This chapter explores how much progress governments and businesses have made in setting nutrition targets at the national, subnational, and company levels.

- National target setting can help drive action on nutrition, and setting targets that are SMART (specific, measurable, achievable, relevant, and time bound) can help ensure focus and accountability. Many countries, however, have failed to set such targets or to make their nutrition targets SMART. An analysis of 122 national nutrition plans with a potential total of 732 targets (six targets for maternal, infant, and young child nutrition in each of 122 plans) revealed only 358 targets—just under half the potential number. When targets existed, only two-thirds of them were SMART.

- Some national governments have begun to set targets related to noncommunicable diseases (NCDs)—indicating a growing commitment—but they are still in the minority. Only about 30 percent of countries that provided data to the World Health Organization have incorporated targets for obesity, diabetes, and salt reduction into their national NCD plans.

- Much nutrition programming has been decentralized to subnational administrative units, yet examples of subnational target setting are few. Even the influential Indian state nutrition missions are inconsistent about setting nutrition targets.

- About half of the 22 large food and beverage companies surveyed have set targets on salt, sugar, and added fats. Virtually none have targets to increase the levels of more health-promoting ingredients (such as whole grains, fruits, and vegetables) in their products, or to ensure accessibility of healthy products.
THROUGH THE WORLD HEALTH ASSEMBLY (WHA), COUNTRIES HAVE SIGNED ONTO GLOBAL NUTRITION TARGETS (PANEL 2.1, CHAPTER 2), AND AS CHAPTER 2 SHOWS, ONE WAY to track countries’ progress is to apply these global targets to the national level. Yet targets that countries set for themselves are likely to be more effective tools for promoting accountability. By definition, these self-generated targets have greater government buy-in and ownership than those set from outside the country. And these targets are most useful for accountability when they are SMART (that is, specific, measurable, achievable, relevant, and time bound).

This chapter focuses on countries’ progress in setting national targets for the indicators tracked in Chapter 2 (Table 2.1). We review countries’ national plans for both nutrition and noncommunicable diseases (NCDs) to identify whether they include clear and SMART targets for progress. Since the setting of targets by other stakeholders is also important (see Chapter 1), we review the evidence on target setting for the 22 food and beverage companies participating in the Access to Nutrition Index.

NATIONAL TARGETS ON MATERNAL, INFANT, AND YOUNG CHILD NUTRITION

Since the 1992 International Conference on Nutrition, the World Health Organization (WHO) has monitored countries’ development and implementation of national plans of action on nutrition.1 The WHO has reviewed nutrition plans to assess how many countries have targets for the six global targets on maternal, infant, and young child nutrition: stunting, wasting, and overweight in children under 5, low birth weight, anemia in women of reproductive age, and exclusive breastfeeding. It has also assessed whether these targets are SMART—that is, whether they are specific (defined in this instance as being aligned with the global targets included in the WHO’s global monitoring frameworks), measurable (including both a baseline2 and an end line value), and time bound (stating a specific time frame).3

The WHO team identified 122 national nutrition plans and analyzed them to assess how many include SMART targets. Ideally, each of the 122 plans would incorporate the full set of six global maternal, infant, and young child nutrition targets, and all would be SMART, making a potential total of 732 SMART targets. The analysis shows, however, that these 122 plans include only 358 targets—less than half of the potential 732 (Figure 3.2). Where targets exist, just 235 of them—66 percent—are SMART.

FIGURE 3.1 Number of 122 national nutrition plans that have targets, SMART targets, and no targets for maternal, infant, and young child nutrition

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number of Plans with SMART Target</th>
<th>Number of Plans with Target, but not SMART</th>
<th>Number of Plans with No Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stunting</td>
<td>58</td>
<td>13</td>
<td>51</td>
</tr>
<tr>
<td>Anemia</td>
<td>54</td>
<td>28</td>
<td>26</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>69</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>Exclusive breastfeeding</td>
<td>92</td>
<td>18</td>
<td>74</td>
</tr>
<tr>
<td>Wasting</td>
<td>36</td>
<td>14</td>
<td>36</td>
</tr>
</tbody>
</table>

Source: Authors, based on data from Chizuru Nishida and Kaia Engesveen.
There is also significant variation between targets. As shown in Figure 3.1, 86 of 122 country plans have targets for exclusive breastfeeding rates. At the other extreme, only 30 of 122 plans have targets for under-5 overweight rates. There are also differences in the proportions of these targets that are SMART: 82 percent of stunting targets are SMART (58 out of 71), but only 40 percent of childhood overweight targets are SMART (12 out of 30).

