Narrative Review

One in Five: Why Stunting is Malaysia's Most Urgent Health Emergency

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ABSTRACT

Background: Childhood stunting remains one of the most persistent public health failures in Malaysia. Despite decades of economic growth, expanding health services, and successive national nutrition plans, 21.2% of Malaysian children under five were stunted in 2022, rising to a UNICEF/WHO/World Bank Joint Child Malnutrition Estimates of 24.3% in 2024. Global stunting prevalence has declined steadily over the same period. Malaysia is one of the very few upper-middle-income countries whose trajectory is moving in the wrong direction.

Aims: This narrative review examines the epidemiology, determinants, neurodevelopmental consequences, and policy implications of childhood stunting in Malaysia. It frames stunting as a sentinel indicator of child wellbeing, equity, and system performance, and assesses the rationale for a stronger First 1,000 Days response.

Source of Evidence: Evidence was drawn from Malaysian national surveys, peer-reviewed literature, and reports from the Ministry of Health Malaysia, UNICEF, the World Health Organization, and the World Bank. International experience from countries that achieved substantial reductions in stunting was reviewed to identify implementation lessons relevant to Malaysia.

Findings: Malaysia carries a stunting burden disproportionate to its income level, with marked inequities across states, ethnic groups, and socioeconomic strata. Orang Asli children face a prevalence of 43.8%, more than double the national figure. The determinants of stunting are predominantly social, spanning pre-pregnancy maternal nutrition, birth outcomes, infant feeding, and household food security. Neuroimaging evidence confirms that stunting alters brain architecture in infancy. Early nutritional deficits carry persistent consequences for cognition, educational attainment, and adult earnings. These consequences may be persistent, although later catch-up and developmental gains remain possible. Countries that have reduced stunting rapidly share four features: trained and incentivized community health workers, statutory intersectoral integration, an explicit First 1,000 Day focus, and independent evaluation.

Conclusion: Stunting should not be treated as a narrow nutrition indicator. It should be recognized as a public health signal that reflects how effectively systems protect children before birth and during early life. Malaysia has sufficient evidence to act. The next frontier is implementation through a whole-of-nation First 1,000 Days approach that reaches high-risk families earlier, more consistently, and beyond the clinic.

Keywords: Stunting, First 1,000 Days, child nutrition, Malaysia, determinants of health, maternal and child health, health equity, community health workers

INTRODUCTION

Childhood stunting is often measured in centimeters, but its significance extends beyond height. It reflects accumulated disadvantages during one of the most developmentally sensitive periods of life, beginning before birth and extending through infancy. The World Health Organization (WHO) defines stunting as height-for-age

below 2 standard deviations below the WHO Child Growth Standards median.[1] This definition supports surveillance and comparison, but it can also make a complex developmental problem appear deceptively simple.

In Malaysia, stunting remains a critical public health concern. The country has achieved high coverage of maternal and child health services, widespread facility-based delivery, and substantial reductions in many traditional child health threats.[2] Yet linear growth outcomes have not improved at the expected pace. National Health and Morbidity Survey (NHMS) 2022 reported that 21.2% of children under five were stunted, 11.0% were wasted, 15.3% were underweight, and 6.0% were overweight.[3]

The persistence of stunting despite decades of program activity suggests that conventional responses are necessary but insufficient. Nutrition counseling, growth monitoring, supplementation, and facility-based services remain important. However, they do not fully address maternal health, food insecurity, housing, sanitation, caregiving constraints, household income, education, and social protection.[4,5] These determinants shape a child's growth long before the child appears in a clinic.

Recent developmental evidence has strengthened the case for wider framing. Early growth faltering is associated with cognitive development, school readiness, educational attainment, earnings, and later health. Stunting, therefore, matters not only to pediatricians and nutritionists but also to policymakers concerned with equity, productivity, and national development.[6-8]

This review synthesizes evidence on childhood stunting in Malaysia through an epidemiological, developmental, and policy lens. It argues that Malaysia's stunting challenge is no longer a knowledge gap. It is an implementation gap. Reducing stunting requires a whole-of-nation First 1,000 Days response that starts before birth, reaches households beyond facility walls, and prioritizes children and communities at greatest risk.

