Children are our future: Keeping a focus on child survival

Decades of progress – together we can keep the momentum going

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The Sustainable Development Goal Framework (SDG) (United Nations, 2023) puts forward a vision of an equitable, just world where the rights of all, including women and children, are realized. It includes an ambitious agenda of achieving universal health coverage and targets focused specifically on ending preventable newborn and child deaths (SDG target 3.2).[1] The Every Woman Every Child Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030) (Global Strategy) translates the broad agenda of the SDGs into concrete guidance on how to accelerate progress in women's, children's, and adolescents' health through a country driven, multi-sectoral approach (Every Woman Every Child, 2015; Kuruvilla et al., 2016). Both the SDG framework and the Global Strategy are consistent with the United Nations Convention on the Rights of the Child (United Nations, 1989) adopted in 1989, which recognizes the inalienable rights of children (to survive and thrive, be protected from harm, and to have their voices heard) and the responsibility of governments to uphold them. Much has been achieved since the Convention was adopted, but significant work remains to give every child a healthy start in life.

The Child Survival Action initiative (Child Health Task Force, 2024) was launched in April 2023 at the 2nd Global Pneumonia Forum in Madrid, Spain. It aims to unite partners – governments, civil society and traditional leaders, academic institutions, and development partners – in the effort to reach SDG target 3.2 and to create a world where children everywhere can receive the health care and other essential services they need to survive and flourish. The initiative includes a results framework with a core set of indicators to raise visibility on equitable progress on child survival (Box 1).

This technical brief provides an assessment of progress on this indicator set and presents a way forward to improve child survival. It is organized into four sections: Section 1 reviews child mortality trends and causes of child deaths; Section 2 provides a snapshot of child nutritional status; Section 3 examines coverage of select child health and nutrition interventions, with a focus on countries that are off track for SDG 3.2.1; Section 4 describes how accelerations in child survival can be achieved through a primary health care approach and renewed global and country commitment to children.

Section 1.
Child survival: Remarkable yet uneven progress

1.1 Levels and trends in child mortality

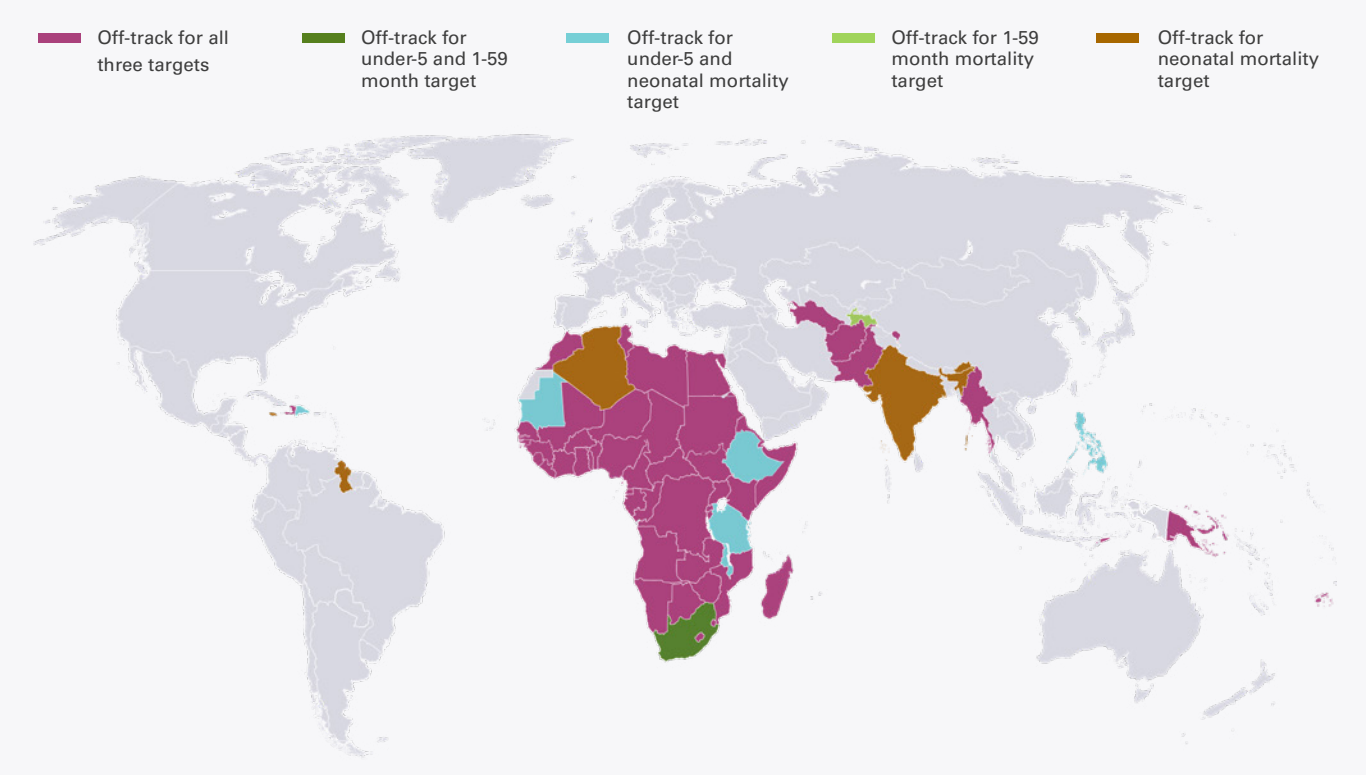
More children are surviving to their fifth birthday than ever before globally, and under-five mortality has declined by over half since 2000 (from 76 per 1,000 live births in 2000 to 37 per 1,000 live births in 2022) (United Nations Children's Fund et al., 2024). However, progress has slowed since the start of 2015, and millions of children still die every year mostly from preventable and treatable causes.

