of underweight children in the region, at 14 per cent. This progress could be enhanced if more infants were exclusively breastfed in the first six months of life. As it stands, only 4 per cent of Congolese children receive this substantial nutritional benefit.

In the Gambia, the proportion of underweight children has been brought from 26 per cent in 1996 down to 17 per cent in 2000. The country's coverage with vitamin A

Burkina Faso's high rate of vitamin A supplementation – 95 per cent. Cameroon has been going backwards at a rate of 2.3 per cent a year, though it still has among the lowest rates of children's underweight in the region.

The children of Sierra Leone are also in dire need of improved nutrition – the country has the highest under-five mortality rate in the world, at 283 per 1,000 live births. A major contributing factor is the high proportion of low-birthweight infants (23 per cent) and the low proportion of infants exclusively breastfed (4 per cent).

It is encouraging that there have been significant and sustained increases in exclusive breastfeeding in West/Central Africa, where levels increased nearly fivefold between 1990 and 2004. Ghana, for example, experienced a huge increase – from 4 per cent in 1988 to 53 per cent in 2003.

But with only 20 per cent of infants exclusively breastfed in West/Central Africa, rates continue to be lower here than in any other region. They are remarkably low in Côte d'Ivoire (5 per cent), Congo and Sierra Leone (both 4 per cent), Chad (2 per cent) and Niger (just 1 per cent). The only countries in the region in which more than half of infants

WEST/CENTRAL AFRICA: SLOW PROGRESS

supplementation is high, at 91 per cent, although there is still substantial room for improvement in its levels of exclusive breastfeeding and salt iodization.

The countries that are improving, although not fast enough to meet the MDG target, are the Democratic Republic of the Congo, Ghana, Guinea, Mali, Nigeria, Senegal and Togo. Nigeria, by far the most populous country in the region, is improving at a rate of 2.2 per cent a year. Its proportion of underweight children – 29 per cent – dominates the regional statistics. Nigeria's rates of exclusive breastfeeding (17 per cent) and vitamin A supplementation coverage (27 per cent) are notably low. On the positive side, Nigeria has become the first country in the region to attain universal salt iodization (97 per cent).

The countries that have stayed the same or deteriorated in terms of children's nutrition since 1990 are Burkina Faso, Cameroon, the Central African Republic, Niger and Sierra Leone. Burkina Faso and Niger have the highest rates of underweight in West/Central Africa and as such can ill afford to make such minimal progress towards the MDG target. Some measure of optimism can be derived from

are exclusively breastfed for the first six months are Ghana, Cape Verde and Sao Tome and Principe.

For children and women in the region, anaemia remains a major threat. A number of countries have conducted national surveys that show unacceptable rates of anaemia in children and their mothers.³⁰

The regional prevalence of wasting in children is 10 per cent, indicating that the nutrition status of children is of serious concern. Moreover, this average hides significant disparities. Wasting rates in under-fives are worrisome in the Sahelian countries – Burkina Faso, Chad, Mali, Mauritania and Niger – and range from 11 per cent to 19 per cent, affecting more than 1 million children. Programme experience in response to the Niger nutrition crisis in 2005 allowed for the admission of more than 300,000 children into UNICEF-supported therapeutic and supplementary feeding programmes through collaborative work with the Government of Niger, the World Food Programme and 24 NGOs, along with facility-based and community-based care and feeding schemes.³¹



Some countries of West/Central Africa have made stunning improvements in the rate of exclusive breastfeeding of infants in the first six months of life. Exclusive breastfeeding rates in the region increased fivefold – from 4 per cent to 22 per cent – during the period 1990–2004, with similar improvements in individual countries. Yet the region posts the lowest rate of exclusive breastfeeding in the developing world.

Indicator: Percentage of infants exclusively breastfed for the first six months of life.

c. 1990
c. 2004

Source: UNICEF analysis of available trend data for countries in West/Central Africa. The analysis covers 68 per cent of total births in the region. Trend estimates will differ slightly from estimates of current breastfeeding levels.

The good news in the Middle East/North Africa is that six countries in the region are on track to meet the MDG target. What is more, 12 countries have underweight prevalence rates of 10 per cent or below, approaching levels common in the industrialized world.

But the region as a whole has gone backwards since 1990 in terms of child nutrition. It has an AARR of -1.6 per cent, with the proportion of underweight children increasing during 1990–2004. Regional statistics have effectively been dragged down by the plight of children in three particularly populous countries: Iraq, Sudan and Yemen.

Forty-six per cent of all children in Yemen are underweight, and since 1990, the situation has gotten worse – the AARR of -3.6 per cent reflects an increase in underweight levels from 30 per cent in 1991–1992. An estimated 53 per cent of Yemeni under-fives are now stunted and 32 per cent of babies are born with low weight.

In Sudan, 41 per cent of children are underweight and 31 per cent of infants have low birthweight. Sudan has a

legacy of poor feeding practices that will be difficult to reverse.

Beyond these three countries there is cause for considerable optimism, with Djibouti, Jordan, the Occupied Palestinian Territory (OPT), Oman, the Syrian Arab Republic and Tunisia all on track to meet the MDG target. OPT, the Syrian Arab Republic and Tunisia are the fastest-improving in the region. OPT has reduced underweight prevalence among children under five by an average of 5.3 per cent per year and ranks with Jordan and Qatar in having reduced the prevalence of stunting in children to less than 10 per cent. Tunisia has achieved universal salt iodization.

Including Iraq, Sudan and Yemen, six countries are not on course to meet the MDG target (see map). Underweight prevalence in Algeria, Egypt and Morocco is 10 per cent or lower, but the rate of progress in these countries is insufficient to reach the MDG target.

It is often presumed that undernutrition will improve with economic growth and development, but this is not always

MIDDLE EAST/NORTH AFRICA: LARGE COUNTRIES SLIPPING BACK



higher proportion of wasted children (16 per cent) than any other country in the region, and a mere 1 per cent of its households consume iodized salt. The nutritional status of Sudanese children, particularly in the south, has been adversely affected by civil war.

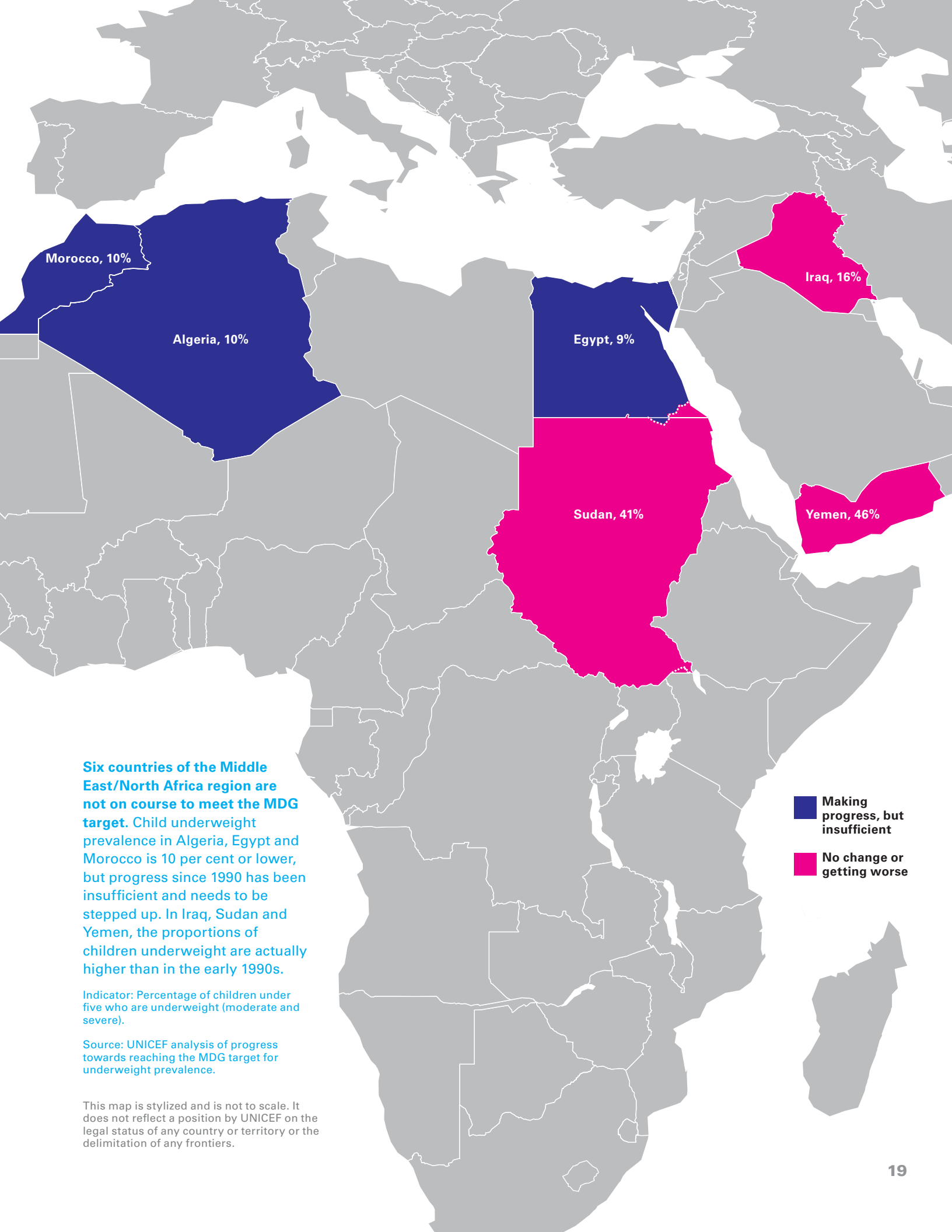
Iraq has also been dominated by conflict. Following the 1991 war, mushrooming rates of undernutrition and child mortality reached a peak in mid-decade and then dropped. Preliminary figures from a UNICEF-supported survey of child nutrition in Iraq carried out in 2002 show that wasting and underweight were at less than half the levels of 1996, while stunting had fallen by nearly 30 per cent during the same period.³²