Search Strategy and Selection Criteria

This narrative review synthesizes data from national health surveys, peer-reviewed literature, policy documents, and grey literature. National surveillance data were drawn from the NHMS series from 2011 to 2022[3,9-12] and the Orang Asli Health Survey 2022.[13] International estimates and frameworks were obtained from UNICEF, the World Health Organization, and the World Bank.[14]

Peer reviewed literature was identified through PubMed, Scopus, and Google Scholar using combinations of the terms "stunting", "child malnutrition", "Malaysia", "First 1,000 Days", "maternal nutrition", "low birth weight", "anemia", "breastfeeding", "complementary feeding", "social determinants", "community health workers", and "nutrition interventions". Priority was given to national surveys, systematic reviews, large cohort studies, high-quality implementation studies, and policy-relevant analyses published between 2010 and 2026. The review was not designed as a systematic review or meta-analysis. Evidence was synthesized thematically to support policy and clinical interpretation.

REVIEW RESULTS

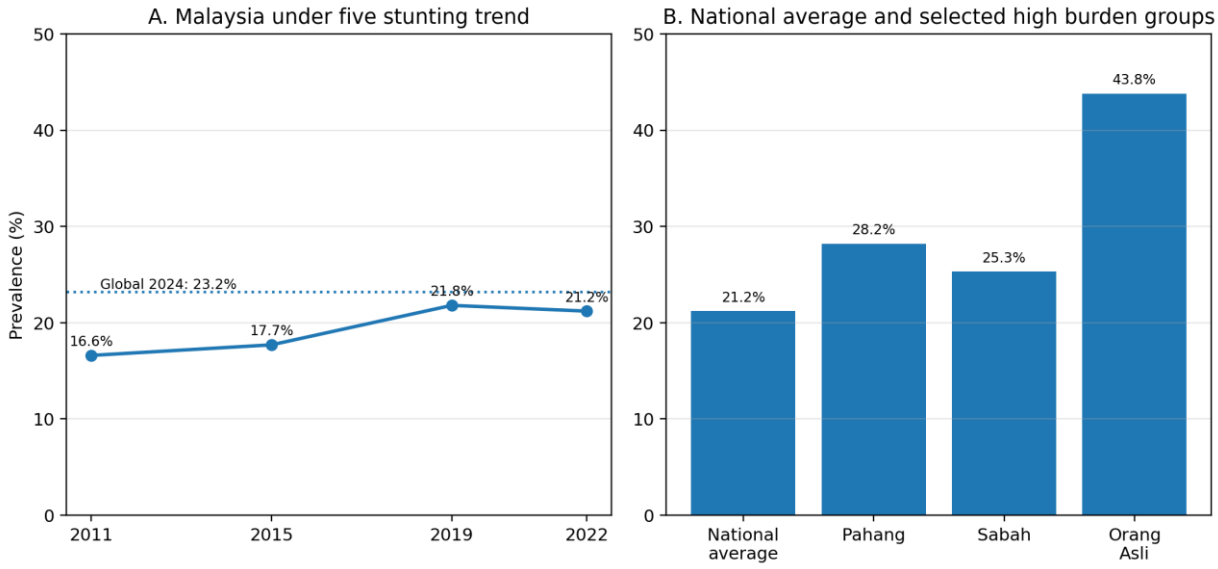
Childhood Stunting in Malaysia: The Epidemiological Landscape

National Trends and Trajectory

Malaysia has made extraordinary gains in maternal and child health over the past four decades. Maternal mortality has fallen sharply. Infant mortality is among the lowest in Southeast Asia. Immunization coverage consistently exceeds 90%.[5] None of these achievements have been matched by improvements in child linear growth. This divergence is the central epidemiological puzzle of Malaysian child health.