To help governments move forward and develop nutrition targets, the WHO has a range of tools to support national target setting. These tools, which are largely focused on undernutrition, are summarized in Panel 3.1.
NATIONAL TARGETS FOR NUTRITION-RELATED NONCOMMUNICABLE DISEASES

The global NCD targets were established as part of the NCD Global Monitoring Framework based on the historical performance of the top-ranked 10th percentile of countries to help set the level of achievement considered possible by 2025 (the targets are listed in WHO 2016p). To fill data gaps, the WHO established age-standardized baselines for 2010 for all targets, based on existing data and estimation methods. The WHO also routinely tracks progress and issues periodic global status reports.

The WHO is now encouraging and supporting member states to develop national targets that build on those set in the NCD Global Monitoring Framework but are based on their own national situations. To adapt the global targets to the national level, the WHO advises that countries review their current performance in preventing and managing NCDs; the current level of NCD-related mortality; exposure to risk factors; and NCD-oriented programs, policies, and interventions, both planned and in place.

The WHO has produced a range of guidance documents to support national governments in setting targets consistent with the global NCD targets. The first is a detailed guidance to member states so they can correctly measure each of the 25 indicators and monitor their progress over time. For each indicator, a complete definition is provided; appropriate data sources are identified; and a detailed calculation, where applicable, is provided. The second tool is an Excel-based worksheet that allows countries to enter current prevalence data to calculate the level they may wish to set for a target and the values they would aim for by 2025 and any interim years they may wish to monitor.4

The WHO supports countries in using these tools in multicountry workshops where countries review their existing data sources, level of programmatic response, and future planned investments in NCD prevention and control, and consider appropriate levels for national target setting. The tools are also used in individual country missions.

The WHO NCD group uses its NCD country capacity survey, which collects self-reported data, to track how many national NCD plans include these targets, including a 0 percent rise in obesity/diabetes and a 30 percent reduction in salt/sodium intake. Table 3.1 shows data reported by 174 countries. Of these, 36 percent have targets for obesity, 31 percent for diabetes, and 25 percent for salt reduction. Some countries have used the same or similar targets as those set globally. For example, Kenya has set national targets of a 0 percent rise in obesity and diabetes by 2020—the same as the global target, but for 2020 rather than 2025 (Panel 3.2). Salt reduction has a lower target of 15 percent by 2020. Other countries have used more ambitious targets. For example, in the South African strategy for the Prevention and Control of Obesity, government ministers “commit [themselves] and call on all

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**FIGURE 3.2** Presence of maternal, infant, and young child nutrition targets in 122 national nutrition plans (%)

Source: Authors, based on data from Chizuru Nishida and Kaia Engesveen.

Note: SMART = specific, measurable, achievable, relevant, and time bound.

**TABLE 3.1** Number of countries with targets for adult obesity, adult diabetes, and salt reduction, by WHO region

<table>
<thead>
<tr>
<th>Region</th>
<th>Obesity</th>
<th>Diabetes</th>
<th>Salt reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>African region</td>
<td>12</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Region of the Americas</td>
<td>11</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Eastern Mediterranean region</td>
<td>7</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>European region</td>
<td>9</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>South-East Asia region</td>
<td>7</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Western Pacific region</td>
<td>17</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>63</strong></td>
<td><strong>55</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>

Source: Unpublished self-reported data from the NCD Country Capacity Survey, provided by the WHO Surveillance and Population-Based Prevention Unit, Department for Prevention of NCDs. Printed with permission.
Few countries in Africa south of the Sahara have national responses to address the obesity epidemic despite the fact that in many countries (such as Ghana, Kenya, Mauritania, Niger, Sierra Leone, Tanzania, and Zimbabwe), the prevalence of overweight and obesity among women 19 to 49 years old is approaching 50 percent in urban areas (MOH 2016). In Kenya, approximately one in two women living in urban areas and one in four living in rural areas is overweight or obese, as are approximately 15 percent of adolescent girls (15 to 18 years old) living in urban areas and 8 percent living in rural areas (Jaacks, Slining, and Popkin 2015), and about 5 percent of children younger than five years (Tzioumis et al. 2016). The increasing prevalence of overweight and obesity has contributed to a rapid increase in noncommunicable diseases (NCDs), which now account for 27 percent of deaths in Kenyans 30 to 70 years of age (WHO 2016q).

