The Sustainable Development Goals Extended Report 2025

Inputs and information provided as of 30 April 2025

Note: This unedited 'Extended Report' includes all indicator storyline contents as provided by the SDG indicator custodian agencies as of 30 April 2025. For instances where the custodian agency has not submitted a storyline for an indicator, please see the custodian agency focal point information for further information. The 'Extended Report' aims to provide the public with additional information regarding the SDG indicators and is compiled by the Statistics Division (UNSD) of the United Nations Department of Economic and Social Affairs. Storylines presented in this document may slightly differ from figures cited in the SDG Report 2025 text due to the timing of the submission and the subsequent updates received upon finalizing the Report.

Contents

Indicator 3.1.1 Maternal mortality ratio 2

Indicator 3.1.2 Proportion of births attended by skilled health personnel 2

Indicator 3.2.1 Under-5 mortality rate 3

Indicator 3.2.2 Neonatal mortality rate 3

Indicator 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations 4

Indicator 3.3.2 Tuberculosis incidence per 100,000 population 4

Indicator 3.3.3 Malaria incidence per 1,000 population 5

Indicator 3.3.4 Hepatitis B incidence per 100,000 population 6

Indicator 3.3.5 Number of people requiring interventions against neglected tropical diseases 6

Indicator 3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease 8

Indicator 3.4.2 Suicide mortality rate 8

Indicator 3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders 9

Indicator 3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol 9

Indicator 3.6.1 Death rate due to road traffic injuries 10

Indicator 3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods 10

Indicator 3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group 11

Indicator 3.8.1 Coverage of essential health services 12

Indicator 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income 12

Indicator 3.9.1 Mortality rate attributed to household and ambient air pollution 12

Indicator 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services) 12

Indicator 3.9.3 Mortality rate attributed to unintentional poisoning 12

Indicator 3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older 13

Indicator 3.b.1 Proportion of the target population covered by all vaccines included in their national programme 14

Indicator 3.b.2 Total net official development assistance to medical research and basic health sectors 14

Indicator 3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis 15

Indicator 3.c.1 Health worker density and distribution 15

Indicator 3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness 16

Indicator 3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms 16

Target 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

Indicator 3.1.1 Maternal mortality ratio

Now is the time for amplified action to reach the global maternal mortality target

The global maternal mortality ratio (MMR) was 197 in 2023 compared to 228 in 2015. Even progress has been achieved the MMR in 2023 is approximately three times higher than the global target and an annual reduction rate of 14.8 per cent is required to reach the global target of 70 maternal deaths per 100,000 live birth in 2030. This means that nearly 700,000 deaths need to be prevented between 2024 and 2030. Globally, the lifetime risk of a 15-year-old girl eventually dying from a maternal cause reduced from 1 in 208 in 2015 to 1 in 272 in 2023.

Countries experiencing violent conflict and high levels of institutional and social fragility accounted for 61 per cent (160,000) of maternal deaths in 2023. The MMR for the group of conflict-affected countries was 504 and in situations experiencing institutional and social fragility in 2023, the MMR was 368.

A lot still needs to be done to ensure positive maternal health outcomes. In 2023 the maternal mortality ratio was 421 in low income countries compared to 10 in high income countries. Declines in maternal mortality has stalled in sub-Saharan Africa and Southern Asia and these regions accounted for 87 per cent of maternal deaths in in 2023 with no progress observed since 2015.

Storyline authors(s)/contributor(s): Jenny Cresswell, WHO; Ann-Beth Moller, WHO

Custodian agency(ies): WHO

Indicator 3.1.2 Proportion of births attended by skilled health personnel

Increased coverage of skilled health personnel during childbirth is a major public health success, but overlapping crises and inequities threaten progress

The presence of skilled health personnel at childbirth, including doctors, nurses, and midwives, is key to improving maternal and newborn survival. Between 2015 and 2024, global coverage of skilled health personnel increased from 80 per cent to 87 per cent. This progress has saved countless lives, yet coverage remains uneven. In 2024, 17 million births occurred without skilled assistance, exposing newborns and mothers to preventable complications. Sub-Saharan Africa remains the most affected, with only 73 per cent of births attended by skilled personnel, far below the Every Woman Every Newborn Everywhere (EWENE) target of 90 per cent. In contrast, Eastern and South-Eastern Asia have reached 97 percent coverage. This persistent inequity means that for many women and newborns, surviving birth is a matter of geography. While coverage has expanded, quality gaps remain. The slowdown in maternal mortality and stillbirth reductions highlights deficits in the quality of care.

The progress made to date is at risk. Health system investments are declining, and political instability, economic downturns, and overlapping crises are eroding gains. While coverage of skilledhealth personnel has demonstrated resilience, even minor disruptions in maternal health services can lead to devastating outcomes. In 2023, an estimated 260,000 women died during pregnancy and childbirth, and in 2022, 2.3 million newborns did not survive their first month. These deaths are overwhelmingly preventable.

The EWENE partnership supports countries to outline acceleration pathways to achieving 90 percent global coverage, but reaching this goal in this context will rely on prioritizing what works and exploring fundamental changes in approach. The next five years are critical. Achieving universal access to skilled health personnel during childbirth is within reach, but only with decisive action to accelerate progress. Investments in healthcare infrastructure, workforce education and training, and quality improvement must be prioritized, particularly in underserved areas. Strengthening local accountability, ensuring sustainable financing, and integrating maternal and newborn health into broader health system resilience efforts are essential. The pathway to 2030 remains open, but the window for acceleration is closing.

Storyline authors(s)/contributor(s): Tashrik Ahmed

Custodian agency(ies): UNICEF, WHO

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

Indicator 3.2.1 Under-5 mortality rate

Indicator 3.2.2 Neonatal mortality rate

Achieving SDG Targets Could Avert Nearly 8 Million Under-Five Deaths by 2030

The global under-5 mortality rate (U5MR) fell to 37 deaths per 1,000 live births in 2023—a 52 per cent reduction from 77 deaths per 1,000 in 2000 and a 16 per cent reduction from 44 deaths per 1,000 in 2015. The global neonatal mortality rate (NMR) dropped to 17 deaths per 1,000 live births in 2023, a 44 per cent reduction from 31 deaths per 1,000 in 2000 and a 12 per cent reduction from 20 deaths per 1,000 in 2015. As a result of this progress, fewer children are dying before their fifth birthday than ever recorded, with 4.8 million under-five deaths in 2023—2.3 million of which occurred in the neonatal period.