The NHMS series tells the story plainly. Stunting prevalence among children under five stood at 16.6% in 2011, rose to 17.7% in 2016, climbed further to 21.8% in 2019, then edged down marginally to 21.2% in 2022.[3,9-11] The 0.6% decline between 2019 and 2022 does not represent a trend reversal. The WHO's modelled estimate for 2024, drawn from the same surveillance series and validated against regional data, places Malaysia's current prevalence at 24.3%.[15,16] Over the same period, global stunting prevalence declined from approximately 33% in 2000 to 23.2% in 2024;[14] however, Malaysia has moved in the opposite direction.

Figure 1. Childhood stunting in Malaysia. Panel A shows national under-five stunting prevalence from NHMS 2011 to 2022, with the 2024 global prevalence shown as a reference line. Panel B shows selected high-burden groups and locations. Sources: NHMS 2011- 2022[3,10-12], Joint Child Malnutrition Estimates 2026[16], and Orang Asli Health Survey 2022[13]



Malaysia's development paradox

The persistence of stunting against a backdrop of sustained economic development demands explanation. Malaysia's gross national income per capita has grown substantially over four decades. Poverty rates have fallen dramatically. The healthcare system is mature, well-funded by regional standards, and highly accessible.[2,8] Under

typical assumptions, these conditions should lead to decreasing stunting rates. However, they haven't, which highlights why health-sector responses alone are insufficient to address this issue.

Economic growth does not automatically improve dietary quality. As household incomes rise in Southeast Asia, food consumption patterns often shift towards energy-dense, nutrient-poor options.[17] Highly processed foods and sugar-sweetened beverages become more accessible, while dietary diversity may remain inadequate to meet children's micronutrient requirements. The result is a nutrition transition that simultaneously increases the risk of overweight and fails to address the micronutrient deficiencies that drive stunting.[18]

National income averages also conceal profound inequalities. Gains among wealthier populations can occur alongside persistent disadvantage in the poorest quintile, among ethnic minorities, rural communities, and marginalized groups who interact infrequently with formal services.[13] When aggregate growth masks concentrated deprivation, stunting persists even as headline economic indicators improve.

Finally, the upstream determinants of stunting originate before pregnancy. Adolescent girls who enter pregnancy malnourished, short-statured, or anemic carry forward intergenerational biological disadvantage that no antenatal intervention can fully reverse.[4] Interventions that begin at birth or later cannot address what was already set in motion months earlier. Economic development creates the conditions for change but does not itself produce change unless it is translated into equitable services, food systems that deliver nutritional quality, and social protection that reaches the most vulnerable.

Beyond prevalence: the double burden of malnutrition

NHMS 2022 reported that 21.2% of children under five were stunted, 11.0% were wasted, and 6.0% were overweight.[3] This coexistence of undernutrition and overweight within the same population, and sometimes within the same household, defines the double burden of malnutrition that characterizes Malaysia's nutritional landscape. The two conditions share common upstream causes: poor dietary quality, inadequate access to nutritious foods, and food systems that privilege caloric density over micronutrient adequacy.[18]

The double burden has direct implications for intervention design. Strategies focused solely on increasing caloric intake risk worsening overweight. Obesity prevention strategies that fail to account for undernutrition will miss a substantial proportion of at-risk children. Malaysia's response must address dietary quality, not simply dietary quantity, and it must do so across the socioeconomic gradient where the burden is concentrated.

Beyond the National Average: Inequality and Concentrated Burden

Why do averages mislead

A national stunting prevalence of 21.2% means that approximately one in five Malaysian children under five is affected.[3] The figure is alarming in aggregate, but it obscures the distributional reality. Stunting is not uniformly distributed across the population. It is concentrated among the poorest households, the most

geographically remote communities, and the most structurally marginalized ethnic groups. Understanding where the burden sits is a prerequisite to targeting resources where they will have the greatest impact.

Geographic and socioeconomic disparities

NHMS 2022 documented substantial state-level variation. Stunting prevalence reached 28.2% in Pahang, 27.8% in Perak, 25.3% in Sabah, and 25.2% in the Federal Territory of Putrajaya.[3] The figure for Putrajaya is even more telling, as Malaysia's administrative capital, it is mainly inhabited by civil servants. The level of stunting there is unlikely to be explained by geographic remoteness or severe poverty alone. A case-control study conducted in Putrajaya identified several independent risk factors: intrauterine growth restriction, low household income, low birth weight, low maternal education, paternal unemployment, childhood anemia, poor dietary diversity, and care by babysitters.[19] This study suggests that social determinants of health may contribute to the burden.