Nevertheless, the proportion of children underweight in Iraq is still substantially higher than in 1990, as is the overall under-five mortality rate. (Data are from 2000.) Levels of exclusive breastfeeding in Iraq are low at 12 per cent; the disruption of breastfeeding by provision of free formula under the Oil for Food Programme has left a

true. Kuwait and the United Arab Emirates, for example, have high gross national incomes (GNI) per capita but show about the same or higher rates of wasting as Yemen, where GNI per capita is low.

Just as there is a wide divergence between the records of individual countries, there are large disparities within the overall figures related to undernutrition in the region. Children in rural areas, for example, are 1.7 times more likely to be underweight than those in urban areas (22 per cent compared with 13 per cent). Children living in the poorest households, moreover, are more than twice as likely to be underweight as children living in the richest households.³³

In the Sudanese province of Darfur, a humanitarian response contributed to reducing the rate of wasting from 22 per cent in September 2004 to 12 per cent in September 2005. The collaboration and complementarity of partners in the response resulted in better coverage, effective case management and local capacity development.³⁴



Six countries of the Middle East/North Africa region are not on course to meet the MDG target. Child underweight prevalence in Algeria, Egypt and Morocco is 10 per cent or lower, but progress since 1990 has been insufficient and needs to be stepped up. In Iraq, Sudan and Yemen, the proportions of children underweight are actually higher than in the early 1990s.

Indicator: Percentage of children under five who are underweight (moderate and severe).

Source: UNICEF analysis of progress towards reaching the MDG target for underweight prevalence.

This map is stylized and is not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

Making progress, but insufficient

No change or getting worse

The East Asia/Pacific region has all but achieved the MDG target on nutrition, with an AARR of 3.6 per cent. This improvement was driven primarily by gains in the world's most populous country, China, where underweight prevalence was reduced by more than half – from 19 per cent in 1990 to 8 per cent in 2002. If not for China, whose 86 million children under five represent 59 per cent of the region's under-five population, the region would not be on track to achieve the MDG target.

China's impressive lowering of underweight prevalence has contributed to a reduction in its under-five mortality rate from 49 per 1,000 live births in 1990 to 31 in 2004. Its incidence of low birthweight has been reduced to just 4 per cent – a rate comparable to that in industrialized countries – while its proportion of households consuming iodized salt is, at 93 per cent, far higher than in any other of the region's countries.

Averages, however, mask substantial disparities, especially between rural and urban areas, with large numbers of children at risk. Five provinces in China, for example, have not achieved universal salt iodization, leaving 1.5 million newborns unprotected against IDD each year.

Cambodia is currently least likely to reach the MDG nutrition target. The country not only has by far the highest rate of child mortality in the region (141 per 1,000 live births), but its proportion of underweight children grew from 40 per cent in 1993–1994 to 45 per cent in 2000. Furthermore, only 12 per cent of Cambodian babies are exclusively breastfed and only 14 per cent of households consume iodized salt.

Iodized salt coverage has increased in several countries of the region, and several have enacted legislation regulating iodization.³⁵ In the Philippines, for example, improvements in iodized salt production and market availability are translating into increased coverage at the household level. Such recent progress is expected to be confirmed by MICS in 2006, and several countries are expected to achieve universal salt iodization.

The December 2004 tsunami that struck the shores of six countries across the Indian Ocean caused massive destruction and tragic loss of life. In the hardest hit area, the Aceh province of Indonesia, a survey conducted in February–March 2005 showed an average wasting level of 11 per cent among children under five displaced by the tsunami, virtually the same as among children not affected

EAST ASIA/PACIFIC: CHINA LEADS THE WAY

The country with the fastest rate of improvement is Malaysia, where underweight prevalence declined from 25 per cent in 1990 to 11 per cent in 2003. Singapore and Viet Nam are also on track to meet the MDG target, along with Indonesia, the region's second most populous country. Singapore now has the lowest under-five mortality rate in the world, at just 3 per 1,000 live births – lower than all industrialized countries except Iceland.

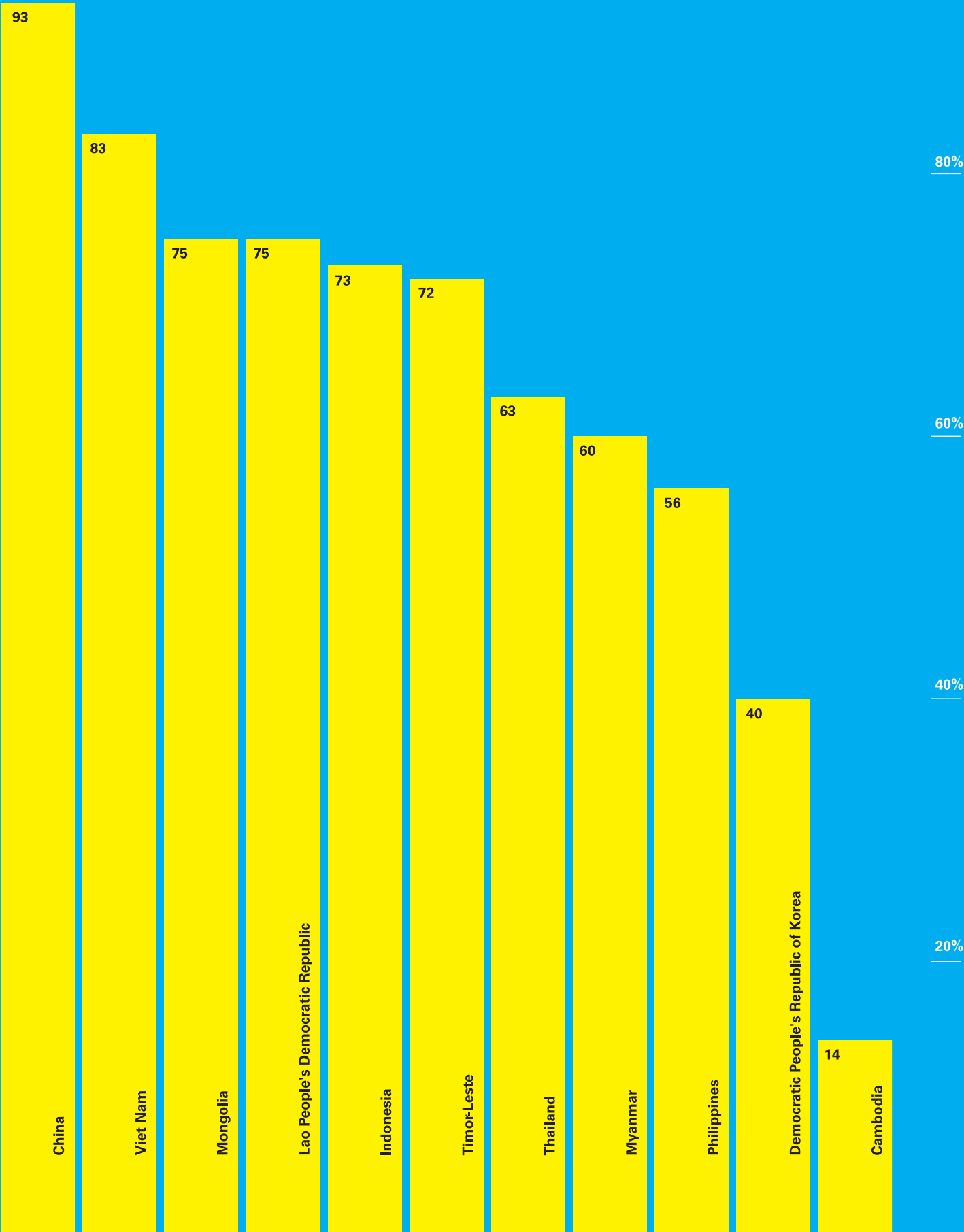
Progress is also being made in the Lao People's Democratic Republic, Myanmar and the Philippines, though it is insufficient at present to meet the MDG target, while Cambodia and Mongolia have stood still or gone backwards. Timor-Leste also gives cause for concern, though the data are insufficient to give a full picture of its progress since independence. The country has the highest proportion of underweight children in the region, at 46 per cent, and fully half (49 per cent) of its children suffer from stunting. Data were insufficient to assess whether the Democratic People's Republic of Korea is on track but the latest available estimate of underweight prevalence is 23 per cent.

and slightly lower than levels seen just after the area was hit. These findings highlighted the fact that poor nutrition is a long-term chronic problem related to poverty, poor nutritional knowledge and practices, and inadequate sanitation and food security. The prevalence of stunting among children in Aceh is, for example, uncomfortably high at 38 per cent.³⁶

The East Asia/Pacific region has the highest level of household iodized salt consumption in the developing world after Latin America/Caribbean. That success is fuelled by China, where 93 per cent of households consume iodized salt.