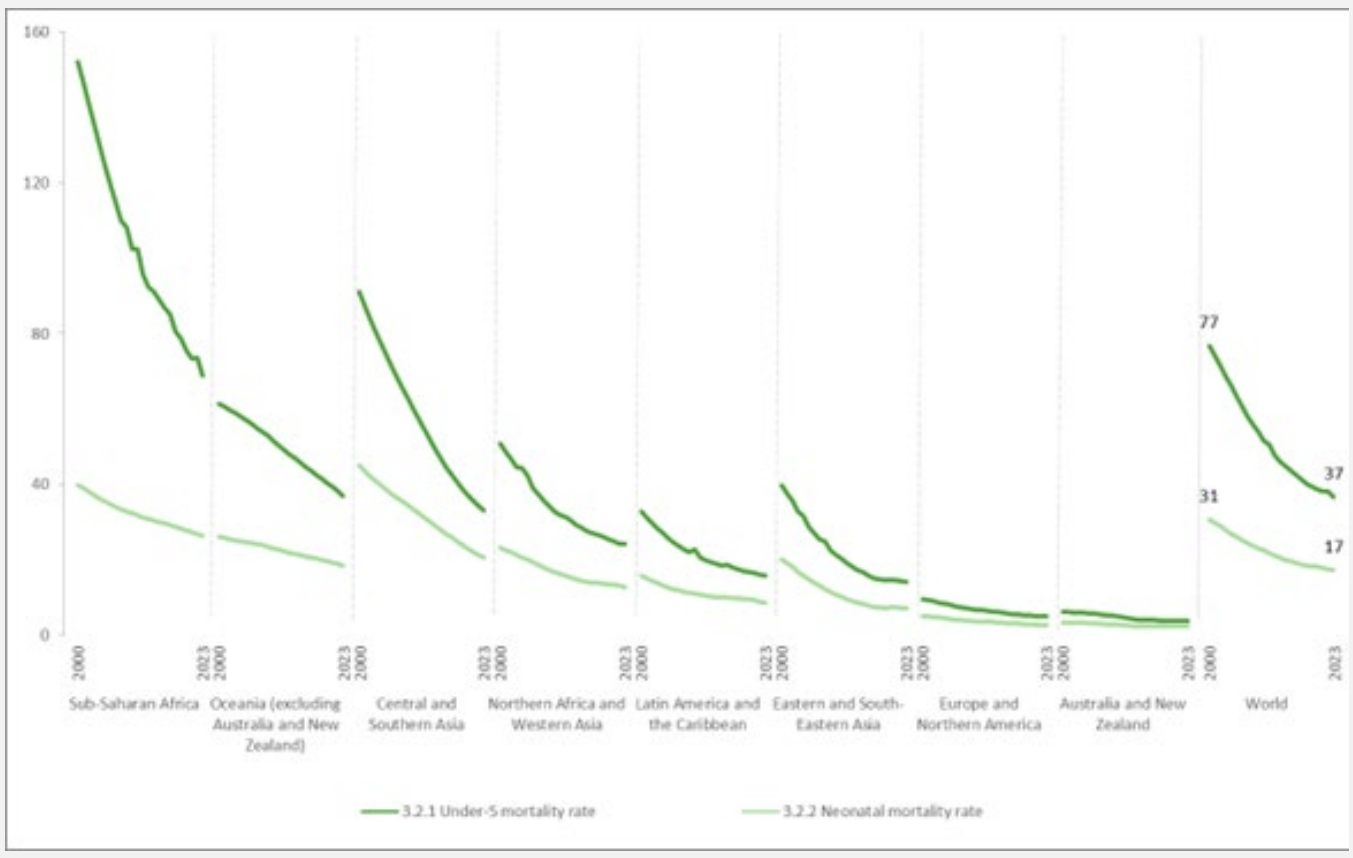
However, progress in reducing under-five and neonatal mortality has slowed since 2015. The global annual rate of reduction (ARR) in under-five mortality decreased from 3.7 per cent during the period 2000–2015 to 2.2 per cent in 2015–2023. Global neonatal mortality followed a similar trend, with the ARR decreasing from 3.0 per cent in 2000–2015 to 1.6 per cent in 2015–2023.

Despite that global progress, stark regional disparities persist. Children born in sub-Saharan Africa face the highest regional risk of childhood death, with a 2023 U5MR of 69 deaths per 1,000 live births—18 times higher than in Australia and New Zealand, the region with the lowest regional U5MR. Sub-Saharan Africa also had the highest regional NMR in 2023, at 26 deaths per 1,000 live births—11 times the rate in Australia and New Zealand, the lowest neonatal mortality region.

As of 2023, 133 countries had already met the SDG target for under-five mortality, and seven more are expected to do so by 2030 if current trends continue. However, 60 countries—nearly 75 percent of them in sub-Saharan Africa—must accelerate progress to reach the target in time. The challenge is even greater for neonatal mortality, where 125 countries have met the SDG target and 10 more are expected to do so by 2030, but 65 countries must substantially speed up mortality reductions to stay on track.

If current trends continue, an estimated 30 million children under age five will die by 2030. Yet this outcome is not inevitable. If all countries met or exceeded the SDG target for under-five mortality, nearly 8 million of these deaths could be prevented. Most under-five deaths occur in low- and lower-middle-income countries, where children's survival depends on maintaining and expanding access to life-saving interventions. To sustain progress in reducing child mortality, it is critical to ensure the continued delivery of essential care and services.

Under-5 and neonatal mortality rate by region, 2000-2023 (deaths per 1,000 live births)



Additional resources, press releases, etc. with links:

- United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), 'Levels & Trends in Child Mortality: Report 2024, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation', United Nations Children's Fund, New York, 2025.
- Website: https://childmortality.org/

Storyline authors(s)/contributor(s): David Sharrow, UNICEF

Custodian agency(ies): UNICEF

Target 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

Indicator 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations

The urgency of now: HIV prevention at a crossroads

Fewer people acquired HIV in 2023 than at any point in time since the late 1980s. Globally, about 39% fewer people acquired HIV in 2023 compared with 2010, with sub-Saharan Africa achieving the steepest reduction (—56%). However, the world is far from reaching the SDG target 3.3.1 of a 90% reduction in new HIV infections since 2010, and an estimated 1.3 million [1.0 million–1.7 million] people still acquired HIV in 2023. Three regions experienced rising numbers of new HIV infections since 2010: North America and Europe (+6%), Oceania (+65%), and Western Asia and North Africa (+93%).

In sub-Saharan Africa, although decreasing, the incidence of HIV among adolescent girls and young women aged 15–24 years remains extraordinarily high. The overall decline in vertical HIV infections has slowed markedly in recent years, particularly in western and central Africa. An estimated 120 000 [83 000–170 000] children acquired HIV in 2023, bringing the total number of children living with HIV globally to 1.4 million [1.1 million–1.7 million], 86% of whom are in sub-Saharan Africa.

Globally, at least half of all people from key populations are not being reached with prevention services. Men and women who inject drugs, gay men and other men who have sex with men, and transgender people are particularly affected.