Ethnicity also shapes the burden. Malay children exhibit a stunting prevalence of 21.1%, compared with 15.3% among Chinese children. Other Bumiputera groups report 21.3%.[3,20] These differences reflect structural differences in household income, food access, and cultural feeding practices rather than any inherent biological vulnerability.[21]

Poverty is a strong and consistent predictor. The Landscape Analysis found that 26.0% of children in the poorest quintile were stunted, compared with 17.6% in the wealthiest quintile.[22] This gradient persists across all NHMS rounds and confirms that stunting is in significant part, a poverty-driven outcome, operating through food insecurity, overcrowded housing, reduced access to healthcare, and lower maternal education.

Orang Asli communities: a persistent and acute inequity

The most severe nutritional emergency in Malaysia is found among the indigenous Orang Asli population. The Orang Asli Health Survey 2022 documented a stunting prevalence of 43.8% among children under five, more than double the national average.[13] Within this population, the burden is concentrated among the Negrito tribes of remote forested areas, where prevalence reaches 58.3%. These communities also report a 32.9% underweight rate, a 24.4% low-birth-weight rate, and food insecurity affecting 37.1% of households.[13]

These figures cannot be attributed solely to individual behaviour or parental decisions alone. They indicate deeper structural disadvantages, including extreme poverty, geographic isolation, limited access to culturally suitable healthcare, high rates of soil-transmitted helminth infections, poor sanitation and lack of clean water, and the disruption of traditional food systems caused by deforestation and land encroachment.[13,23] This population is largely absent from routine NHMS surveillance. Its burden is systematically undercounted. No universal program designed for the general population can reach these communities with the intensity and cultural sensitivity required.

Why stunting matters beyond height

Stunting is not simply a description of a short child. It is a marker of chronic early exposure to disadvantage. The height deficit is visible. The developmental consequences are less visible but no less important. The first years of life are a period of rapid brain development. Nutrition, infection, stress, caregiving, and environmental exposure shape neural connectivity, myelination, synaptic development, and executive function. Cusick and Georgieff describe the First 1,000 Days as a critical window for brain development because nutrient deficits during this period can influence later cognitive and behavioral outcomes.[24]

The neurological case for acting within the First 1,000 Days is no longer based solely on proxy indicators. In 2023, a neuroimaging study published in *Nature Human Behaviour* demonstrated that stunted children in rural India showed significantly impaired visual working memory compared with age-matched peers of normal height.[7] Stunted infants were more easily distractible, showed reduced activation of the left anterior intraparietal sulcus, a region central to working memory maintenance, and scored lower on problem-solving tasks at follow-up one year later.[7] These findings are consistent with and mechanistically extend longitudinal cohort evidence from Bangladesh, Cambodia, and Latin America.[8,25]

The First 1,000 Days represent a period of accelerated neural connectivity, myelination, and synaptic pruning, during which the developing brain is highly sensitive to nutritional adequacy, infection load, and the quality of caregiving. Inadequate micronutrient and energy intake reduces overall brain volume, diminishes neuronal density, and disrupts connectivity within circuits that govern language, memory, and executive function.[24,26] Iron deficiency, which affects 46.5% of Malaysian children aged 6 to 59 months, specifically disrupts dopaminergic neurotransmission and hippocampal neurogenesis, pathways critical for learning and memory.[7,22,24]

The downstream educational and economic consequences are substantial. Stunted children are more likely to start school late, repeat grades, and leave school earlier.[27] Adults who experienced stunting in early childhood earn less, work less productively, and are more vulnerable to metabolic disease.[8,28] The developmental consequences can be enduring because early childhood is a sensitive period for neurological development. However, some children may achieve catch-up growth or developmental gains when nutrition, health, caregiving, and learning environments improve,[29] although recovery may be incomplete and is not assured. Prevention and early intervention, therefore, remain essential.[6,27,30]