Indicator: Percentage of households consuming adequately iodized salt (15 parts or more per million).

Source: UNICEF analysis of latest available estimates of household consumption of adequately iodized salt (2000–2004).



The Latin America/Caribbean region is on track to meet the MDG nutrition target, having reduced underweight in children under five by an average 3.8 per cent every year between 1990 and 2004. This represents faster progress than in any other region and leaves the proportion of underweight children at 7 per cent. The region has the lowest under-five mortality rate in the developing world, at 31 per 1,000 live births. It also has the highest proportion of households consuming iodized salt: 86 per cent.

The encouraging figures should not create the illusion, however, that children in Latin America/Caribbean do not face serious nutritional problems. The region is marked by severe disparities and serious economic and social crises that continue to affect child nutrition. Stunting, which affects 16 per cent of children in the region, and iron-deficiency anaemia are major challenges that will not be solved by 2015.

Some individual countries have made impressive progress in reducing underweight prevalence. Cuba, for example, has reduced its underweight prevalence from 9 per cent to 4 per cent in just four years (1996–2000). Underweight

Ecuador, Honduras, Nicaragua and Trinidad and Tobago are making insufficient progress towards the MDG target, although even here things are improving. Levels of underweight prevalence in Ecuador decreased from 17 per cent in 1987 to 12 per cent in 2000 and in Honduras from 21 per cent in 1987 to 17 per cent in 2001; in Nicaragua from 12 per cent in 1993 to 10 per cent in 2001 and in Trinidad and Tobago from 7 per cent in 1987 to 6 per cent in 2000.

The highest proportion of underweight children is found in Guatemala (23 per cent), but its AARR of 2.7 per cent means the country should reach its target. With 49 per cent of its under-fives being too short for their age, Guatemala also has the region's highest rates of stunting and one of the highest rates in the world. Stunting is prevalent in many areas throughout the region, revealing the tip of an iceberg of prolonged, persistent undernutrition.

While the headline numbers and annual progress rates in Latin America/Caribbean are encouraging, the region has a legacy of inequality and social disparity that is as evident in its record on child nutrition as in other areas of development. A UNICEF rapid nutritional assessment of

LATIN AMERICA/CARIBBEAN: ON TRACK, BUT SEVERE DISPARITIES REMAIN

prevalence in the Dominican Republic dropped from 10 per cent in 1991 to 5 per cent in 2002, in Jamaica from 7 per cent in 1989 to 4 per cent in 2002, and in Peru from 11 per cent in 1991–1992 to 7 per cent in 2000. Chile has the best record on child nutrition in the region, with an underweight prevalence of just 1 per cent and, like Jamaica and several other countries of the region, has achieved universal salt iodization.

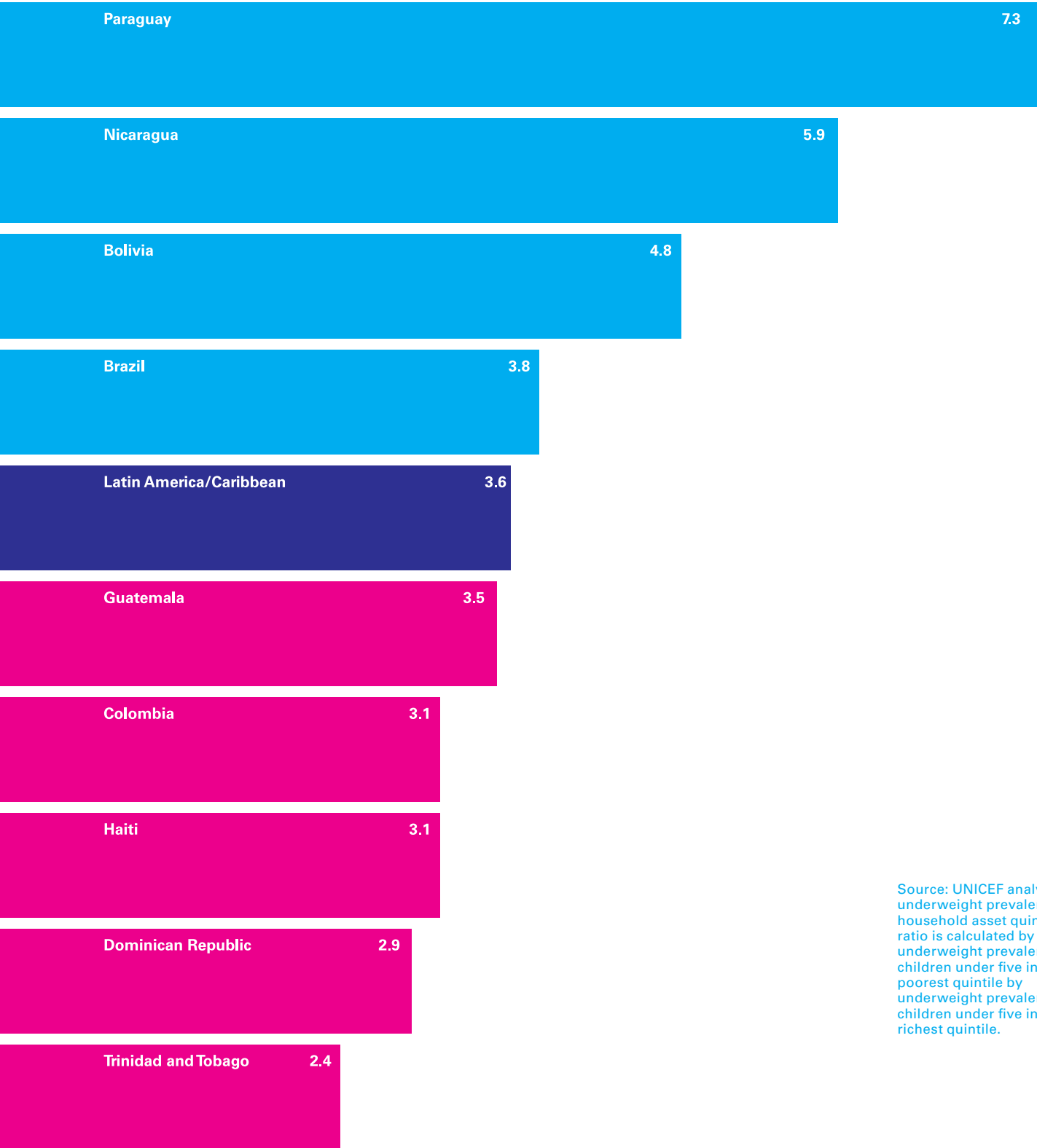
The two most populous countries in the region clearly have a disproportionate impact on regional success rates. Brazil has a relatively low prevalence of underweight children, at 6 per cent, and is thought to be on track to achieve the target of a 50 per cent reduction between 1990 and 2015. (It should be noted, however, that Brazil has not conducted a national-level assessment of child undernutrition levels since 1996.) Mexico has achieved a more spectacular reduction, from 14 per cent in 1988 to 8 per cent in 1998–1999.

Latin America/Caribbean in 2002 revealed that national averages tend to hide the extreme disparities that leave children vulnerable to undernutrition.³⁷ Throughout the region, for example, children living in rural areas are well over twice as likely to be underweight (13 per cent) as children living in urban areas (5 per cent). Children living in rural areas in Bolivia, Honduras, Mexico and Nicaragua are more than twice as likely to be underweight as children living in urban areas. That likelihood doubles to four times in Peru.³⁸

While gender disparities in the region are relatively small, underweight prevalence is 3.6 times more common among children living in poor households than among children living in rich households (based on data from nine countries) – this compares with a global poor-rich ratio of underweight children of 2:1, again underlining the massive disparities within the region.³⁹

Some of the largest disparities in the regions of the developing world are found in Latin America/Caribbean. Children living in the poorest households are 3.6 times as likely to be underweight as children living in the richest households. Poor-rich ratios in Bolivia, Brazil, Nicaragua and Paraguay are even higher.