There are many success stories to celebrate. Low- and middle-income countries as diverse as Bangladesh, Ethiopia, Nepal, Peru, Rwanda, and Senegal, for example, achieved major reductions in child and neonatal mortality in the past two decades through a combination of health system strengthening activities and targeted efforts to reach disadvantaged children (Exemplars in Global Health, 2022). However, latest global estimates show that 59 countries are off-track for achieving SDG 3.2.1, 64 are off-track for 3.2.2, and 52 are off track for the proposed target for children ages 1-59 months (United Nations Children's Fund et al., 2024).

Where a child is born still largely determines whether she or he will survive childhood (Figure 1). In 2022, 57% of all deaths in children under five years of age occurred in sub-Saharan Africa, and 34% in South Asia. Mortality rates are also higher in low-income countries where children are 13 times more likely to die before the age of five than children born in high-income countries. Children who live in fragile and conflict-affected countries are especially vulnerable. Almost half of all child deaths in 2022 occurred in these settings (United Nations Children's Fund et al., 2024).

Within countries, there is marked variation in child mortality levels across subnational regions, urban and rural areas, and by household wealth, reflecting the critical role of social determinants in shaping child survival prospects (United Nations Inter-agency Group for Child Mortality Estimation, 2023; Victora et al., 2020). Although disparities in under-five mortality between the poorest and richest households have narrowed, the poorest children in all countries are still at much higher risk of death (Cha & Jin, 2019; Chao et al., 2018).

FIGURE 1 CHILD MORTALITY IS CONCENTRATED IN SUB-SAHARAN AFRICA AND SOUTH ASIA



Note: This map does not reflect a position on the legal status of any country or territory or the delimitation of any frontiers

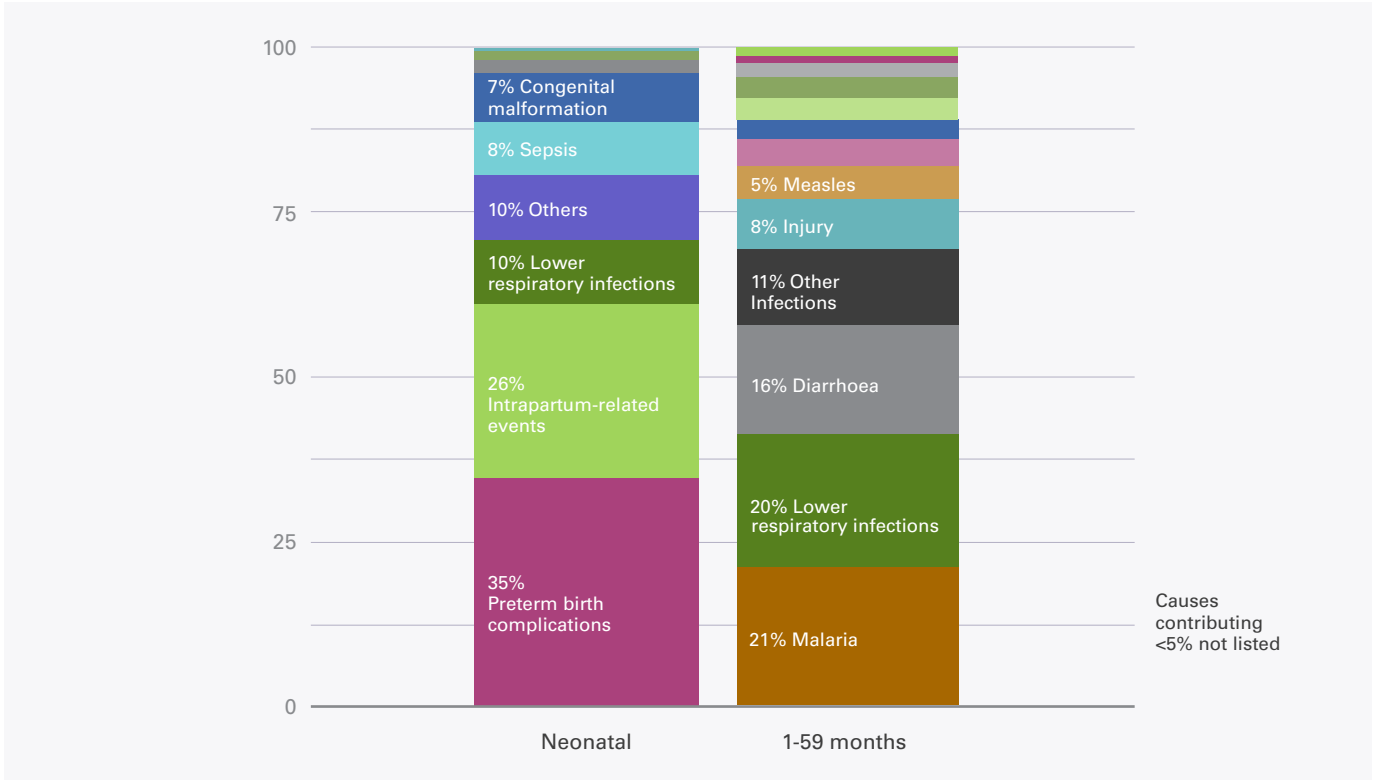
Source: United Nations Interagency Group for Child Mortality Estimation (UN IGME, 2024). Under-five mortality rate: The under-five mortality rate is the probability of a child-born in a specific year or period dying before reaching the age of 5 years, measured in terms of the number of deaths per 1,000 live births. Neonatal mortality rate: The neonatal mortality rate is the probability that a child born in a specific year or period will die during the first 28 completed days of life, measured in terms of the number of deaths per 1,000 live births. 1-59 month mortality rate: the probability of a child born in a specific year or period dying between the exact age of 1 month and exact age of 60 months, measured in terms of the number of deaths per 1,000 children aged 28 days.