Economic Burden: The Compounding Cost

The economic case for investing in stunting reduction is among the strongest in public health. Horton and Steckel estimated that adult stunting cost approximately 8% of GDP across the twentieth century.[2] Galasso et al. demonstrated that per capita income losses from childhood stunting range from 5% to 7% in low- and middle-income countries, operating through reduced schooling, lower cognitive skill formation, and diminished wages.[31]

A 2022 study in *EClinicalMedicine* estimated that across 95 low- and middle-income countries, childhood stunting costs the private sector at least USD 135.4 billion in lost sales annually, equivalent to 0.01% to 1.2% of

each country's national Gross Domestic Product (GDP).[32] UNICEF's synthesis of intervention returns estimates a 6- to 17-fold return on every dollar invested in stunting reduction.[33] The World Bank estimates that undernutrition and micronutrient deficiencies cost the global economy at least USD 3.5 trillion annually.[18] For Malaysia, pursuing high-income country status under the 13th Malaysia Plan while sustaining one of the highest stunting rates in upper-middle-income Asia is a direct contradiction in human capital strategy.[34]

Determinants: Why the Health System Cannot Act Alone

The UNICEF Conceptual Framework on Maternal and Child Nutrition categorizes determinants across immediate, underlying, and enabling levels. Immediate determinants include diet, feeding, health, and care. Underlying determinants include food security, services, caregiving resources, and living environments. Enabling determinants include governance, resources, norms, poverty, and broader political economy.[5]

Evidence from Malaysia supports this layered model, as shown in Table 1. Key predictors comprise maternal short stature, maternal underweight, low birth weight, delayed or no antenatal care, breastfeeding practices, dietary diversity, poverty, rural location, and Orang Asli status. These factors are not isolated from clinical risks but tend to cluster within household, community, and structural contexts.[3,13,22]

This matter is significant as it influences the policy diagnosis. If stunting were primarily attributable to inadequate parental knowledge, then educational interventions alone might suffice. However, the evidence indicates otherwise. Malaysia requires enhanced counseling services, affordable, nutritious food options, improved maternal nutrition, responsive primary healthcare, comprehensive social protection measures, safe environments, and community support programs that consistently reach families.

Table 1. Determinants of childhood stunting and policy levers in Malaysia

Determinant level	Examples in the Malaysian context	Why it matters	Policy and clinical levers
Immediate	Poor dietary diversity, suboptimal breastfeeding, recurrent infection, child anemia	Directly affects nutrient intake, immunity, growth, and development	Growth monitoring, breastfeeding support, complementary feeding counseling, infection prevention, anemia detection and treatment
Underlying	Maternal nutrition, low birth weight, household food insecurity, service access, caregiving constraints	Shapes risk before and during the First 1,000 Days	Quality antenatal care, iron and folate adherence, nutrition-sensitive social protection, referral completion, community follow-up
Enabling	Poverty, food prices, housing, water, sanitation and hygiene (WASH), education, remoteness, social exclusion	Determines whether families can act on health advice and access support	Whole-of-nation governance, local government engagement, food system action, targeted support for high-burden communities

Global Evidence: What Rapid Stunting Reduction Requires

Countries that have achieved substantial, sustained reductions in childhood stunting are not uniformly wealthy, nor are their contexts uniformly simple. What distinguishes them from countries that have failed to reduce stunting despite economic growth is the deliberate architecture of their response. Four operational features are consistently present, as presented in Table 2.