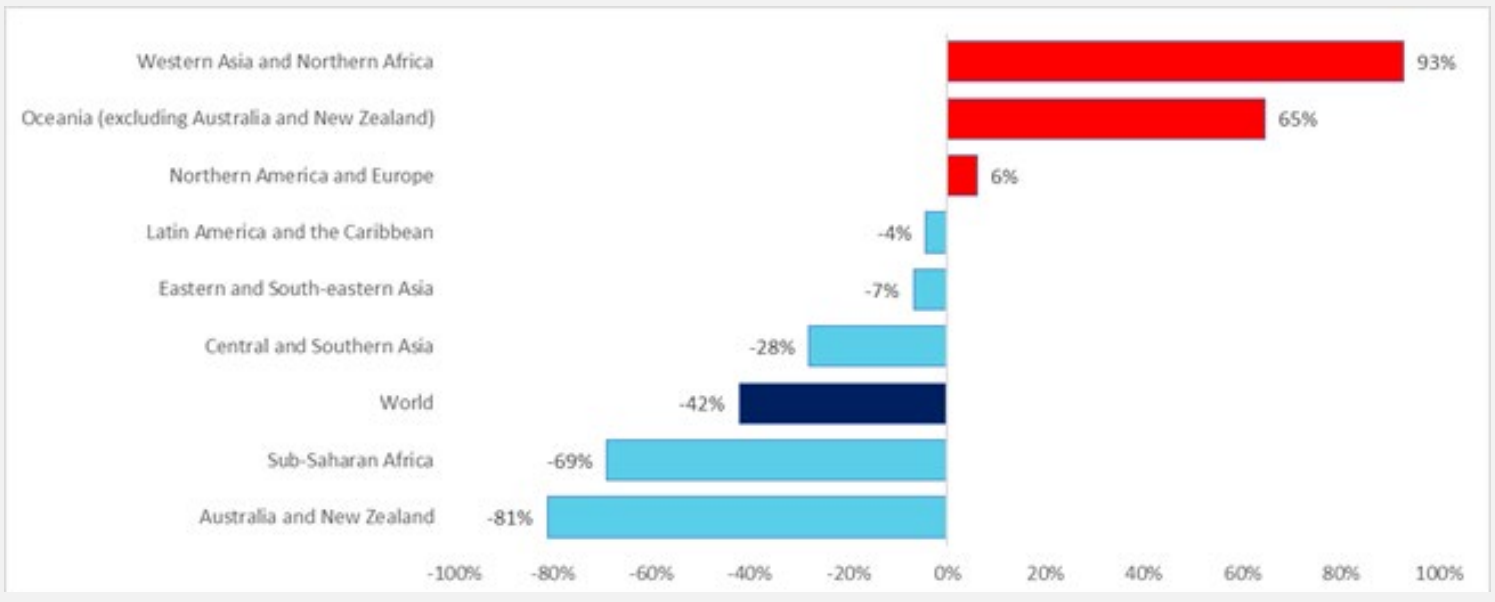
HIV prevention programmes continue to be under-funded, uptake of low-cost HIV prevention methods has slowed, and access to prevention tools such as pre-exposure prophylaxis (PrEP) products and the dapivirine ring remains unequal. Condom use remains the most effective low-cost HIV prevention method, but condom programmes have been defunded and social marketing schemes cut back in many countries.

Interventions that address social and structural barriers will be critical to preventing new HIV infection. Recent innovations have the potential to herald a breakthrough for HIV prevention if made available rapidly and affordably to potential users. For example, a six-month long-acting injectable PrEP product, lenacapavir, has shown to be highly effective in preventing HIV among adolescent girls and women in Africa.

Rapid, wider access to PrEP, including to long-acting injectable lenacapavir, could reduce the numbers of new HIV infections, especially among people from key populations and among women in areas where HIV incidence is currently high – if costs came down and stigma and discrimination were reduced to create an enabling environment, leading to increased access to this prevention option. Effective HIV prevention programming relies on strong partnerships.

Nongovernmental organizations, including community-led organizations, serve the HIV-related needs of many, including hard to reach populations. Continued recognition, support, and funding for this work could ensure that everyone has access to HIV prevention services.

Percent change in HIV incidence rates as new cases per 1,000 uninfected adults aged 15 to 49 years, between 2010 and 2023



Additional resources, press releases, etc. with links:

- 2024 global AIDS report — The Urgency of Now: AIDS at a Crossroads 2024 global AIDS report — The Urgency of Now: AIDS at a Crossroads | UNAIDS

Storyline authors(s)/contributor(s): Anne-Claire Guichard, UNAIDS; Juliana Daher, UNAIDS

Custodian agency(ies): UNAIDS

Indicator 3.3.2 Tuberculosis incidence per 100,000 population

Global TB incidence stabilizes, yet progress lags behind 2025 goals

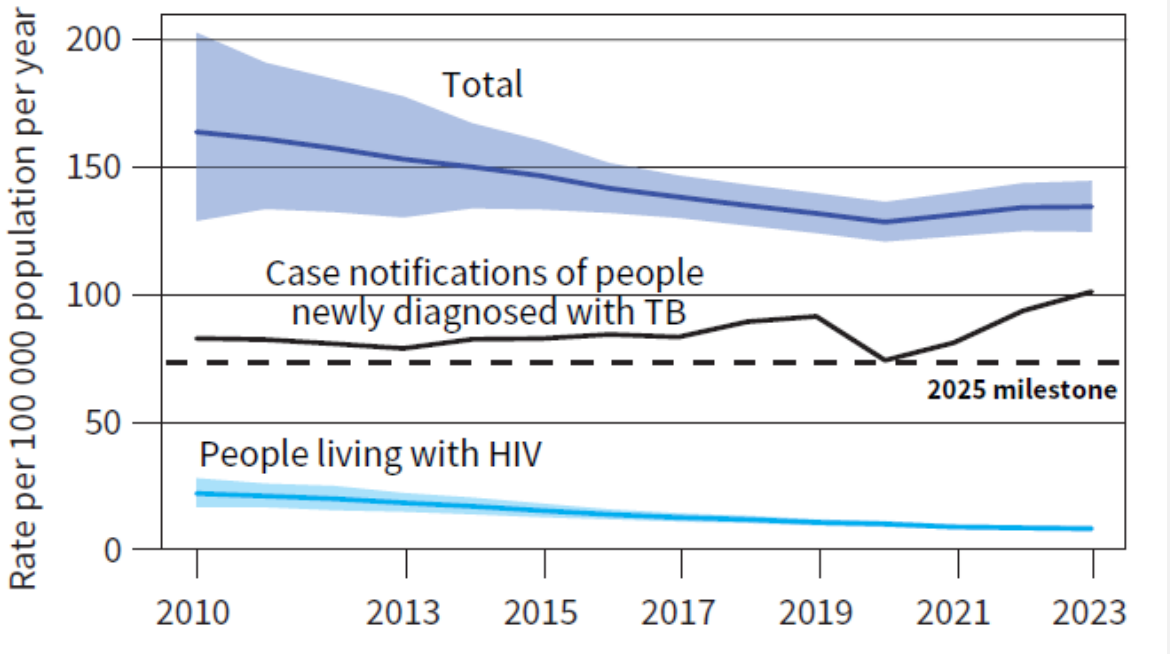
Despite the ongoing challenge of eradicating the global tuberculosis (TB) epidemic, recent data reveals promising trends. While the total number of TB incident cases globally reached 10.8 million in 2023, a slight increase from 2022 largely attributed to population growth, the incidence rate has slowed and stabilized. The burden of TB remains concentrated in 30 high-burden countries, accounting for 87% of global cases, with India, Indonesia, China, the Philippines, and Pakistan making the most substantial contributions. In 2023, men represented the majority of TB cases.

A record 8.2 million people were diagnosed with TB globally in 2023, a strong increase over previous years. This surge likely reflects both increased detection and the clearing of a COVID-19-related backlog in diagnosis.

Encouragingly, TB-related deaths decreased in 2023, continuing the downward trend initiated in 2022 after a COVID-19-induced surge. An estimated 1.25 million deaths occurred in 2023, falling below pre-pandemic levels. However, TB is likely once again the leading cause of death from a single infectious agent, surpassing COVID-19.

Progress towards the WHO End TB Strategy targets remains insufficient. The global reduction in TB incidence rate since 2015 is only 8.3%, far from the 2025 milestone of 50%. The African and European regions have shown the most progress. While the WHO End TB Strategy's 2025 milestone for reducing TB incidence is far from being met, the increase in diagnoses indicates progress in closing the detection gap.