Target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births. Proposed target for children 1-59 months of age derived from SDG 3.2.1 and 3.2.2: By 2030, reduce 1 to 59 month mortality rate to at least as low as 13 deaths per 1,000 children aged 28 days.

1.2 Most child deaths can be prevented or treated with simple, cost-effective interventions

As global child mortality rates have declined, the proportion of child mortality occurring in the neonatal period has increased and now approximates 47% of all under-five deaths (United Nations Children's Fund et al., 2024). Figure 2 shows the cause distribution of child deaths in the 59 countries off track for SDG 3.2.1. Among children ages 1 to 59 months, the top three causes of death are malaria, lower respiratory infections, and diarrhoea – conditions associated with poverty because of higher risks of exposures due to living conditions as well as lower access to health services. Effective promotive, preventive, and treatment interventions are available for these and other infectious causes of child deaths (e.g., measles, tuberculosis, meningitis, HIV) through primary health care. The leading causes of neonatal deaths in these countries are preterm birth complications, intrapartum related events and lower respiratory infections. Neonatal conditions are deeply connected with maternal health and often require more intensive levels of care.

FIGURE 2 CAUSES OF CHILD DEATHS IN THE 1-59 MONTH AND NEONATAL AGE GROUPS, 2021, COUNTRIES OFF-TRACK FOR SDG 3.2.1



Source: Causes of child deaths available at https://childmortality.org/causes-of-death/data. Villavicencio F, Perin J, Eilerts-Spinelli et al., Global, regional, and national causes of death in children and adolescents younger than 20 years: an open data portal with estimates for 2000-21. The Lancet Global Health; 12(1), E16-17. Doi:https://doi.org/10.1016/S2214-109X(23)00496-5.

Section 2.
Child Nutritional Status

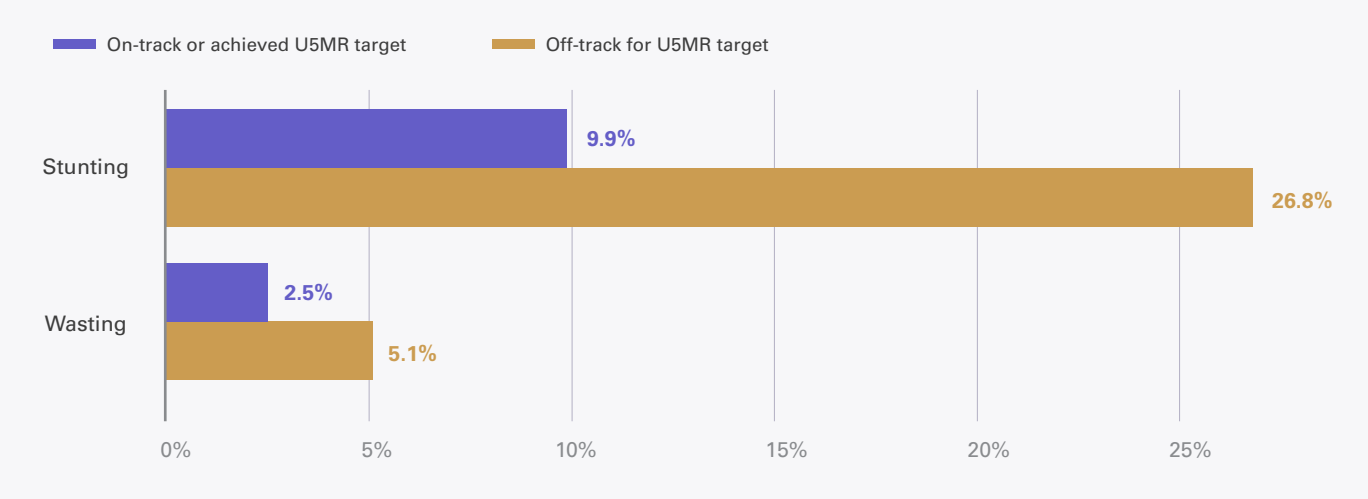
2.1 Tackling poor childhood nutrition is paramount to improving child survival