Indicator: Percentage of children who are underweight (moderate and severe); ratio of underweight prevalence among children under five in the poorest quintiles compared to the richest quintiles.



Source: UNICEF analysis of underweight prevalence by household asset quintile. The ratio is calculated by dividing underweight prevalence in children under five in the poorest quintile by underweight prevalence in children under five in the richest quintile.

Equally likely | Twice as likely | Three times as likely | Four times as likely | Five times as likely | Six times as likely | Seven times as likely | Eight times as likely

Data from Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) are incomplete, so it is unclear whether the region as a whole will meet the MDG target. But several countries with sufficient available data are on track.

Only 5 per cent of children are underweight, a lower proportion than in any other region in the developing world, despite the fact that the under-five mortality rate is marginally higher in CEE/CIS than in Latin America/Caribbean and East Asia/Pacific. All but three countries for which there are data have single-digit percentages of underweight children, while in Croatia and Ukraine the proportion of underweight children has been reduced to just 1 per cent.

Three countries achieved impressive reductions in underweight prevalence: Kazakhstan has reduced its rate from 8 per cent in 1995 to 4 per cent in 1999, Turkey from 10 per cent in 1993 to 4 per cent in 2003, and Uzbekistan from 17 per cent in 1996 to 8 per cent in 2002.

There is still, however, cause for concern about children's nutritional status, as indicated by the proportion of under-fives who are stunted and the problem of micronutrient

deficiencies, or 'hidden hunger', characterized by iodine deficiency and anaemia. Fourteen countries in the region have reported stunting rates of 10 per cent or higher among children under five. In Albania and Tajikistan, over a third of children (34 per cent and 36 per cent, respectively) suffer from stunting, while in Kyrgyzstan, Turkmenistan and Uzbekistan, the figures stand at more than 20 per cent.

The latest regional statistics indicate that CEE/CIS has a smaller proportion of households consuming iodized salt than any other region (47 per cent), but recent progress in this area has been striking – the level is up from percentages that were in the mid-20s in 2000.⁴⁰

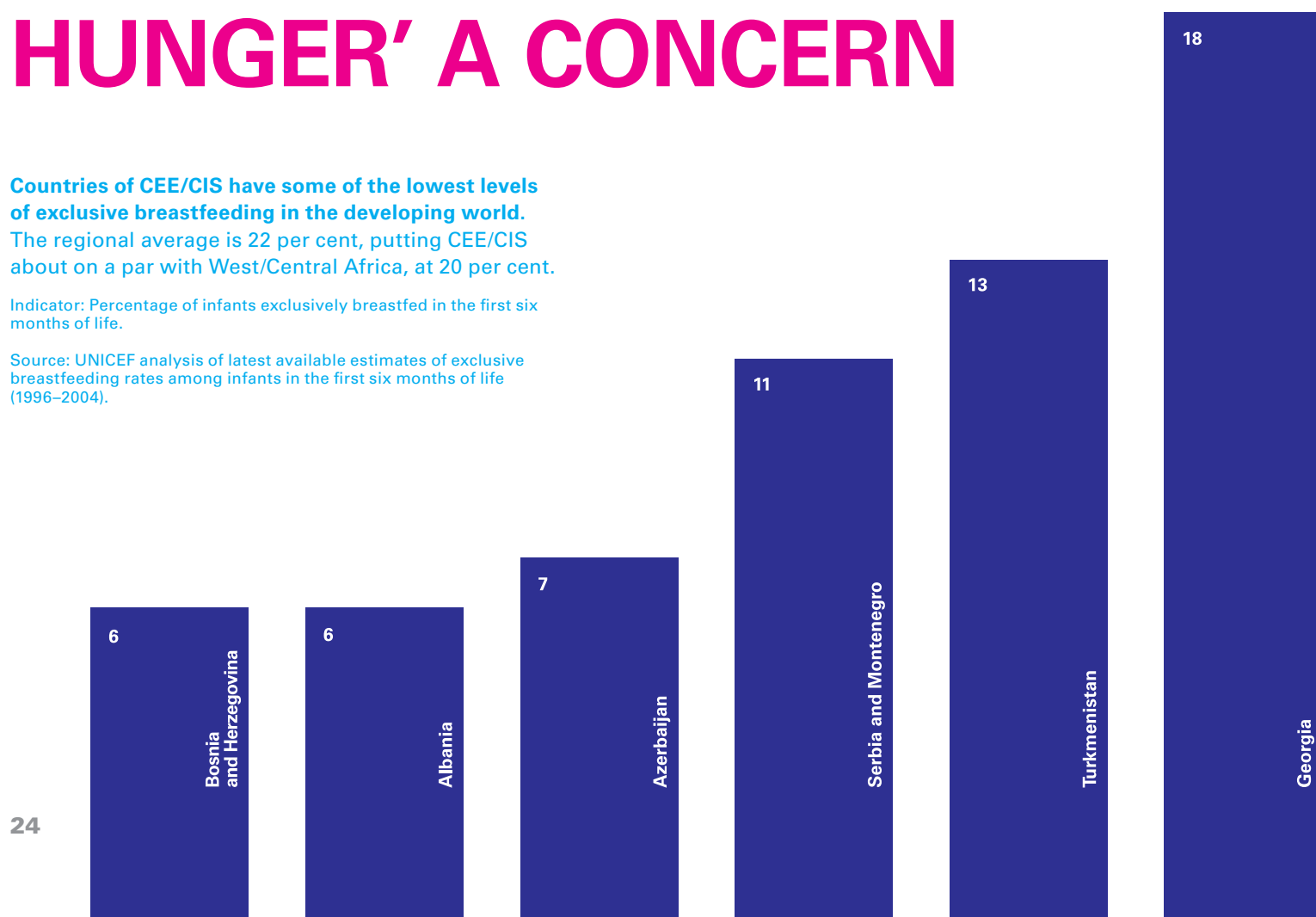
The next round of MICS is expected to confirm that universal salt iodization has been achieved in six countries: Armenia, Bulgaria, Croatia, Serbia and Montenegro, Turkmenistan and the former Yugoslav Republic of Macedonia. The goal is expected to be achieved in 2006–2007 in Azerbaijan, Bosnia and Herzegovina, Georgia, Kazakhstan and Romania, and by 2008 in Albania, Belarus, Kyrgyzstan, the Republic of Moldova, Tajikistan and Turkey. The use of iodized salt in processed foods has been a favourable development in regional efforts to eliminate IDD.

CEE/CIS: 'HIDDEN HUNGER' A CONCERN

Countries of CEE/CIS have some of the lowest levels of exclusive breastfeeding in the developing world. The regional average is 22 per cent, putting CEE/CIS about on a par with West/Central Africa, at 20 per cent.

Indicator: Percentage of infants exclusively breastfed in the first six months of life.

Source: UNICEF analysis of latest available estimates of exclusive breastfeeding rates among infants in the first six months of life (1996–2004).