Global trend in the estimated TB incidence rate, 2010–2023



Note: The horizontal dashed line shows the 2025 milestone of the End TB strategy, which is a 50% reduction in the TB incidence rate between 2015 and 2025. Shaded areas represent 95% uncertainty intervals.

Additional resources, press releases, etc. with links:

- Global tuberculosis report 2024. https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2024

Storyline authors(s)/contributor(s): WHO Global Programme on Tuberculosis & Lung Health

Custodian agency(ies): WHO

Indicator 3.3.3 Malaria incidence per 1,000 population

Reinvigorated global efforts needed to curb rising malaria threat

Global malaria response efforts are yielding results. Since 2000, an estimated 2.2 billion cases and 12.7 million deaths have been averted worldwide. By the end of 2024, 44 countries and one territory had been certified malaria-free by WHO, and many others were progressing toward elimination.

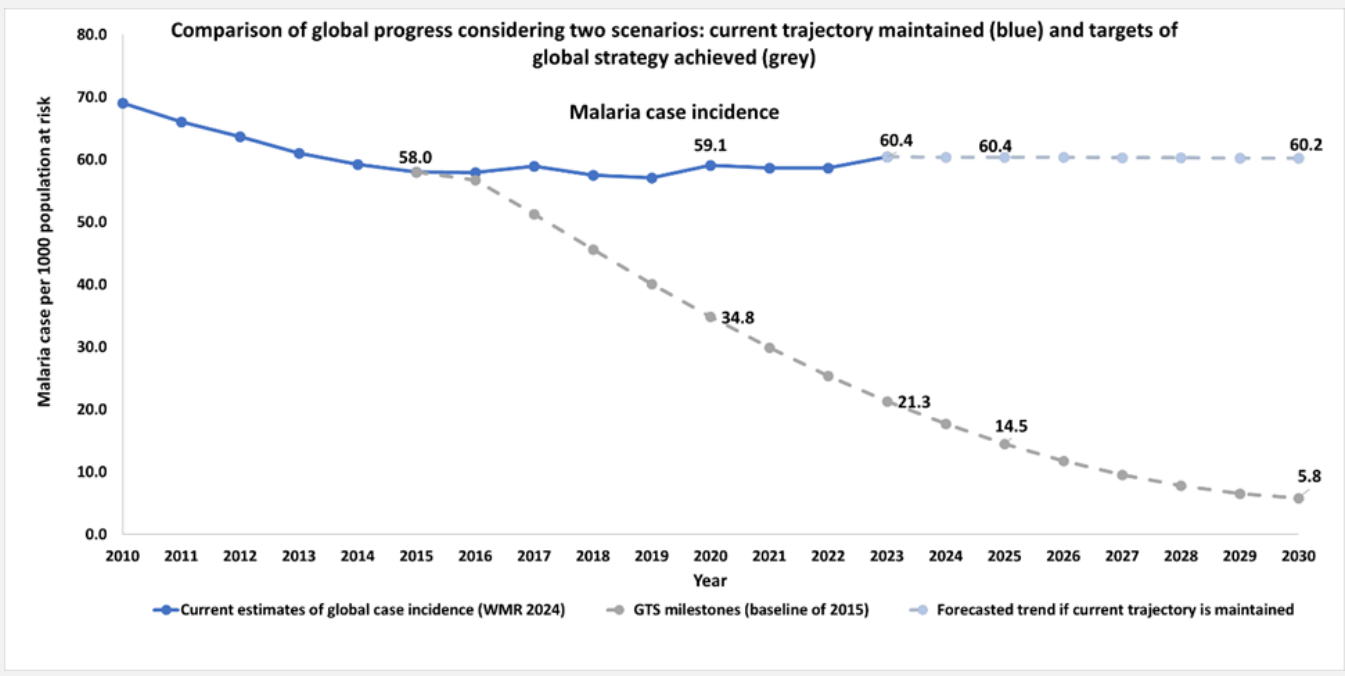
However, malaria remains a serious global health challenge. According to the latest edition of the World malaria report, published in December 2024, there were an estimated 263 million cases in 83 countries in 2023, compared to 226 million in 2015. Case incidence reached 60.4 cases per 1000 population at risk in 2023 compared to 58 cases per 1000 population in 2015.

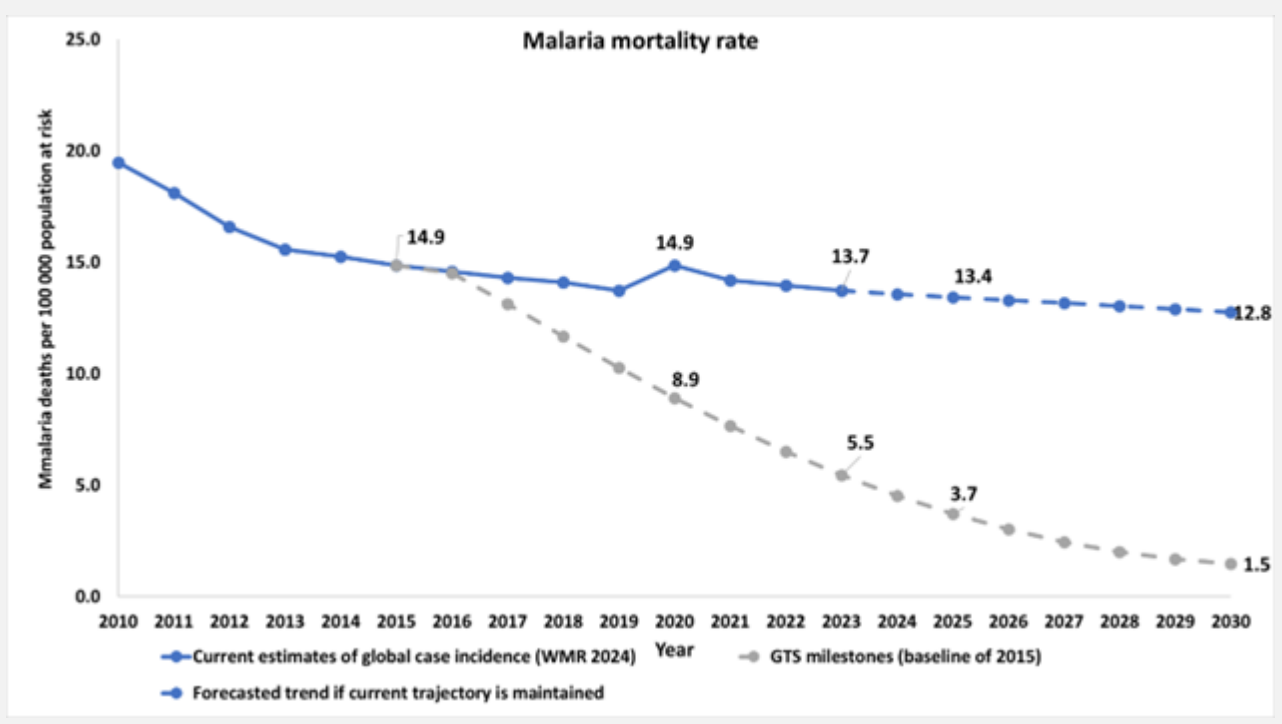
Too many people at high risk of malaria are still missing out on prevention, detection and treatment services. In 2023, for example, more than 40% of children under the age of five and pregnant women in sub-Saharan Africa were not sleeping under insecticide-treated nets—a primary malaria prevention tool. Only 44% of pregnant women in Africa received the WHO-recommended 3-dose regimen of preventive malaria therapy in 2023, compared to 42% the previous year.