Nearly half of all child deaths are attributable to undernutrition, which compromises children's immune system, increases susceptibility to infections, and delays recovery from disease (Lawn et al., 2023). Childhood undernutrition often reflects intergenerational cycles of poverty and is grounded in household food insecurity and limited access to healthcare. Women who are undernourished during pregnancy are at greater likelihood of having a low-birth-weight baby (defined as weight at birth <2500 grams). A baby born with a low birth weight starts life at a disadvantage and at a multi-fold risk of stunting (defined as a child who is too short for his or her age) (United Nations Children's Fund et al., 2023).

Although stunting rates globally have steadily declined since 2000, this condition affected an estimated 148 million (22.3%) children in 2022.[2] Around 95% of these children live in Asia or Africa (United Nations Children's Fund et al., 2023). The median stunting prevalence in 2022 for the 59 countries off-track for SDG 3.2.1 was 26.8% and 26 of these countries had stunting levels over 30% (considered very high). On average, stunting levels are over twice as high in countries that are off track for SDG 3.2.1 compared to low-and middle-income countries on-track/have achieved the target (Figure 3).

Child wasting (defined as a child who is too thin for his or her height/length) is a life-threatening condition, especially when it is severe. In 2022, approximately 45 million children under the age of five suffered from wasting (United Nations Children's Fund et al., 2023). Over three-quarters of these children lived in Asia, and another 22% in Africa. The median wasting prevalence for countries off track for SDG 3.2.1 was 5.1%, over twice as high as the rate for low-and middle- income countries that are on track for/have achieved the target (Figure 3).

FIGURE 3 MEDIAN PREVALENCE (%) OF STUNTING AND WASTING IN LOW-AND MIDDLE-INCOME COUNTRIES WITH AVAILABLE DATA THAT ARE OFF-TRACK COMPARED WITH THOSE THAT ARE ON-TRACK/HAVE ACHIEVED SDG TARGET 3.2.1



Source: Stunting: UNICEF/WHO/World Bank Joint Child Malnutrition Estimates Database, May 2023. Stunting data are available for 74 on-track/achieved SDG 3.2.1 and 59 off-track countries. Wasting: data sources are Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other national surveys from 2018 -2023. Data are available for 38 on-track/achieved SDG 3.2.1 and 38 off-track countries.

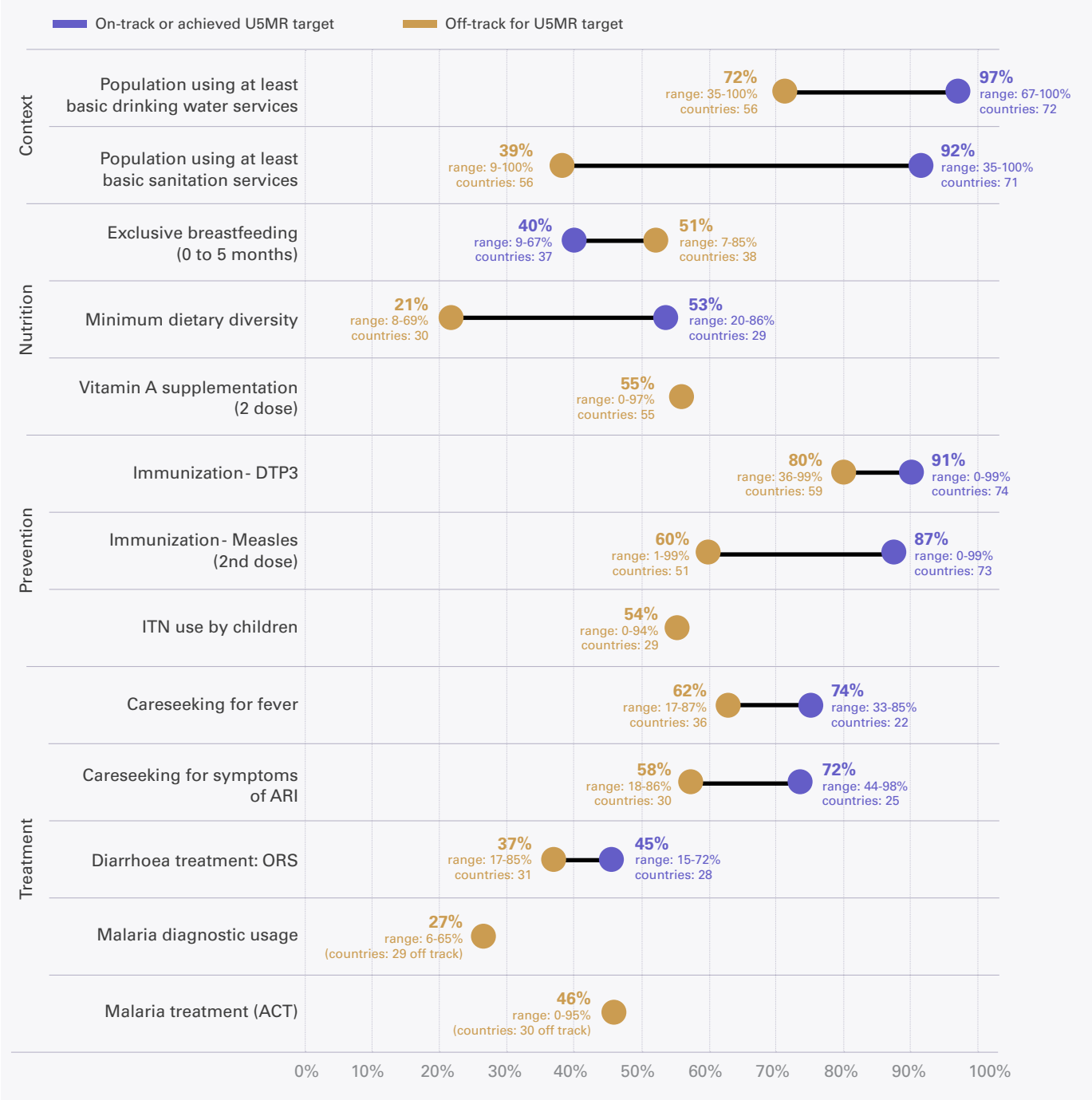
Indicator definitions Stunting: Prevalence of stunting (height-for-age falling below minus 2 standard deviations from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age. Prevalence of wasting (weight-for-height falling below minus 2 standard deviations from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age. LMIC countries: According to the World Bank definition, for the current 2024 fiscal year, low- and middle-income countries (LMIC) are those with a GNI per capita between $0 and $13,845 calculated using the World Bank Atlas method.