Table 2. International case studies in rapid stunting reduction: mechanisms and applicability to Malaysia

Country	Core approach	Lesson for Malaysia
Peru	Political commitment, results-based budgeting, social protection, targeted maternal and child interventions	Stunting can fall when nutrition becomes a national accountability issue
Bangladesh	Community health worker platforms, household counseling, NGO (non-governmental organization) and government collaboration	Repeated household contact can change practices and service use
Indonesia	National mandate, village-level convergence, Posyandu community platform	Regional experience shows value of local accountability and community delivery
Ethiopia	Health extension workers with agriculture and WASH improvements	No single sector can reduce stunting alone

Sources: World Bank Nutrition Overview 2024[18]; Miranda et al. 2023[35]; Golan et al. 2019[36]; Kumar et al. 2021[37]

Peru's experience is the most instructive comparator for Malaysia's current position. It is an upper-middle-income country in which stunting has resisted earlier health-sector-focused efforts. The shift that drove rapid reduction was not a new nutritional intervention. It was results-based budgeting, a conditional cash transfer program that reached the poorest households, and a statutory multisectoral delivery structure that made every relevant ministry accountable for a specific component of the response.[18]

Indonesia's trajectory is the most immediately relevant regional lesson. Starting from a prevalence above 30% in 2018, Indonesia achieved a 9.3% reduction in five years. The mechanism was Presidential Regulation 2021, which created a formal mandate for village-level Human Development Workers across all 514 districts, along with mandatory quarterly public reporting against national targets.[35] The operational analogue in Malaysia is the existing MyChampion, currently voluntary and under-resourced. The evidence from Indonesia, Bangladesh, and Ethiopia consistently identifies the formalization, training, and adequate resourcing of community health workers as the single most impactful operational lever available.[35,36,38,39]

The four shared features across all successful cases are: 1) trained and incentivized community health workers as the primary delivery mechanism; 2) statutory intersectoral integration of nutrition, social protection, WASH, and education under a single accountability structure; 3) an explicit and sustained focus on the First 1,000

Days as the primary intervention window; and 4) independent program evaluation informing adaptive scale-up decisions.

DISCUSSION

The evidence presented in this review indicates a singular, concerning conclusion that Malaysia's burden of stunting is not predominantly a clinical issue. It is a governance problem. The determinants are known. The interventions that work are documented. The countries that have succeeded are identified, and their mechanisms are replicable. What has been missing in Malaysia is not knowledge or resources. It is the institutional architecture for converting evidence into coordinated, household-facing action across the sectors that determine whether a child grows normally.

Every previous national nutrition plan has operated predominantly within the Ministry of Health. Stunting, however, requires simultaneous action on food systems, social protection, water and sanitation, maternal education, and housing quality. None of these domains sit within the Ministry of Health's direct authority. The independent outcome evaluation of the National Plan of Action for Nutrition of Malaysia III, conducted in 2025, found that 43% of outcome indicators were not achieved over a decade, and approximately 25% lacked any recent monitoring data.[40] Child undernutrition rates showed minimal decline, and dietary quality indicators remained stagnant. This is not a failure of nutritional science but a failure of governance design.

The 2022–2030 National Strategic Plan to Combat the Double Burden of Malnutrition Among Children in Malaysia represents a more ambitious institutional response. It encompasses five core strategies and 31 initiatives, explicitly involving multiple ministries beyond health, and is overseen by a Special Committee chaired at the deputy-prime-ministerial level.[41] Whether this governance structure translates into measurable household-level impact will depend on three conditions that previous plans have not met: statutory budget authority that crosses ministry lines, mandatory public reporting against subnational targets, and rigorous independent evaluation with scale-up decisions explicitly linked to findings.

The community health worker question sits at the center of the operational gap. Malaysia has an existing cadre, MyChampion, with reach into communities that facility-based services cannot match. But voluntary, under-incentivized health workers cannot replicate what trained, salaried, supervisory-supported community health workers achieved in Indonesia, Ethiopia, and Bangladesh.[35,38,39] The evidence from these countries clearly shows that formalizing the community health worker role with specific competencies, consistent supervision, fair pay, and clear responsibilities during the First 1,000 Days is the most effective operational strategy for reducing stunting across the population.[39]

The detection gap in Malaysia's clinical system compounds the governance gap. A stunting prevalence of 22.8% among children under 6 months confirms that the primary causal window is antenatal, not postnatal.[22,42] Yet Malaysia's growth monitoring system effectively ends at 18 months, when the immunization schedule

concludes, and stunting is typically identified at kindergarten entry, at age 5, 3 years after the biological window for meaningful intervention has closed.[43] The main clinical focus continues to be the antenatal period, involving routine screening for maternal short stature, underweight, and iron-deficiency anemia, with subsequent active referral to nutritional and social support services for high-risk dyads.