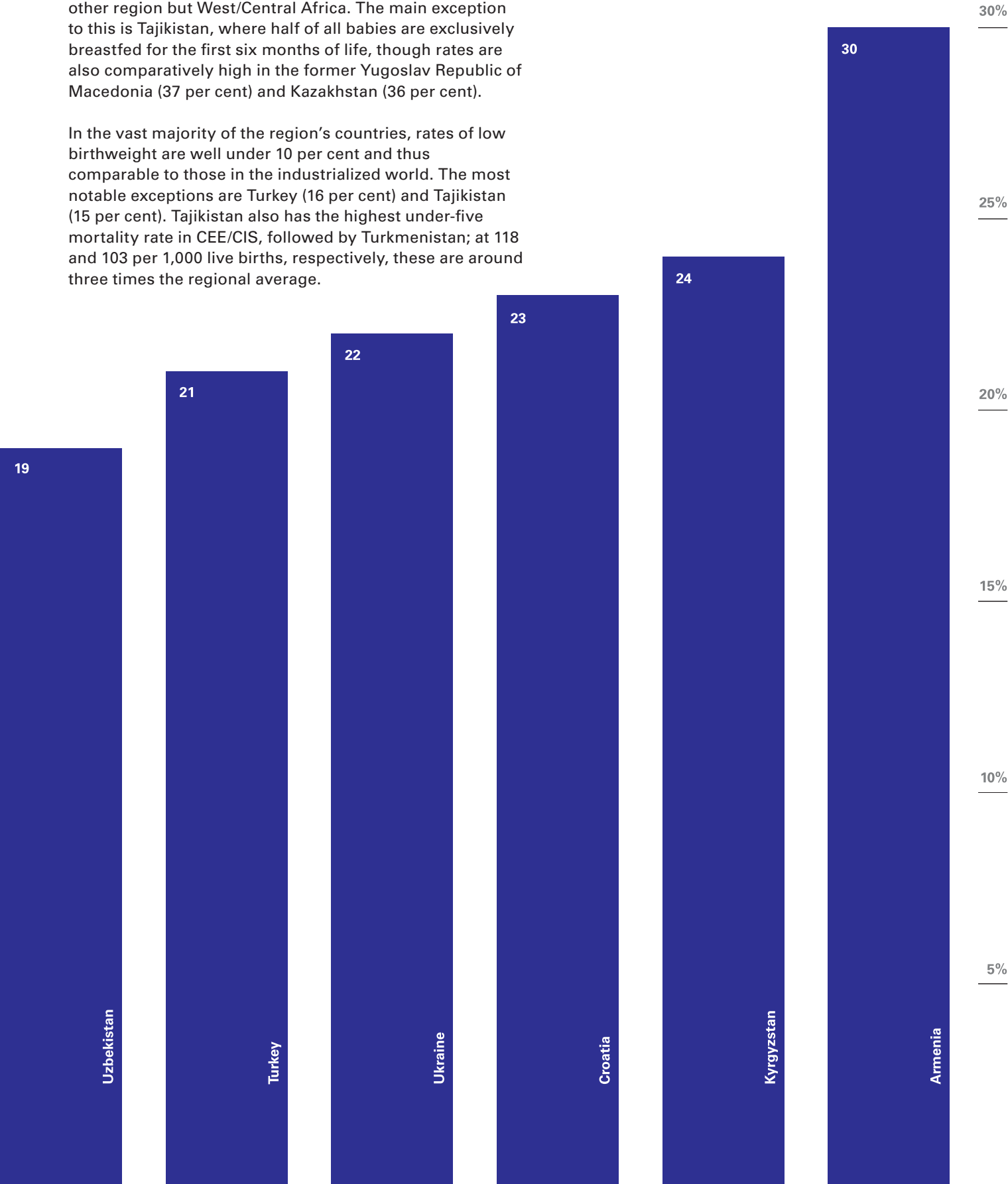


Because of its impact on child mortality, vitamin A deficiency is a concern, especially in Central Asia, where levels among children under five are as high as 27 per cent in Kazakhstan and Tajikistan and 53 per cent in Uzbekistan.⁴¹

Rates of exclusive breastfeeding are generally low in CEE/CIS – the average of 22 per cent is lower than in any other region but West/Central Africa. The main exception to this is Tajikistan, where half of all babies are exclusively breastfed for the first six months of life, though rates are also comparatively high in the former Yugoslav Republic of Macedonia (37 per cent) and Kazakhstan (36 per cent).

In the vast majority of the region’s countries, rates of low birthweight are well under 10 per cent and thus comparable to those in the industrialized world. The most notable exceptions are Turkey (16 per cent) and Tajikistan (15 per cent). Tajikistan also has the highest under-five mortality rate in CEE/CIS, followed by Turkmenistan; at 118 and 103 per 1,000 live births, respectively, these are around three times the regional average.

The region, further, shows disparities between and within countries, stemming from its political, economic, socio-cultural and ecological diversity.



Many industrialized countries collect data on nutritional status, but they analyse these data using a methodology that is not comparable to that used for developing countries. They often report, for example, on mean weights and heights rather than on the percentage below minus two standard deviations from the median weight for age of the standard reference population. The only industrialized country that has figures comparable to those of the developing world is the United States, where 2 per cent of children are underweight, 1 per cent are stunted and 6 per cent are wasted.

Data are available on low birthweight, for which the industrialized average is 7 per cent, on a par with East Asia/Pacific. The lowest incidence of low birthweight in the industrialized world (4 per cent) is registered in Estonia, Finland, Iceland, Lithuania and Sweden.

The low incidence of low birthweight in industrialized countries is clearly a reflection of good maternal nutrition. But the percentage of infants with low birthweight has actually increased in industrialized countries in recent years, a phenomenon attributed to three main causes:

where sustainability of IDD programmes is undermined by complacency.⁴⁶ Universal salt iodization should be as much a priority for these countries as for developing nations.

Data on exclusive breastfeeding are also limited. Rates are typically low in industrialized countries and are improving only slowly in Europe. This is the case in France and the United Kingdom, for example. Recent data from the World Health Organization show that the Netherlands increased its breastfeeding rate in the first four months of life to 23 per cent in 2000–2001 from 12 per cent in 1996–1997; Poland to 29 per cent in 1997 from 13 per cent in 1995 and 2 per cent in 1988; and Sweden to 69 per cent in 1999 from 51 per cent in 1990.⁴⁷ These rates, however, are not comparable with those of developing countries, for which the standard indicator is exclusive breastfeeding for six months.

Malnutrition is an issue in industrialized countries, but it is less likely to result from insufficient food than from unhealthy diets dominated by inappropriate food choices and practices, including foods containing excess dietary energy, fats and refined carbohydrates. Increasing levels of

INDUSTRIALIZED COUNTRIES: DISPARITIES AMID ACHIEVEMENT

increasing numbers of multiple births (due to use of fertility drugs); women bearing children later in life (shown to reduce birthweight); and improved medical technology and prenatal care that allow more pre-term babies to survive.⁴²

Disparities, according to gender, geographic location and socio-economic position, both within and between countries, represent the biggest threat to child nutrition in industrialized countries. Social inequalities are rising throughout the industrialized world, particularly in some countries of eastern Europe.⁴³

In Australia, low birthweight is more common in babies born to families of low socio-economic status, single mothers and indigenous mothers.⁴⁴ In the United States, low birthweight is increasing among all groups, but the highest levels are found among ethnic minorities.⁴⁵

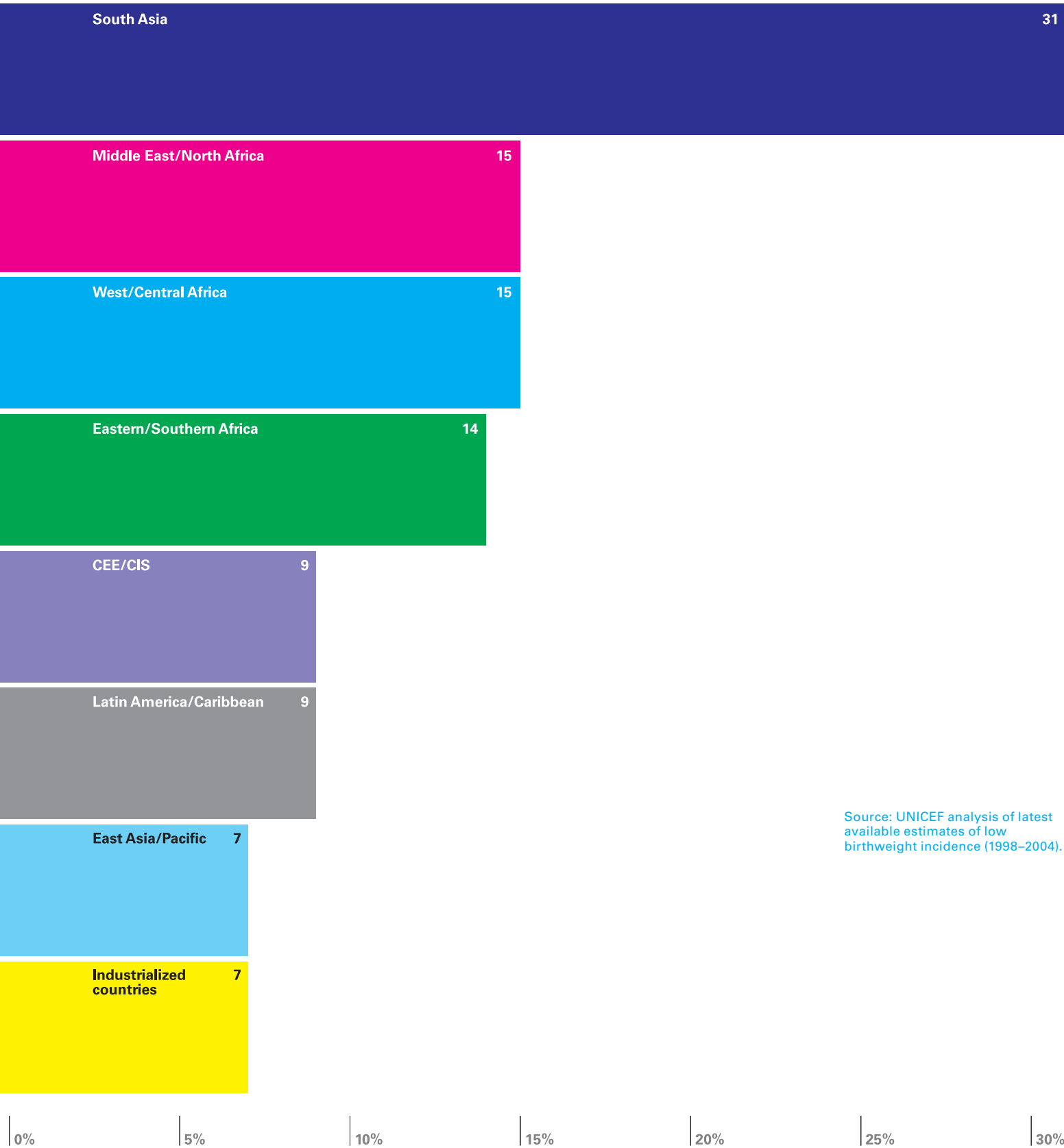
Data on salt iodization in the industrialized world are sketchy, but there is evidence of declining levels in Europe,