Section 3.
Intervention coverage levels and trends

3.1 Effective interventions are available, but are we delivering high quality care for all children?

Interventions known to prevent and successfully treat the leading infectious causes of child deaths in the 1-to-59-month period and to promote good childhood nutrition are available through primary health care delivered in facilities and communities. However, their implementation and scale-up often lags in high child mortality countries. Figure 4 shows the median coverage levels of the core CSA interventions (Box 1) in low- and middle-income countries with available data that are off track for SDG 3.2.1 compared with those that are on track/have achieved the target. Countries that are off-track are far from achieving universal coverage for all the interventions, and coverage is lower than 50% for five of them. According to the latest estimates, an alarming 10,068,048 children living in the 59 countries off-track for SDG 3.2.1 received zero immunization doses in 2022. Figure 4 also shows that, except for exclusive breastfeeding (a practice grounded in sociocultural norms), countries that are off-track have lower coverage levels on average for all the interventions compared to countries that are on-track/ have achieved SDG 3.2.1.

FIGURE 4 MEDIAN COVERAGE LEVELS FOR THE CORE CSA CONTEXTUAL, NUTRITION, PREVENTION AND TREATMENT INTERVENTIONS IN LOW- AND MIDDLE-INCOME COUNTRIES WITH AVAILABLE DATA THAT ARE OFF-TRACK COMPARED WITH COUNTRIES ON-TRACK/HAVE ACHIEVED SDG 3.2.1



Source: Population using at least basic drinking water services and sanitation services, WHO and UNICEF Joint Monitoring Programme for Water Supply and Sanitation (2022 data published 2023), immunization estimates, WHO/UNICEF Estimates of National Immunization Coverage (2022 data published 2023); vitamin A, UNICEF global databases (2023) based on administrative reports (data from 2018–2023); all other indicators, UNICEF global databases (2022 for minimum dietary diversity, 2023 for exclusive breastfeeding, 2024 for ITN and treatment indicators), based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and other national surveys (data from 2018–2023).

Note: Median coverage values are not shown for interventions that had less than 15 countries with available data. This includes vitamin A supplementation, ITN coverage, malaria diagnostic usage, and malaria treatment (ACT) for countries on-track/achieved the SDG 3.2.1 target. The number of countries with available data will vary by intervention depending upon whether the data source is from a global estimation process or from household surveys.