The government is beginning to take action—one of only a few examples of such action from the region. In 2015 the Ministry of Health published the Kenya National Strategy for the Prevention and Control of Non-communicable Diseases 2015–2020, which includes a target of no increase in obesity and diabetes among adults. This target is similar to the obesity target set in the NCD Global Monitoring Framework. The National Nutrition Action Plan (2012–2017) (Kenya, Ministry of Public Health and Sanitation 2012) outlines specific activities to address the increase in overweight and obesity in Kenya, including the following: review, develop, and disseminate a comprehensive strategy and guidelines for preventing, managing, and controlling nutrition-related NCDs; train service providers and create public awareness on the importance of preventing, managing, and controlling nutrition-related NCDs; scale up community screening of body mass index (BMI) and waist circumference; and improve nutrition in schools (that is, review, develop, and disseminate nutrition guidelines for schools, mobilize resources to sustain optimal feeding programs, and integrate nutrition education into school curricula).

For childhood obesity, the country’s 2013 national maternal, infant, and young child nutrition policy guidelines state that childhood obesity is an emerging public health problem (Kenya, Ministry of Health, Division of Nutrition 2013), and in 2014, the nation’s first lady made a commitment to addressing nutrition, urging a particular focus on childhood obesity. In response to this call to action, the Ministry of Health is currently developing a National Action Plan for the Prevention of Childhood Obesity based on the WHO tools contained in its publication Prioritizing Areas for Action in the Field of Population-Based Prevention of Childhood Obesity (WHO 2016m). A major gap noted by the ministry, however, is the lack of data for children 5 to 14 years of age.

While Kenya is taking steps in the right direction by integrating overweight and obesity into national health policies and plans of action, the country still needs to allocate funds for obesity programming, as well as greater funding for nutrition in general. Further political support and will, including support from multiple sectors, are needed if the goal of halting the increase in obesity is to be achieved.

stakeholders to support and strengthen efforts to prevent and reduce the prevalence of obesity by 10 percent by 2020” (South Africa, Department of Health 2015, 10).

Panel 3.2 provides more detail about the developing plans to address obesity and NCDs in Kenya, including through the adoption of targets.

**SUBNATIONAL TARGETS**

There is a rising need for nutrition targets at the level of subnational administrative units. Policy makers need targets to guide actions that will lead to zero levels of malnutrition, subnational administrators need them as responsibility for implementing nutrition programs gets decentralized, businesses need them to identify opportunities, external donors need them to target their interventions, and those in civil society need them to promote accountability for the most vulnerable. But setting targets at the subnational level is not easy: it requires capacity at the subnational level to monitor progress against targets, and it requires politically courageous subnational leaders as their efforts become more transparent.

The state nutrition missions of India are an example of where laudable commitment has not, to date, been fully backed up with targets. These missions serve six states,
Although declines in India’s child under-nutrition rates have accelerated since 2006, these faster developments are still well below the rates of progress needed to achieve the global nutrition targets adopted by the World Health Assembly (WHA) to which India is a signatory. India lags behind many poorer countries in Africa south of the Sahara; at current rates of decline, India will achieve the current stunting rates of Ghana or Togo by 2030 and that of China by 2055. Further, nutritional status and progress in India vary markedly across its states. India urgently needs to take target setting to the subnational level to achieve global nutrition targets and Sustainable Development Goals (SDGs).

To look at challenges related to state-level target setting for nutritional outcomes, we assessed whether states that have declared commitment to nutrition in the form of an independent state nutrition mission also included time-bound targets for improvements in nutrition. Maharashtra was the first state in India to launch its mission in the form of an autonomous technical and advisory body, in 2005, under the Department of Women and Child Development. Subsequently, five other states have launched their respective missions based on the Maharashtra model: Madhya Pradesh, Uttar Pradesh, Odisha, Gujarat, and Karnataka. All six state nutrition missions focus on the 1,000-day postconception period and commit to improving intersectoral coordination in order to improve child nutrition.

### PANEL 3.3 STATE NUTRITION MISSIONS IN INDIA: DOING POORLY ON TARGET SETTING

**NEHA RAYKAR AND PURNIMA MENON**

Although declines in India’s child under-nutrition rates have accelerated since 2006, these faster developments are still well below the rates of progress needed to achieve the global nutrition targets adopted by the World Health Assembly (WHA) to which India is a signatory. India lags behind many poorer countries in Africa south of the Sahara; at current rates of decline, India will achieve the current stunting rates of Ghana or Togo by 2030 and that of China by 2055. Further, nutritional status and progress in India vary markedly across its states. India urgently needs to take target setting to the subnational level to achieve global nutrition targets and Sustainable Development Goals (SDGs).