obesity are now a major public health problem in the poorer socio-economic strata of industrialized countries and increasingly in many developing countries too.⁴⁸ A major concern is the coexistence, especially in disadvantaged populations, of the so-called 'double burden of disease' with overnutrition in the form of obesity and non-communicable diseases occurring in the same communities, and even families, in which child undernutrition is common.

Obesity carries with it increased general health risks, including a higher incidence of cardiovascular disease, hypertension, non-insulin-dependent diabetes, certain kinds of cancer, gall bladder disease, menstrual abnormalities, and complications of arthritis and gout. In several western European countries, the prevalence of child overweight, including obesity, rose from around 10 per cent in the early 1980s to around 20 per cent by the end of the 1990s. In several areas in southern Europe, one child in three is overweight.⁴⁹

The world's lowest incidence of low birthweight is found in industrialized countries and in the East Asia/Pacific region. South Asia has the highest incidence of low birthweight.

Indicator: Percentage of infants with low birthweight (less than 2,500 grams).



Source: UNICEF analysis of latest available estimates of low birthweight incidence (1998–2004).

Improving nutrition has a huge impact on child survival, helping to prevent deaths from diarrhoea, pneumonia, malaria and measles, as well as deaths in the neonatal period. It can, moreover, make a vital contribution to the achievement of all the MDGs, from eradicating poverty to ensuring that all children can go to school, learn and take full advantage of investments being made in the education sector; from reducing maternal mortality to combating major diseases. Good nutrition not only helps children to grow, but it saves lives and advances human development, economic growth and poverty reduction across the board.

Millions of children's lives will be transformed if the MDG target to reduce hunger is fulfilled in 2015. This is by no means a far-fetched scenario. Much is known about the measures that make a difference in the field of child nutrition. Food is not the only answer; access to health services and good care, especially in early childhood, are just as important.

Among the food and nutrient interventions that have been proved to work are exclusive breastfeeding in the first six months of life, breastfeeding with complementary feeding after six months, vitamin A supplementation, the iodization of salt and the fortification of staple foods.

It is also clear that the priority of nutrition interventions must be children under two years old. Undernutrition in early childhood has a devastating impact on child survival and development because children are most vulnerable to disease and mortality during that period. Early childhood also offers a window of opportunity. Nutrition-related interventions during this period have the greatest impact.

In addition, interventions need to focus on women – before they become pregnant, while pregnant and when lactating – through antenatal care and other opportunities, because mothers deprived of good nutrition are likely to give birth to underweight babies. The best scenario is when a woman moves into her first pregnancy already well nourished.

The health and nutrition needs of children in complex emergencies must remain a priority of the international community. But there is, further, an urgent need to focus on the major causes of death and undernutrition in 'silent' emergencies – outside camps, in stable environments and in communities affected by HIV/AIDS, particularly in southern Africa.

New evidence⁵⁰ indicates that if such high-impact health and nutrition interventions as breastfeeding, complemen-

ENDNOTE: THE TIME TO ACT IS NOW

The drive for nutrition will also involve working across sectors, recognizing that water, sanitation and HIV/AIDS, for example, are inextricably connected with child health and nutrition. It will involve efforts:

- At the **micro** level, empowering families by providing them with the information, resources and services they need to improve their health, feeding and childcare practices.
- At the **meso** level, strengthening district and community health and nutrition systems and ensuring access to water and sanitation.
- At the **macro** level, integrating child health and nutrition needs into national policies, plans and budgets.
- At the **global** level, ensuring the sustainable supply of affordable health and nutrition commodities, as well as the delivery of increased financial resources already promised to make it possible to achieve the MDGs.

tary feeding and vitamin A and zinc supplementation are scaled up, they will have a synergistic impact on growth and development, as well as survival. Even countries with low per capita incomes can make significant progress if appropriate policies are matched by political will, which such countries as Costa Rica, Cuba and Sri Lanka have demonstrated over many years.

The evidence that good nutrition advances not only human but economic development is so strong that policymakers are negligent if they do not promote it by all means within their power. Better nutrition can change a nation's fortunes. But this can happen only if child undernutrition is recognized as a problem and a priority, and if it is addressed in a comprehensive national policy. Nutrition-related services for children must be an integral part of national poverty-reduction strategies and expenditure plans. Many countries still fail to recognize this.

Better nutrition can happen, too, only when every level of society works in partnership. Individuals and communities, governments and the private sector,

humanitarian agencies and health professionals must all work together to ensure that children's nutrition rights are met and that caregivers and families are empowered to meet them.

In that regard, the new *Ending Child Hunger and Undernutrition Initiative* led by the World Food Programme and UNICEF will bring together a range of partners to build momentum in the 10 years that remain before the MDG deadline. It will urge governments in developing countries to take action to improve policies relevant to fulfilling their commitments to reduce hunger and undernutrition among children, and will encourage donor governments to provide the material and financial resources that will be needed to achieve the goal.

As the World Bank advocates in its recent publication, nutrition needs to be repositioned in national development if the MDGs are to be achieved.⁵¹

The time to act is now. To begin with, the MDGs have been adopted by United Nations Member States – already a big step forward for children and humankind. And in the push towards the MDGs, the battle against poverty has moved to centre stage.

The world is certainly capable of getting on track to meet the MDGs on child nutrition and health. There can be no excuses if another generation of children is allowed to fall by the wayside.

Achieving the MDG target – halving the proportion of underweight children between 1990 and 2015 – will involve efforts at micro, meso, macro and global levels, as well as partnerships among all sectors of society.

**MDG deadline:
2015**

global
ensure the sustainable supply of affordable health and nutrition commodities and the delivery of increased financial resources

macro
integrate child health and nutrition needs into national policies, plans and budgets

meso
strengthen district and community health and nutrition systems; ensure access to water and sanitation