Indicator definitions: Access to at least basic water source: Proportion of the population that uses basic (drinking water from an improved source, provided collection time is not more than 30 minutes for a roundtrip, including queuing) or safely managed (drinking water from an improved source that is accessible on premises, available when needed and free from faecal and priority chemical contamination) service. Access to at least basic sanitation: Proportion of the population using basic (improved facilities not shared with other households) or safely managed (of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or removed and treated off-site) service. Exclusive breastfeeding: Percentage of infants 0–5 months of age fed exclusively with breast milk. Vitamin A two-dose coverage - the proportion of 6 to 59-month-olds receiving two high-dose vitamin A supplements in a calendar year (lower than semester 1 and semester 2 coverage). Minimum Diet Diversity: Percentage of children 6–23 months of age who consumed foods and beverages from at least five out of eight defined food groups during the previous day. ITN use by children - Percentage of children under age five who slept under an insecticide-treated mosquito net the night before the survey. Measles Second Dose - The percentage of children who have received two doses of measles-containing vaccine (MCV2) in a given year, according to the nationally recommended schedule. Third dose of DTP-containing vaccine: The percentage of one-year-olds who have received three doses of the combined diphtheria, tetanus toxoid, and pertussis-containing vaccine in a given year. Care seeking for ARI - Percentage of children under age 5 with acute respiratory infection symptoms for whom advice or treatment was sought from a health facility or provider. Care seeking for febrile children - Percentage of children under age 5 with fever for whom advice or treatment was sought. Malaria diagnostics - Percentage of febrile children under age 5 who had a finger or heel stick for malaria testing. Updating malaria treatment definition: Malaria treatment (ACT) - Percentage of febrile children under age 5 receiving artemisinin-based combination therapy (first-line antimalarial drug), among those receiving any antimalarial drugs. Diarrhoea treatment with ORS - A percentage of children under age five who had diarrhea in the two weeks preceding the survey were given oral rehydration salts (ORS packets or pre-packaged ORS fluids). LMIC countries: According to the World Bank definition, for the current 2024 fiscal year, low- and middle-income countries (LMIC) are those with a GNI per capita between $0 and $13,845 calculated using the World Bank Atlas method.

Section 4.
A way forward for children

The message is clear: Countries and their partners should increase their investments in primary health care systems to provide essential services to all children, combat leading causes of child deaths, and support nurturing care. These investments should focus on improving service integration so that children receive a cohesive package of health promoting, prevention, and treatment services. Evidence shows that domestic and external aid for women's, children's, and adolescents' health has been insufficient to support country efforts to shore up their health systems (Pitt et al., 2021). This trend needs remedying through improved health financing including greater alignment of partner resources with country priorities and needs (Kruk et al., 2018).

Key strategies for child health described below incorporate the dimensions of protection, illness prevention, and effective treatment of childhood illnesses and injuries. They have been rolled out to varying degrees in the past 30 years. Challenges in their scale-up suggests that greater coordination across stakeholders is needed to improve their implementation and adaptation to local contexts.

The Integrated Management of Newborn and Childhood Illnesses (IMNCI) strategy, including its component on Integrated Community Case Management (iCCM), represents a holistic, primary health care approach to child survival. It has been introduced in over 100 countries, yet implementation remains incomplete in many countries, especially for prevention and system strengthening activities (Boschi-Pinto et al., 2018). Efforts are needed to improve IMNCI and iCCM roll-out. In tandem with these efforts, activities to strengthen referral networks for maternal and newborn services, and for children experiencing severe illness, complications, malnutrition, or injury are also essential for sustained progress and for addressing complex conditions that require functioning health care systems with highly trained health care workers and a consistent supply of drugs and medicines. Greater support to caregivers will also enable more children to benefit from responsive, nurturing care.