In many countries, efforts to expand access to essential malaria services have been hindered by humanitarian crises, restricted funding and fragile health systems. Compounding these challenges are the overlapping impacts of climate change, conflict, natural disasters, population displacement and threats such as drug and insecticide resistance.

Urgent and concerted action is needed to set the world back on a trajectory towards achieving the SDG target of ending malaria by 2030 and the targets of the WHO Global technical strategy for malaria 2016-2030 (GTS). The 2023 global malaria incidence rate of 60.4 cases per 1000 population at risk is nearly 3 times higher than the 21.3

Malaria case incidence: comparison of global progress considering two scenarios - current trajectory maintained (blue) and targets of global strategy achieved (grey)





cases per 1000 needed to reach the GTS target. In addition, there were 13.7 malaria deaths per 100 000 population at risk in 2023, more than twice the GTS target of 5.5 deaths per 100 000.

In recent years, the wide-scale deployment of new malaria control tools has offered renewed hope for endemic countries, particularly in the hard-hit AfricanRegion. As of December 2024, 17 African countries had introduced WHO-recommended malaria vaccines through routine childhood immunization programmes. The continued scale-up of these vaccines is expected to save tens of thousands of young lives every year.

New-generation nets, which provide better protection against malaria than pyrethroid-only nets, are also becoming more widely available, supporting efforts to combat mosquito resistance to pyrethroids. In 2023, these new types of nets accounted for 78% of the 195 million nets delivered to sub-Saharan Africa, an increase from 59% in 2022.

The World malaria report 2024 emphasized the need for more inclusive action to protect those most vulnerable to malaria—communities living in poverty, children and pregnant women, displaced and marginalized populations, and other hard-to-reach groups. To improve malaria responses worldwide, WHO is calling on countries and their development partners to pursue data-driven policies and actions that are gender-responsive, equity-oriented, and grounded in human rights principles.

Additional resources, press releases, etc. with links:

- World malaria report 2024 https://www.who.int/publications/i/item/9789240104440
- Press release: Reinvigorated global efforts needed to curb rising malaria threat https://www.who.int/news/item/11-12-2024-reinvigorated-global-efforts-needed-to-curb-rising-malaria-threat

Storyline authors(s)/contributor(s): Global Malaria Program, World Health Organization

Custodian agency(ies): WHO

Indicator 3.3.4 Hepatitis B incidence per 100,000 population

Custodian agency(ies): WHO

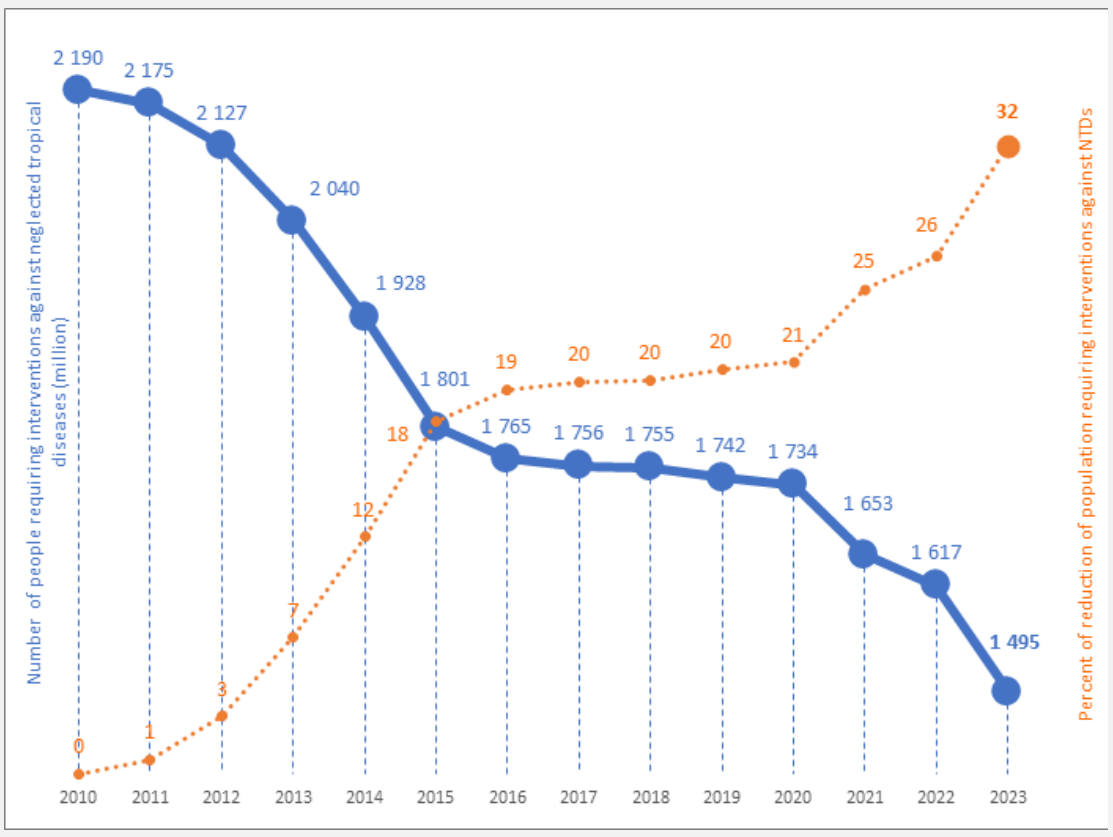
Indicator 3.3.5 Number of people requiring interventions against neglected tropical diseases

Number of people requiring interventions against neglected tropical diseases: financing for data is key to safeguard progress and support evidence-based decision-making

Neglected tropical diseases (NTDs) are a diverse group of conditions caused by parasites, bacteria, viruses, fungi and toxins. NTDs cause immense human suffering. They affect some of the world's most vulnerable people, who often live in remote communities, especially in least developed countries (LDCs), thereby creating NTD-related generational cycles of poverty. Addressing the burden of NTDs breaks this cycle and can contribute to the health, social and economic well-being of entire communities.

In 2023, 1.495 billion people were reported to require mass or individual treatment and care for NTDs, down from 2.19 billion in 2010, and about 122 million people fewer than in 2022, when 1.617 billion people required interventions against NTDs. The main drivers of reduction in the number of people requiring interventions are the progressive attainment of end-point programmatic targets (interruption of transmission, elimination as a public health problem) by countries, the achievement of post-intervention surveillance status, and the reclassification of endemic areas from requiring to not requiring interventions because of improvement of epidemiological conditions or access to water and sanitation. The progress demonstrates that NTDs can be defeated by combining diverse interventions including mass and individual treatment, vector control, veterinary public health, and provision of safe water and sanitation. Today, 13 of the 21 diseases or groups of disease recognized by WHO as NTDs are targeted for eradication, elimination of transmission or elimination as a public health problem, and 54 countries have eliminated at least one NTD by the end of 2024.

Reduction of number of people requiring interventions against NTDs



Some 493 million people required treatment and care for NTDs in the LDCs, representing 43% of those countries' populations, down from 79% in 2010. About 1 billion people living outside the group of LDCs still required treatment and care for NTDs.