micro
empower families to improve their health, feeding and childcare practices

CHILD NUTRITION

Countries and territories	U5MR 2004	% of under-fives (1996–2005) suffering from:					Other indicators			
		under-weight*	AARR 1990-2004	Progress towards the MDG	stunting*	wasting*	% of infants with low birthweight 1998-2004*	% of children exclusively breastfed (<6 months) 1996-2004*	Vitamin A supplemen- tation (6-59 months) 2003	% of households consuming iodized salt 1998-2004*
SOUTH ASIA										
Bhutan	80	19	6.4	on track	40	3	15	–	–	95
Maldives	46	30	4.3	on track	25	13	22	10	–	44
Afghanistan	257	39	3.1	on track	54	7	–	–	86 t	28
Sri Lanka	14	29	2.9	on track	14	14	22	84	–	88
Bangladesh	77	48	2.8	on track	43	13	36	36	87 t	70
Pakistan	101	38	1.7	insufficient	37	13	19 x	16 x,k	95 t	17
India	85	47	1.6	insufficient	46	16	30	37 k	45 w	50
Nepal	76	48	-0.5	no progress	51	10	21	68	96 t	63
EASTERN/SOUTHERN AFRICA										
Botswana	116	13	7.8	on track	23	5	10	34	–	66
Malawi	175	22	2.3	insufficient	48	5	16	44	92	49
Tanzania, United Rep. of	126	22	2.2	insufficient	38	3	13	41	91 t	43
Kenya	120	20	1.1	insufficient	30	6	10	13	33	91
Namibia	63	24	1.1	insufficient	24	9	14	19	93	63
Mozambique	152	24	1.1	insufficient	41	4	15	30	50	54
Rwanda	203	27	1.0	insufficient	41	6	9	84	86	90
Eritrea	82	40	0.7	insufficient	38	13	21 x	52	52	68
Uganda	138	23	0.1	no progress	39	4	12	63	–	95
Zambia	182	23	0.0	no progress	49	5	12	40	73 t	77
Ethiopia	166	47	-0.1	no progress	52	11	15	55	65	28
Lesotho	82	18	-0.3	no progress	46	5	14	15	75 t	69
Madagascar	123	42	-0.4	no progress	48	13	17	67	91 t	75
Burundi	190	45	-1.0	no progress	57	8	16	62	95	96
Zimbabwe	129	13	-1.6	no progress	27	6	11	33	46	93
Comoros	70	25	-3.7	no progress	42	12	25	21	–	82
South Africa	67	12	-5.6	no progress	25	3	15	7	–	62
Swaziland	156	10	–	–	30	1	9	24	80	59
Mauritius	15	15 x	–	–	10 x	14 x	14	21 k	–	0 x
Somalia	225	26	–	–	23	17	–	9	–	–
Angola	260	31	–	–	45	6	12	11	68	35
Seychelles	14	–	–	–	–	–	–	–	–	–
WEST/CENTRAL AFRICA										
Gambia	122	17	10.8	on track	19	8	17	26	91	8
Congo	108	14	4.4	on track	19	4	–	4 k	89	–
Benin	152	23	4.1	on track	31	8	16	38	98 t	72
Mauritania	125	32	4.0	on track	35	13	–	20	–	2
Côte d'Ivoire	194	17	3.2	on track	21	7	17	5	–	31
Nigeria	197	29	2.2	insufficient	38	9	14	17	27	97
Mali	219	33	2.2	insufficient	38	11	23	25	61	74
Congo, Dem. Rep. of the	205	31	1.7	insufficient	38	13	12	24	80 t	72
Ghana	112	22	1.4	insufficient	30	7	16	53	78 t	28
Senegal	137	17	1.1	insufficient	16	8	18	24 k	–	16
Togo	140	25	0.8	insufficient	22	12	18	18	84 t	67
Guinea	155	26	0.6	insufficient	35	9	16	23	98 t	68
Sierra Leone	283	27	0.5	no progress	34	10	23	4	84 t	23
Niger	259	40	0.2	no progress	40	14	13	1	95	15
Central African Republic	193	24	-0.6	no progress	39	9	14	17	84	86
Burkina Faso	192	38	-1.4	no progress	39	19	19	19	95 t	45
Cameroon	149	18	-2.3	no progress	32	5	11	21	86	61
Gabon	91	12	–	–	21	3	14	6	30	36
Sao Tome and Principe	118	13	–	–	29	4	20	56	–	74
Equatorial Guinea	204	19	–	–	39	7	13	24	–	20 x
Guinea-Bissau	203	25	–	–	30	10	22	37	–	2
Liberia	235	26	–	–	39	6	–	35	–	–
Chad	200	28	–	–	29	11	10	2	–	58
Cape Verde	36	–	–	–	–	–	13	57 k	–	0 x
MIDDLE EAST/NORTH AFRICA										
Syrian Arab Republic	16	7	8.9	on track	18	4	6	81 k	–	79
Tunisia	25	4	8.4	on track	12	2	7	47	–	97
Occupied Palestinian Territory	24	4	5.3	on track	9	3	9	29 k	–	65
Jordan	27	4	4.7	on track	9	2	10 x	27	–	88
Oman	13	18	4.2	on track	10	7	8	–	–	61
Djibouti	126	18	3.8	on track	26	13	–	–	75	–
Morocco	43	10	1.8	insufficient	18	9	11 x	31	–	41
Egypt	36	9	0.8	insufficient	16	4	12	30	–	56
Algeria	40	10	0.8	insufficient	19	8	7	13	–	69
Sudan	91	41	-2.4	no progress	43	16	31	16	34	1

Countries and territories	U5MR 2004	% of under-fives (1996–2005) suffering from:				Other indicators				
		under- weight*	AARR 1990-2004	Progress towards the MDG	stunting* wasting*	% of infants with low birthweight 1998-2004*	% of children exclusively breastfed (<6 months) 1996-2004*	Vitamin A supplemen- tation (6-59 months) 2003	% of households consuming iodized salt 1998-2004*	
MIDDLE EAST/NORTH AFRICA (continued from previous page)										
Iraq	125	16	-3.6	no progress	22	6	15	12	–	40
Yemen	111	46	-3.6	no progress	53	12	32 x	12	36	30
Lebanon	31	3	–	–	12	3	6	27 k	–	87
Libyan Arab Jamahiriya	20	5 x	–	–	15 x	3 x	7 x	–	–	90 x
Qatar	21	6 x	–	–	8 x	2 x	10	12 k	–	–
Bahrain	11	9 x	–	–	10 x	5 x	8	34 x,k	–	–
Kuwait	12	10	–	–	24	11	7	12 k	–	–
Iran (Islamic Republic of)	38	11	–	–	15	5	7 x	44	–	94
United Arab Emirates	8	14 x	–	–	17 x	15 x	15 x	34 x,k	–	–
Saudi Arabia	27	14	–	–	20	11	11 x	31 k	–	–
EAST ASIA/PACIFIC										
Singapore	3	3	–	on track	2	2	8	–	–	–
Malaysia	12	11	7.1	on track	–	–	9	29 k	–	–
China	31	8	6.7	on track	14	–	4	51	–	93
Viet Nam	23	28	3.5	on track	32	7	9	15	99 t,w	83
Indonesia	38	28	2.7	on track	–	–	9	40	62	73
Myanmar	106	32	1.2	insufficient	32	9	15	15 k	87 t	60
Philippines	34	28	0.9	insufficient	30	6	20	34	76 t	56
Lao People's Dem. Rep.	83	40	0.8	insufficient	42	15	14	23	64	75
Mongolia	52	13	-0.3	no progress	25	6	7	51	87 t	75
Cambodia	141	45	-1.3	no progress	45	15	11	12	47	14
Thailand	21	18 x	–	–	13 x	5 x	9	4 x,k	–	63
Korea, Dem. People's Rep. of	55	23	–	–	37	7	7	65	95 t	40
Timor-Leste	80	46	–	–	49	12	12	31	95	72
Korea, Republic of	6	–	–	–	–	–	4	–	–	–
Brunei Darussalam	9	–	–	–	–	–	10	–	–	–
Fiji	20	–	–	–	–	–	10	47 x,k	–	31 x
Cook Islands	21	–	–	–	–	–	3	19 k	–	–
Micronesia (Federated States of)	23	–	–	–	–	–	18	60 k	95 t	–
Tonga	25	–	–	–	–	–	0	62 k	–	–
Palau	27	–	–	–	–	–	9	59 x,k	–	–
Nauru	30	–	–	–	–	–	–	–	–	–
Samoa	30	–	–	–	–	–	4 x	–	–	–
Vanuatu	40	–	–	–	–	–	6	50 k	–	–
Tuvalu	51	–	–	–	–	–	5	–	–	–
Solomon Islands	56	–	–	–	–	–	13 x	65 k	–	–
Marshall Islands	59	–	–	–	–	–	12	63 x,k	23	–
Kiribati	65	–	–	–	–	–	5	80 x,k	45	–
Papua New Guinea	93	–	–	–	–	–	11 x	59	1	–
Niue	–	–	–	–	–	–	0	–	–	–
LATIN AMERICA/CARIBBEAN										
Cuba	7	4	20.3	on track	5	2	6	41	–	88
Dominican Republic	32	5	6.7	on track	9	2	11	10	40	18
Jamaica	20	4	5.8	on track	5	2	10	–	–	100
Mexico	28	8	5.6	on track	18	2	8	38 x,k	–	91
Peru	29	7	5.2	on track	25	1	11 x	67	–	93 x
Guyana	64	14	4.6	on track	11	11	12	11	–	–
Haiti	117	17	4.4	on track	23	5	21	24	25	11
Colombia	21	7	3.7	on track	14	1	9	26	–	92 x
Bolivia	69	8	3.6	on track	27	1	7	54	38	90
Venezuela (Bolivarian Rep. of)	19	4	3.2	on track	13	3	9	7 k	–	90
Brazil	34	6	2.9	on track	11	2	10 x	–	–	88
Guatemala	45	23	2.7	on track	49	2	12	51	–	67
Chile	8	1	2.6	on track	2	0	5	63	–	100
El Salvador	28	10	2.6	on track	19	1	7	24	–	91 x
Nicaragua	38	10	2.4	insufficient	20	2	12	31	91	97
Ecuador	26	12	2.0	insufficient	26	–	16	35	–	99
Honduras	41	17	1.5	insufficient	29	1	14	35	35	80
Trinidad and Tobago	20	6	1.3	insufficient	4	4	23	2	–	1
Panama	24	8	-1.2	no progress	18	1	10	25 x	–	95
Paraguay	24	5	-2.3	on track	14	1	9 x	22	–	88
Costa Rica	13	5	–	–	6	2	7	35 x,k	–	97 x
Uruguay	17	5 x	–	–	8 x	1 x	8	–	–	–
Argentina	18	5	–	–	12	3	8	–	–	90 x
Suriname	39	13	–	–	10	7	13	9	–	–
Antigua and Barbuda	12	–	–	–	–	–	8	–	–	–
Barbados	12	–	–	–	–	–	10 x	–	–	–
Bahamas	13	–	–	–	–	–	7	–	–	–
Dominica	14	–	–	–	–	–	10	–	–	–
Saint Lucia	14	–	–	–	–	–	8	–	–	–
Grenada	21	–	–	–	–	–	9	39 k	–	–
Saint Kitts and Nevis	21	–	–	–	–	–	9	56 k	–	100
Saint Vincent and the Grenadines	22	–	–	–	–	–	10	–	–	–
Belize	39	–	–	–	–	–	6	24 k	–	90 x