Community-based first-1,000-days programs that integrate home visiting, growth monitoring, infant feeding support, and linkage to social protection have demonstrated population-level impact in every context where they have been rigorously evaluated.[26,35,38,39] In Malaysia, where the community health worker infrastructure exists but is inadequately resourced for this role, the policy question is not whether this model works. It does. The policy question is whether governance will formalize, fund, and evaluate it at sufficient scale to produce a national impact, and whether that evaluation will be genuinely independent, subnational in its granularity, and explicitly tied to financing decisions for scale-up.

The Orang Asli burden demands separate recognition. A stunting prevalence of 43.8%,[13] more than double the national average, cannot be addressed by any universal program. This population requires a dedicated, community-designed, culturally appropriate response that addresses compounded structural disadvantages: food insecurity, inadequate sanitation, geographic isolation, and disruption of traditional food systems.[13,15] Progress on national stunting targets will not be achievable without a targeted sub-strategy for this population, designed with Orang Asli communities rather than for them.

There is also an invisible population that current surveillance does not count. Refugee, stateless, and undocumented migrant children are excluded from the NHMS. Their nutritional status is unknown. Given the structural disadvantages these populations face, including poverty, food insecurity, and limited access to health services, the true national stunting burden is almost certainly higher than any published figure reflects.[15]

The economic argument for urgent action is compelling. Malaysia is pursuing high-income country status while maintaining one of the highest stunting rates among upper-middle-income countries globally. The World Bank estimates that childhood undernutrition costs the global economy at least USD 3.5 trillion annually.[18,44] In Malaysia, a simple calculation shows that the cognitive and productivity losses associated with current stunting rates constitute a direct tax on the country's efforts to develop human capital. Investing in stunting reduction should not be regarded as a welfare expenditure. Instead, it represents the most cost-effective human capital investment accessible to the Malaysian government.[33,44]

For the pediatric and child health community, the implication is clear and actionable. Pediatricians and child health practitioners are the best professionals positioned to shift the detection frontier from kindergarten to the antenatal clinic. Growth monitoring from the first antenatal contact, systematic screening for maternal undernutrition and iron-deficiency anemia, active referral to social protection services, and institutional advocacy for the Ministry of Health's community-based First 1,000 Days initiative represent the highest-yield clinical actions available. Stunting detected at kindergarten entry is stunting detected three years too late.

Limitations

The NHMS provides cross-sectional rather than longitudinal data, limiting causal inference on stunting trajectories. Stunting data for refugee, stateless, and undocumented migrant children are absent from national surveillance, understating the true burden among the most marginalized populations in Malaysia. Community-based First 1,000 Days program evaluations in the Malaysian context are limited in number, and the local generalizability of international case study evidence requires validation through domestic implementation science. International case study contexts are heterogeneous, and direct program transfer to Malaysia requires adaptation to local governance structures, population demographics, and service delivery systems.

Conclusion

One in five Malaysian children enters life already carrying a measurable developmental deficit. Malaysia does not face a knowledge deficit in childhood stunting. The epidemiology is documented, the determinants are increasingly understood, and the broad features of effective action are known. The challenge is implementation.

Stunting should no longer be treated as a narrow nutrition indicator or a late clinical finding. It should be recognized as a sentinel indicator of child development, equity, and system performance. The shortest crisis is also one of the most consequential. It unfolds before birth, accelerates during infancy, and becomes visible by the time the optimal prevention window has already begun to close.

A whole-of-nation First 1,000 Days response offers the most credible path forward. It must begin with maternal health, reach households continuously, prioritize high-burden communities, and use rigorous evidence and evaluation to guide scale. The goal is not only to reduce prevalence but also to ensure that every child in Malaysia has a fair opportunity to grow, learn, and thrive.

Conflict of Interest

The author declares no conflict of interest.

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