Globally, there is a 32% decrease in the number of people requiring interventions against NTDs from 2010, but it does not provide the required trajectory to attain the road map's global target of a 90% reduction by 2030. Challenges persist, and the slow progress highlights the complexities of addressing NTDs on a global scale. Uncertain and evolving health, political and financial landscapes contribute to the difficulties in meeting the ambitious targets set in the road map. While progress has been slower than anticipated, there is optimistic confidence in bridging the gap and returning to the planned trajectory towards 2030. Addressing these challenges head-on and fostering innovative solutions will be critical in ensuring positive progress and sustained success in the global fight against NTDs.

Within this challenging context, the importance of securing financial support for collection, analysis and dissemination of data on NTDs cannot be overstated, as this impacts the capacity of countries to track programmatic progress and inform planning, both when scaling up interventions and when scaling them down as elimination targets approach. Currently, much of the NTD data reported are generated by the monitoring and evaluation component of mass drug administration (MDA) campaigns, but as this scales down, data gaps will widen. Without robust surveillance, measuring disease incidence, prevalence and health impact, such as mortality or disability-adjusted life years (DALYs), becomes challenging. Sustainable investment in data systems is essential to ensure continuous monitoring, guide

interventions and prevent resurgence. Strengthening surveillance beyond MDA will safeguard progress and support evidence-based decision-making in the fight against NTDs.

Storyline authors(s)/contributor(s): Alexei Mikhailov, WHO; Albis Gabrielli, WHO

Custodian agency(ies): WHO

Target 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

Indicator 3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease

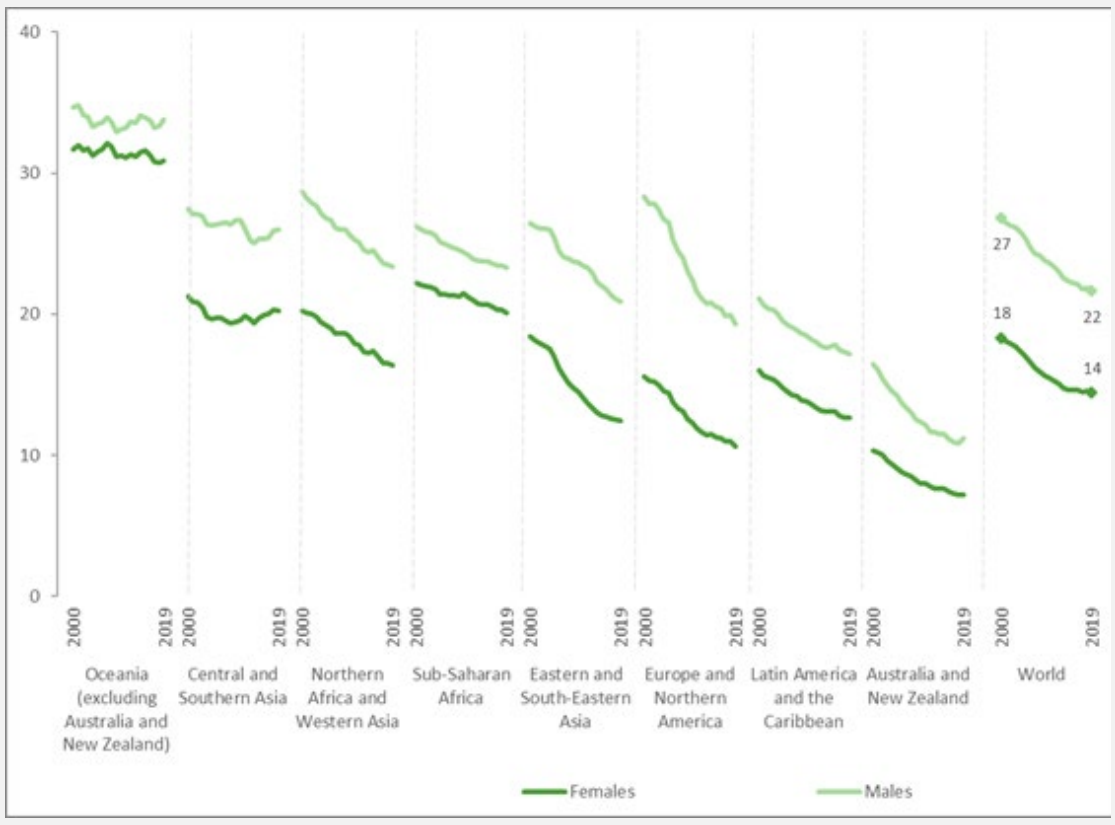
Progress is too slow to meet SDG target 3.4

Globally in 2021, it is estimated that 18 million people under age 70 died from a non-communicable disease (NCD). This represents more than half of deaths under age 70 – more than injuries, infections including COVID-19 and HIV, and maternal deaths combined. The risk of premature death from an NCD is measured by SDG indicator 3.4.1, the unconditional probability of dying from any of the four main NCDs (cardiovascular disease, cancer, diabetes or chronic respiratory disease) between exact ages 30 and 70 years. This risk fell from 22.5% in 2000 to 18.4% in 2015 and 18.0% in 2019 just prior to the onset of the COVID-19 pandemic. During 2020-2021, disruptions associated with the COVID-19 pandemic affected countries' ability to monitor trends in NCD mortality and may have resulted in misclassification of NCD deaths. Where reliable data are available, the risk of premature death from an NCD plateaued during this period. If health systems recover and resume trends prior to 2019, by 2030 the risk of premature NCD mortality will fall to 16.3%. However, neither the globe nor any region is on track to meet the target of reducing the risk for premature NCD mortality by 1/3 by 2030.

Women's risk of dying prematurely from a noncommunicable disease is lower than men's. In 2019, a 30-year-old male experienced a 21.6% chance of dying from one of the four main NCDs before his 70th birthday; for women, the risk was 14.4%. This pattern is repeated in all regions (Figure).

High-quality data on NCD mortality are essential to identify and evaluate evidence-based approaches to reduce NCD mortality. The best source of data on NCD mortality is complete death registration including medically certified cause of death. Only four in 10 countries have a functioning system for generating cause-specific mortality data on a routine basis. Improving death registration systems is essential to monitor progress toward SDG target 3.4.

Risk of dying from cardiovascular disease, cancer, diabetes or chronic respiratory disease between ages 30 and 70 (%), by sex.



Storyline authors(s)/contributor(s): Gretchen Stevens, WHO; Bochen Cao, WHO; Melanie Cowan, WHO