The Global Action Plan for Prevention and Control of Pneumonia and Diarrhoea (GAPPD) (World Health Organization & United Nations Children's Fund, 2013) is a strategy aligned with IMNCI/iCCM aimed at improving breastfeeding practices and reaching all children with immunization services, effective case management of pneumonia and diarrhoea, and nutrition services. GAPPD also stresses the importance of environmental interventions that improve water and sanitation services and indoor and outdoor air quality to reduce children's risk of contracting diarrhoeal diseases and respiratory infections, respectively (Sharma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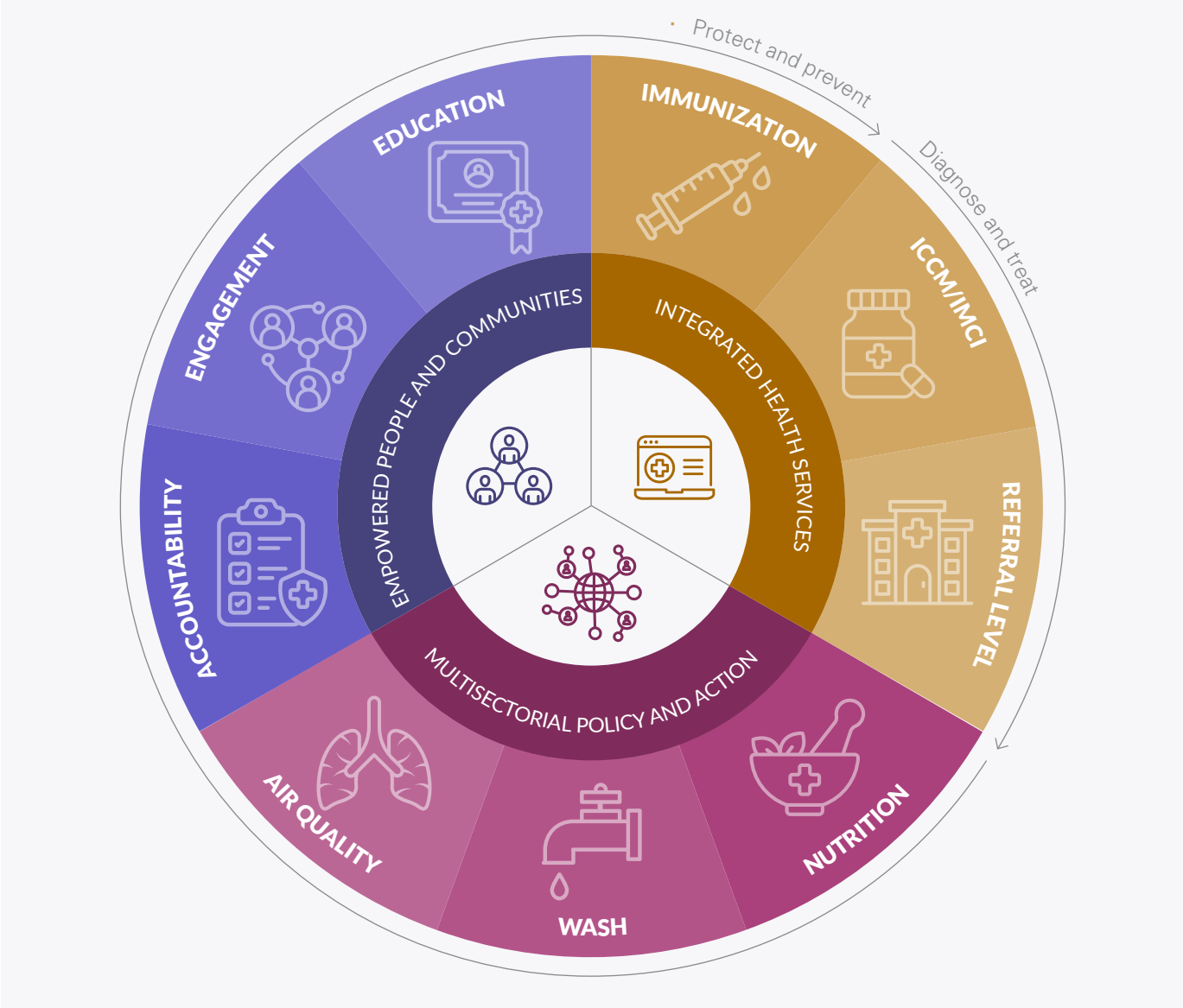
Waddington et al., 2023; United Nations Children's Fund & World Health Organization, 2023; World Health Organization, 2018). It has a set of ambitious targets for 2025 that the world is far from achieving.

Broader social determinants such as women's educational attainment and socio-economic status have profound effects on child survival. Children of women with higher education levels, greater autonomy to make health care decisions, and who live in societies with greater gender parity in terms of economic prospects and political representation have better chances of reaching their development potential than other children (Bagade et al., 2020; Ewerling et al., 2020). Reductions in child marriage, early childbearing, and domestic violence also vastly improve child survival (UNICEF Data and Analytics Section, 2023). This evidence suggests that gender equality should be a central aim of national health policies and plans.

The poor roll-out of IMNCI/iCCM and other community-based interventions to support child growth and development, slow progress towards implementing the GAPPD recommendations, continued weak referral networks in many countries, and evidence on broader determinants all indicate that moving the needle on child survival necessitates health sector reforms plus multisectoral action. Expanding household access to clean water and sanitation services, addressing underlying social and economic determinants, and improving food systems are all actions that governments and their partners should prioritize. The primary health care model (Hone et al., 2018) incorporates three pillars: 1) **Integrated promotive, preventive, treatment, and rehabilitative health services**, 2) **Multisectoral action to address health determinants**, and 3) **Empowered people, families, and communities** who can participate in the development of services, advocate for and hold governments to account for quality services and optimize their own and others' health as caregivers. Figure 5 shows an adaptation of the primary health care model for child health and well-being, with the dimensions of protect, prevent, diagnose, and treat.

FIGURE 5 PRIMARY HEALTH CARE FOR CHILDREN: THE CHILD HEALTH WHEEL



Every child has the right to survive and thrive, no matter where they live.

Governments and their partners should work together to foster strong primary health care systems as envisioned in the child health wheel (Figure 5) so that all children have access to essential health, nutrition, and social services. Specifically, governments and partners can jointly:

- Prioritize child health by including it as a top agenda item and allocating sufficient resources to support comprehensive child health and nutrition programs.
- Develop and implement policies and costed plans for child health and nutrition that support nurturing care and include targeted activities to reach the most vulnerable children.
- Coordinate and harmonize implementation strategies across projects and initiatives so that child health and nutrition services are delivered as a holistic package. This includes greater support for the uptake of IMNCI/iCCM, treatment programs for acute malnutrition, and follow-up services for children at elevated risk.
- Strengthen community delivery strategies and community health care worker programs to increase service availability where children live and to improve caregiver knowledge and support.
- Invest in referral networks so that care is available for emergencies and for children with complex conditions.
- Build effective partnerships for multisectoral action across government sectors and local actors to tackle determinants of child health such as water and sanitation, air pollution, food security, and gender equity.