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### BUSINESS TARGETS

Countries are not the only stakeholders for whom target setting can provide focus and promote accountability. As the Global Nutrition Report 2015 demonstrated, busi-
nesses have a large influence on nutrition outcomes. How many of the large food and beverage companies set nutrition targets? The Access to Nutrition Index (ATNI) assesses the extent to which major food and beverage companies make clear commitments or have formal policies on key issues and, in selected areas, whether they set quantifiable targets.

In the 2016 global ATNI, 22 companies were scored on whether they set targets in 14 areas that lend themselves to more quantitative goals. Figure 3.3 shows that companies have generally not made or published clear, measurable targets.

With respect to the nutritional composition of their products, 62 percent of companies (13 of 21 for whom it is relevant) have set targets for reducing salt (or sodium) in their products. Ten out of 21 companies—nearly 50 percent of relevant companies—have set a target on trans fats. And while some have set targets to reduce saturated fats or sugar, hardly any have set targets to increase the levels of more health-giving ingredients, such as whole grains, fiber, fruits, and vegetables.

In the other areas where ATNI assesses whether companies have targets, such as the accessibility or affordability of health-promoting products, research and development spending for fortified products, or financial support for undernutrition programs, performance is lamentable, with only one company setting a target on two out of the four dimensions of performance. Even in the area of employee health and wellness, only eight companies (36 percent) set targets for the level of participation they hope to encourage in these programs.

Companies are run, and their value assessed, by setting and performing against key targets: targets for revenue and margin growth, market penetration, brand

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PANEL 3.3  STATE NUTRITION MISSIONS IN INDIA: DOING POORLY ON TARGET SETTING

NEHA RAYKAR AND PURNIMA MENON

Some insights arose from examining target setting in the context of Indian state nutrition missions:

1. Only two of the six states have clear, measurable targets for nutritional outcomes—Uttar Pradesh State Nutrition Mission and Odisha’s Nutrition Operation Plan. The action plan of Maharashtra’s Rajmata Jijau Mother-Child Health and Nutrition Mission includes monitoring of 10 important indicators related to maternal and child health but does not specify measurable targets and time frames for these indicators. The states of Gujarat, Madhya Pradesh, and Karnataka do not include any specific targets in their mission statements.

2. Not all targets align with the global nutrition targets: Uttar Pradesh includes four of the six targets—it excludes low birth weight and overweight prevalence but includes underweight prevalence as an additional indicator that is not a global target. Odisha’s Nutrition Operation Plan includes only stunting, wasting, and underweight, excluding the other global targets of women’s anemia, exclusive breastfeeding, child overweight, and low birth weight.

3. In states that have targets, the targets are based on older data. For example, the Uttar Pradesh State Nutrition Mission’s plan for 2014–2024 is based on findings from India’s National Family Health Survey 3 (NFHS-3), from 2005–2006, and includes time-bound targets for stunting, wasting, underweight, exclusive breastfeeding, and women’s anemia. Progress across the target indicators could instead be measured using the recently released Rapid Survey on Children 2014 data for baseline values to reflect the most recent status of undernutrition in the state. Likewise, Odisha’s Nutrition Operation Plan, aimed at accelerating underweight reduction in 15 high-burden districts of the state, includes targets for stunting, wasting, and underweight based on NFHS-3, 2005–2006 levels.

An urgent action call is needed for all states to use new, updated data to report the current status of nutrition and set new targets, cover all six globally agreed target indicators, and ensure the availability of appropriate data collection mechanisms that deliver comparable data on these targets over time. Target setting is the first order of business to strengthen accountability. The next is collecting data on stated targets.
recognition, and many more metrics. That is to say, managers know that what gets measured gets managed.

**CALLS TO ACTION**

1. **Set more SMART targets.** All national governments should establish SMART national targets for stunting, wasting, exclusive breastfeeding, low birth weight, anemia, childhood overweight, adult obesity, diabetes, and salt reduction by the end of 2017. These targets should be ambitious but achievable and aligned.

2. **Establish more subnational targets.** National nutrition plans should develop and incorporate nutrition outcome and input targets for major administrative regions.

3. **Food and beverage companies should set and report against a larger number of SMART targets to improve nutrition.** Key areas are adherence to the International Code of Marketing of Breast-milk Substitutes, significant reductions in advertising and marketing to children, and the reduction of sugar, salt, and fat across their entire product lines. Companies should also clearly publish these targets, as well as their performance against them. The next Access to Nutrition Index evaluation should report substantial progress in these areas from the 22 largest global food and beverage companies assessed.

**FIGURE 3.3** Share of companies in the Access to Nutrition Index that set clear targets in a range of areas

Source: Analysis and data from Rachel Crossley, Access to Nutrition Foundation.

Note: Number of companies = 22. R&D = research and development.