Custodian agency(ies): WHO

Indicator 3.4.2 Suicide mortality rate

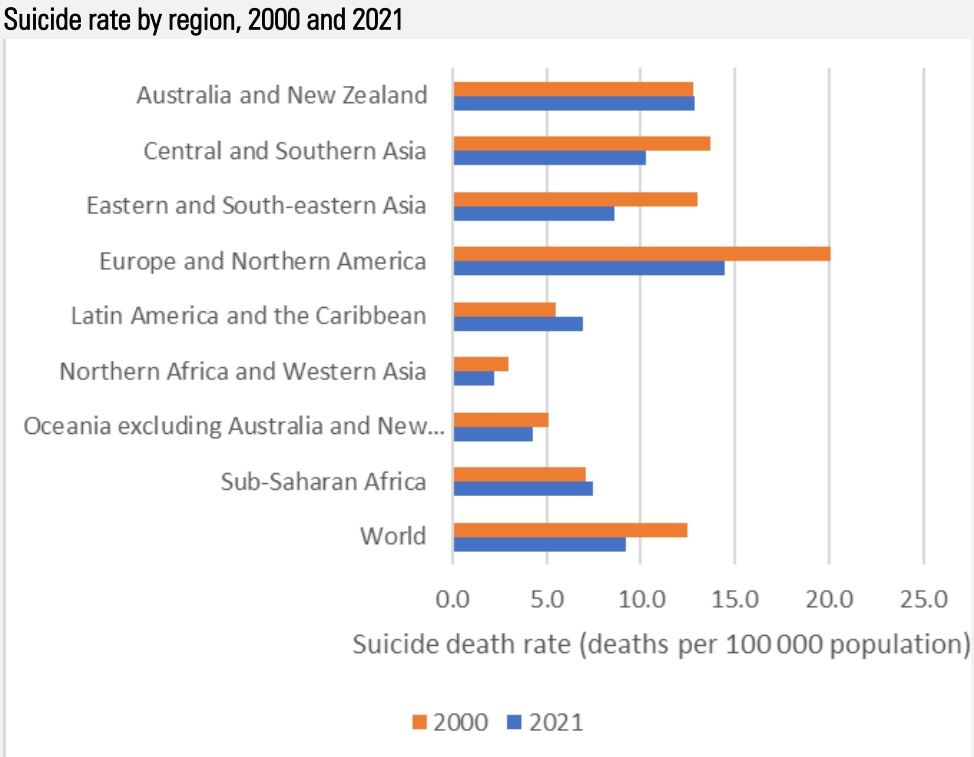
Towards a coordinated multisectoral approach for suicide prevention

In 2021, 727 000 people died by suicide worldwide. Progress has been made in reducing the global suicide rate (from 12.5 in 2000 to 9.2 per 100 000 in 2021), however this does not apply to all regions and countries. Whereas the crude suicide rate decreased in most regions, including Central Asia by 51% between 2000 and 2021, followed by Europe and Eastern Asia with decreases of 40% and 37% respectively, it increased in Northern Amercia (33%), Latin America and the Caribbean (25%), and South-eastern Asia (10%). For females, Eastern Asia was leading the decrease in the suicide rate (-45%) in the same time period, with increases observed in Northern America (34%), Latin America and the Caribbean (30%), Australia and New Zealand (20%), and Oceania (12%). For males, Central Asia saw the strongest decrease in the suicide rate (-56%) in the same time period, and Northern America (31%), Latin America and the Caribbean (27%), and South-eastern Asia (22%) showed substantial increases.

In 2021, Nothern America had the highest suicide rate (15.0 per 100 000) for both sexes. The highest suicide rate in 2021 for females was found in Southern Asia (8.7 per 100 000), and the higest for males in Northern America (23.6 per 100 000).

Given the multifaceted nature of suicide, suicide prevention efforts require political will and strategic action. WHO's LIVE LIFE initiative for suicide prevention in countries prioritizes four effective evidence-based interventions focusing on means restriction, responsible reporting of suicide by the media, fostering socio-emotional life skills in adolescents, and early identification, management and follow-up of anyone affected by suicidal behaviours. These key interventions are supported by foundational pillars including situation analysis, multisectoral collaboration, awareness raising, capacity building, financing, and surveillance.

Suicide rate by region, 2000 and 2021



Additional resources, press releases, data blog/stories, etc. with links:

- https://www.who.int/initiatives/live-life-initiative-for-suicide-prevention
- https://www.who.int/publications/i/item/9789240026629

Storyline authors(s)/contributor(s): Gretchen Stevens, WHO; Bochen Cao, WHO; Melanie Cowan, WHO

Custodian agency(ies): WHO

Target 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Indicator 3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders

Custodian agency(ies): WHO, UNODC

Indicator 3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol

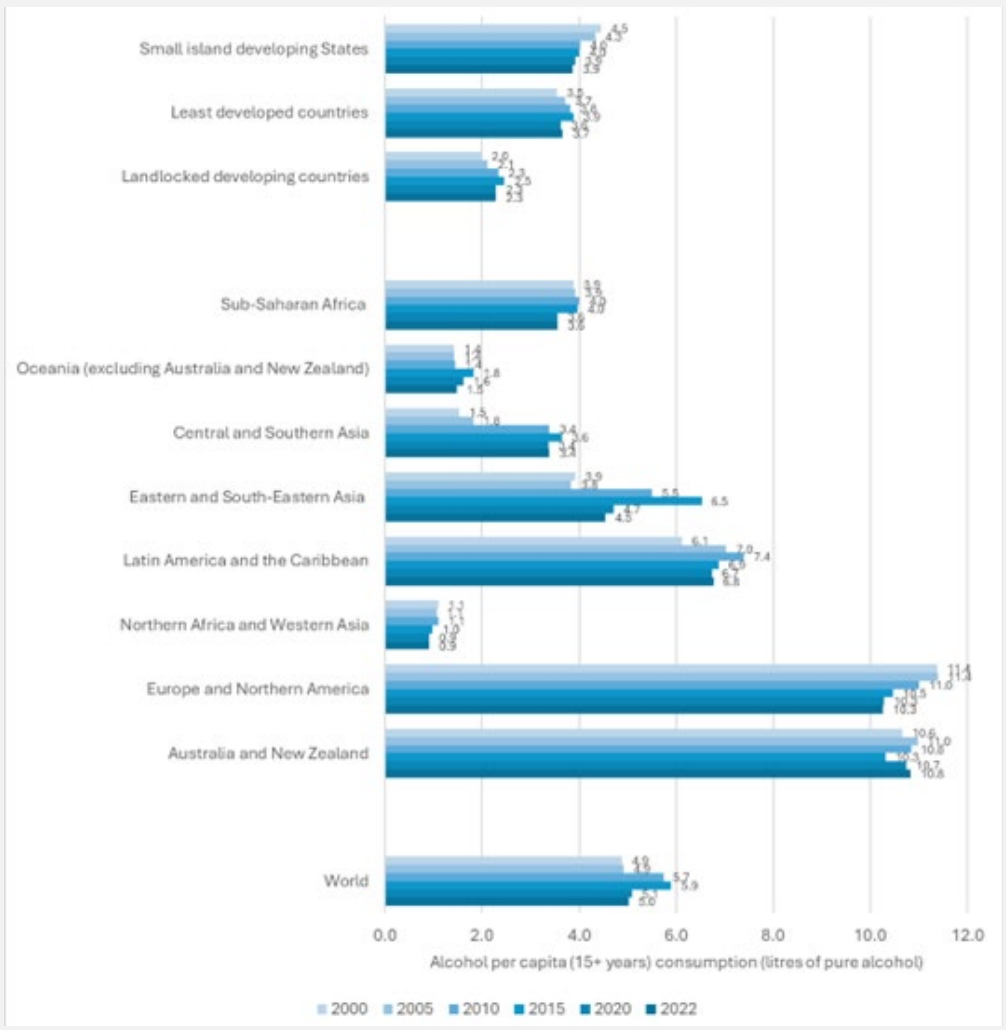
The level of drinking in populations is highest in Australia and New Zealand and Europe and Northern America, and is increasing in Central and Southern Asia

Despite some positive global trends in the prevalence of heavy episodic drinking and number of age-standardized alcohol-attributable deaths between 2010 and 2019, the overall burden of disease and injuries caused by the harmful use of alcohol is high, particularly in Europe and Africa.

In 2022, alcohol consumption in the world, measured in litres of pure alcohol per person of 15 years of age or older, was 5.0 litres, which is a 12% relative decrease from 5.7 litres in 2010. Australia and New Zealand had the highest per capita consumption in the world (10.8 litres per capita) in 2022, and their per capita consumption was the same as in 2010. In all (SDG) regions, fewer women drink alcohol than men, and when they drink, they drink less. In 2019, 56% of the world population aged 15 years or older (65% of women; 48% of men) abstained from drinking alcohol in the past 12 months.