- Engage communities and civil society in the design and prioritization of approaches to improve child health so that services are tailored to local needs.
- Establish robust data collection mechanisms and analytical tools to monitor key indicators and trends related to child health. Regularly report progress and disseminate findings to stakeholders for evidence-based decision-making and intervention adjustments.
- Create accountability mechanisms such as regular evaluations of performance targets to ensure all stakeholders are actively contributing to improving child health.

The academic and research community and civil society organizations are also essential to success in improving child survival. Academic institutions can play a key role in independent analyses of country progress, equipping governments with the evidence they need for revising policies and programs and civil society organizations with data they can use to advocate for children and hold governments to account for promises made. In addition, civil society organizations can help ensure the voices of children, their families, and communities are heard when child health programs are being developed, introduced, and scaled up.

Through accelerated collective action and unified efforts, the SDG targets for child survival can be achieved.

BOX 1 CHILD SURVIVAL ACTION PLAN: RESULTS FRAMEWORK

Child Survival Action: a call to all partners to address the challenges that have hampered progress in ending preventable child deaths, with a focus on children 1-59 months of age.

The Child Survival Results Framework supports **advocacy, accountability, and action** for child survival. It is consistent with the Child Survival Action theory of change and guiding principles around child rights, government ownership and leadership, and family centeredness of health care. The results framework includes two components – one consisting of a limited set of standardized impact, outcome, and contextual factors indicators that enable global and cross-country monitoring, and the second on implementation milestones adaptable to country contexts. The focus of this technical brief is on the first component.

The core set of impact, outcome, and contextual factors indicators were selected through a multi-step process involving extensive consultation with expert groups. The set consists of five types of indicators – impact, outcome indicators related to **promotion**, **prevention**, and **treatment**, and **contextual factors**. The results framework also includes approaches for measuring equity and a learning agenda. Companion quality of care measures and subnational targets for the core indicators are under development.

TABLE CSA IMPACT, OUTCOME, CONTEXTUAL FACTORS INDICATORS AND ASSOCIATED SDG TARGETS

Indicator	Associated SDG target
Impact	
Under-five mortality	SDG 3.2: Reduce under five mortality rate to at least as low as 25 deaths per 1,000 live births by 2030 (indicator 3.2.1)
1-59 months mortality	Proposed global target derived from SDG 3.2.1, and SDG 3.2.2: Reduce 1 to 59-month mortality rate to at least as low as 13 deaths per 1,000 children aged 28 days by 2030
Wasting prevalence (moderate/severe)	SDG 2.2: By 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons (indicator 2.2.2)
Stunting prevalence (moderate/severe)	SDG 2.2: By 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons (indicator 2.2.1)

Outcome – Promote	
Exclusive breastfeeding (0-5 months)	N/A (World Health Assembly target is: By 2025, at least 50% of infants are exclusively breastfed in the first 6 months)
Minimum dietary diversity	N/A
Vitamin A supplementation (2 dose)	N/A
Outcome – Prevent	
Insecticide treated bednets (under-five)	SDG 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable disease (indicator 3.3.3)
Immunization – three doses of diptheria, tetanus, and pertussis	SDG 3.b. and 3.b.1: Proportion of the target population covered by all vaccines included in their national programme
Immunization – measles immunization coverage (second dose)	SDG 3.b. and 3.b.1: Proportion of the target population covered by all vaccines included in their national programme
Zero dose (absolute number)	N/A (Immunization Agenda 2030 target is by 2030, 50% reduction in the number of zero dose children at country, regional, and global levels)
Outcome – Treat	
Oral rehydration salt solution and zinc for treatment of diarrhea	SDG 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (indicator 3.8.1, included as part of the index)
Careseeking for symptoms of acute respiratory infection	SDG 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (indicator 3.8.1, included as part of the index)
Careseeking for fever	N/A
Malaria diagnostics usage	SDG 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable disease (indicator 3.3.3)
Malaria treatment (ACT or other first-line treatment according to national policy)	SDG 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable disease (indicator 3.3.3)
Contextual factors	
Population using at least basic drinking water services	SDG 6.1: By 2030, achieve universal and equitable access to safe and affordable drinking water for all (indicator 6.1.1)
Population using at least basic sanitation services	SDG 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations (indicator 6.2.1)
Population with at least basic handwashing facilities at home	SDG 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations (indicator 6.2.1)
Food insecurity experience scale	SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture.
Gender equality/women's empowerment	SDG 5.1: End all forms of discrimination against all women and girls everywhere (indicator 5.1.1)

END NOTES

1. SDG Goal 3 refers to Good health and well-being. SDG Target 3.2 states, "By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births."

2. The related World Health Assembly Global Nutrition 2025 targets are: achieve a 40% reduction in the number of children under five who are stunted and reduce and maintain childhood wasting to less than 5%.

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