Countries and territories	U5MR 2004	% of under-fives (1996–2005) suffering from:					Other indicators			
		under-weight*	AARR 1990-2004	Progress towards the MDG	stunting*	wasting*	% of infants with low birthweight 1998-2004*	% of children exclusively breastfed (<6 months) 1996-2004*	Vitamin A supplemen- tation (6-59 months) 2003	% of households consuming iodized salt 1998-2004*
CEE/CIS										
Ukraine	18	1	–	on track	3	0	5	22	–	32
Armenia	32	3	–	on track	13	2	7	30	–	84
Georgia	45	3	–	on track	12	2	7	18k	–	68
Bosnia and Herzegovina	15	4	–	on track	10	6	4	6	–	77
Kazakhstan	73	4	15.2	on track	10	2	8	36	–	83
Uzbekistan	69	8	12.8	on track	21	7	7	19	93t	19
Turkey	32	4	10.2	on track	12	1	16	21	–	64
Romania	20	3	6.0	on track	10	2	9	–	–	53
Azerbaijan	90	7	2.0	insufficient	13	2	11	7	–	26
Serbia and Montenegro	15	2	-4.3	on track	5	4	4	11 k	–	73
Croatia	7	1	–	–	1	1	6	23	–	90
Russian Federation	21	3x	–	–	13x	4x	6	–	–	35
Moldova, Republic of	28	3	–	–	10	3	5	–	–	33
The former Yugoslav Rep. of Macedonia	14	6	–	–	7	4	6	37	–	80
Kyrgyzstan	68	11	–	–	25	3	7x	24	–	42
Turkmenistan	103	12	–	–	22	6	6	13	–	100
Albania	19	14	–	–	34	11	3	6	–	62
Belarus	11	–	–	–	–	–	5	–	–	55
Bulgaria	15	–	–	–	–	–	10	–	–	98
Tajikistan	118	–	–	–	36	5	15	50	–	28

INDUSTRIALIZED COUNTRIES										
United States	8	2	–	–	1	6	8	–	–	–
Iceland	3	–	–	–	–	–	4	–	–	–
Czech Republic	4	–	–	–	–	–	7	–	–	–
Finland	4	–	–	–	–	–	4	–	–	–
Japan	4	–	–	–	–	–	8	–	–	–
Norway	4	–	–	–	–	–	5	–	–	–
Slovenia	4	–	–	–	–	–	6	–	–	–
Sweden	4	–	–	–	–	–	4	–	–	–
Austria	5	–	–	–	–	–	7	–	–	–
Belgium	5	–	–	–	–	–	8x	–	–	–
Denmark	5	–	–	–	–	–	5	–	–	–
France	5	–	–	–	–	–	7	–	–	–
Germany	5	–	–	–	–	–	7	–	–	–
Greece	5	–	–	–	–	–	8	–	–	–
Italy	5	–	–	–	–	–	6	–	–	–
Portugal	5	–	–	–	–	–	8	–	–	–
Spain	5	–	–	–	–	–	6x	–	–	–
Switzerland	5	–	–	–	–	–	6	–	–	–
Australia	6	–	–	–	–	–	7	–	–	–
Canada	6	–	–	–	–	–	6	–	–	–
Ireland	6	–	–	–	–	–	6	–	–	–
Israel	6	–	–	–	–	–	8	–	–	–
Luxembourg	6	–	–	–	–	–	8	–	–	–
Malta	6	–	–	–	–	–	6	–	–	–
New Zealand	6	–	–	–	–	–	6	–	–	83
United Kingdom	6	–	–	–	–	–	8	–	–	–
Estonia	8	–	–	–	–	–	4	–	–	–
Hungary	8	–	–	–	–	–	9	–	–	–
Lithuania	8	–	–	–	–	–	4	–	–	–
Poland	8	–	–	–	–	–	6	–	–	–
Slovakia	9	–	–	–	–	–	7	–	–	–
Latvia	12	–	–	–	–	–	5	–	–	–

No nutrition data: Andorra, Cyprus, Holy See, Liechtenstein, Monaco, the Netherlands and San Marino.

REGIONAL SUMMARIES										
South Asia	92	46	1.7	insufficient	44	15	31	38	58	49
Sub-Saharan Africa	171	28	0.8	insufficient	38	9	14	30	64	64
Eastern/Southern Africa	149	29	0.0	no progress	41	7	14	41	68	60
West/Central Africa	191	28	1.6	insufficient	35	10	15	20	60	68
Middle East/North Africa	56	17	-1.6	no progress	23	8	15	29	–	58
East Asia/Pacific	36	15	3.6	on track	19	–	7	43	73**	85
Latin America/Caribbean	31	7	3.8	on track	16	2	9	–	–	86
CEE/CIS	38	5	–	–	14	3	9	22	–	47
Industrialized countries	6	–	–	–	–	–	7	–	–	–
Developing countries	87	27	1.7	insufficient	31	10	17	36	61**	69
Least developed countries	155	36	1.1	insufficient	42	10	19	34	76	53
World	79	26	1.7	insufficient	30	10	16	36	61**	68

Notes:

– Data were not available or were insufficient to estimate trends.

* Moderate and severe levels of underweight, stunting and wasting. Data refer to the most recent year available during the period 1996–2005. For other indicators, data refer to the most recent year available during the period shown in the column heading.

AARR Average annual rate of reduction (%) in underweight prevalence. Regions are classified according to the same thresholds as in the map on pages 4 and 5. Note that the threshold described for countries and territories on track to reach the target does not apply at the regional level. Thus, CEE/CIS is not classified – underweight prevalence in this region is 5 per cent but there are insufficient data to calculate the AARR.

** This figure does not include China.

x Data refer to years or periods other than those specified in the column heading, differ from the standard definition, or refer to only part of a country.

k Data refer to exclusive breastfeeding for less than four months.

t Country has achieved a second round of vitamin A coverage greater than or equal to 70 per cent.

w Country's vitamin A supplementation programme does not target children up to 59 months of age.

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- ² Malnutrition is a broad term commonly used as an alternative to undernutrition, but technically it also refers to overnutrition – to the current epidemic of obesity and related diseases, such as diabetes, in both the industrialized and developing worlds.
- ³ Prevalence estimates will differ slightly from estimates based on the trend analysis, as the current prevalence was estimated based on data for 110 countries and the trend analysis was based on data for a subset of 73 countries where data were available for the period 1990–2004.
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- ⁵ UNICEF analysis of underweight prevalence by place of residence in 89 countries, covering 90 per cent of the developing world's under-five population.
- ⁶ UNICEF analysis of underweight prevalence by household asset quintile in 68 countries.
- ⁷ UNICEF analysis of underweight prevalence by gender in 105 countries, covering 90 per cent of the developing world's under-five population.
- ⁸ Incidence of low birthweight is based on latest available estimates during 1998–2004.
- ⁹ United Nations Children's Fund and the World Health Organization, *Low Birthweight: Country, regional and global estimates*, UNICEF and WHO, New York and Geneva, 2004, pp. 2–3.
- ¹⁰ Ibid., p. 9.
- ¹¹ Trend estimates of low birthweight are based on surveys in 20 developing countries, covering about half of the developing world's population (excluding China). See also *Low Birthweight: Country, regional and global estimates*.
- ¹² Breastfeeding levels are based on the latest available estimates for 111 countries during 1996–2004.
- ¹³ Breastfeeding trend estimates are based on a subset of 37 countries for which trend data were available, covering about 60 per cent of births in the developing world (excluding China). The sub-Saharan Africa analysis covers 59 per cent of total births in the region; the West/Central Africa analysis covers 68 per cent of total births in the region; and the Eastern/Southern Africa analysis covers about half of total births in the region. Trend estimates will differ slightly from estimates of present breastfeeding levels, as the trend analysis was based on data for 37 countries and present breastfeeding levels were estimated based on data for 111 countries. This applies to all regions.
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