Proven, cost-effective actions to reduce the harmful use of alcohol include increasing taxes on alcoholic beverages, bans or comprehensive restrictions on alcohol advertising, restricting the physical availability of alcohol, enacting and enforcing drink-driving laws, and providing brief psychosocial interventions. High-income countries are more likely to have introduced these policies, raising issues of global health equity and underscoring the need for greater support to low- and middle-income countries.

Alcohol per capita (15+ years) consumption by region



Custodian agency(ies): WHO

Target 3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents

Indicator 3.6.1 Death rate due to road traffic injuries

Custodian agency(ies): WHO

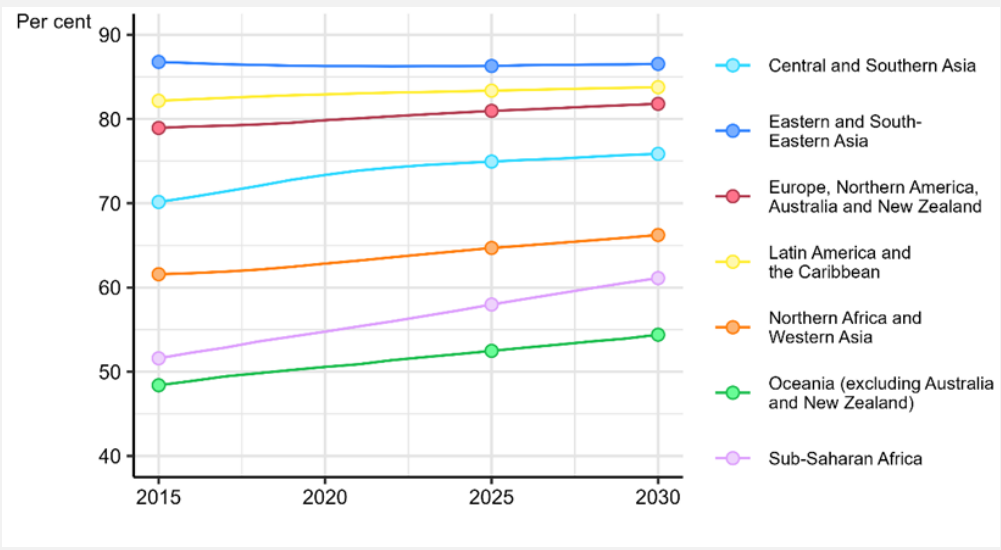
Target 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

Indicator 3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods

The progress in meeting the demand for family planning with modern methods will depend on the progress in regions where populations are relatively young and where contraceptive use is still low

In 2025, more women than ever are using modern contraceptive methods to avoid pregnancy. Worldwide, the proportion of women of reproductive age (15 to 49 years) having their need for family planning satisfied with modern methods is 77.2 per cent, a slight increase from 76.4 per cent in 2015. Nearly all world regions witnessed increases in the proportion of women of reproductive age having their need for family planning satisfied with modern methods since 2015 (figure 1), with sub-Saharan Africa seeing the largest increase from 51.6 to 57.9 per cent. Eastern and South-eastern Asia, which continues to have the highest proportion worldwide at above 86 per cent in 2025, is the only region in which the proportion declined slightly.

Figure 1. Women of reproductive age (15-49 years) whose demand for family planning is satisfied with modern methods, by SDG region, 2015-2030

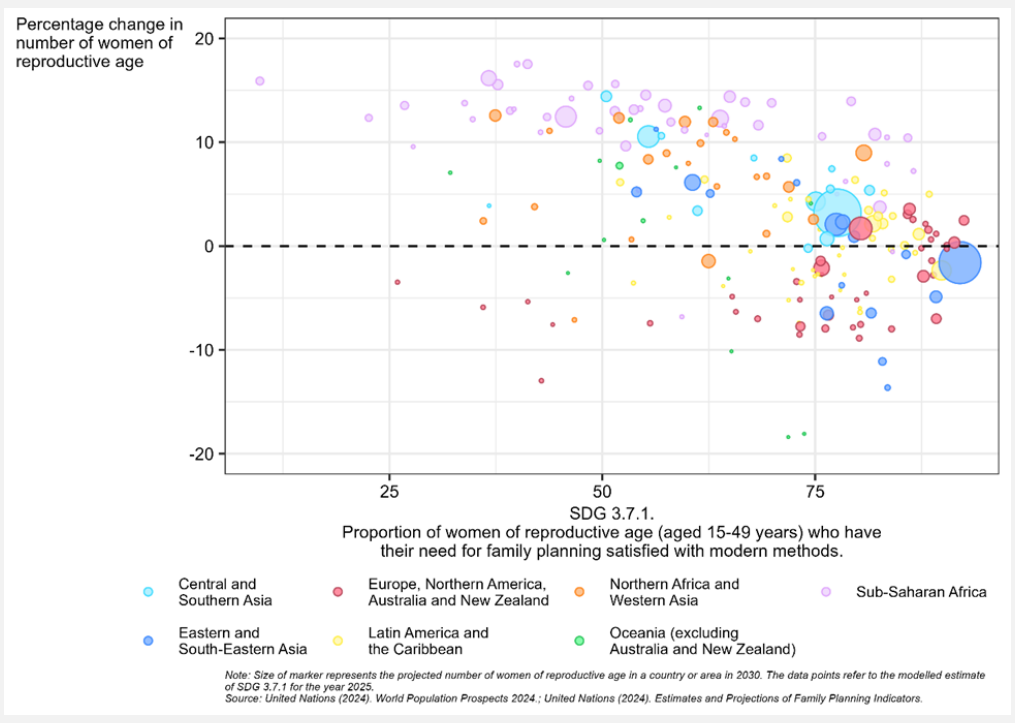


There are now 878 million women of reproductive age using (or their partner using) a modern method of contraception, that is 70 million more women of reproductive age using modern methods than there were in 2015. The global growth in the numbers of users of modern methods has been driven by increases in Central and Southern Asia (56 million more users since 2015, an increase by 31.6 per cent) and sub-Saharan Africa (31 million more users, an increase by 60.8 per cent), followed by Northern Africa and Western Asia (8.4 million, an increase by 24.9 per cent) and Latin America and the Caribbean (7.7 million, an increase by 8.7 per cent). Similarly, in Oceania (excluding Australia and New Zealand), the number of women who use modern methods increased by more than one-third from 620 thousand to 831 thousand. Regions with declines in the number of women of reproductive age, have seen declines in the number of users of modern contraceptive methods. In Eastern and South-eastern Asia, the decline has been largest, decreasing by about 34 million users. A more modest decline of about half a million women has occurred in Europe, Northern America, Australia and New Zealand since 2015.

Global progress in reducing the gaps between fertility intentions and use of modern methods will increasingly be driven by progress in sub-Saharan Africa. Over the next five years and beyond, sub-Saharan Africa's population of women of reproductive age is expected to grow faster than any other region in the world. This demographic trend – coupled with increasing rates of contraceptive use – means that an increasing proportion of the world's users of modern contraception will be in sub-Saharan Africa, and global progress in this area will increasingly depend on the progress made in the region. Over the next five years, there will be a projected increase of 40 million women using modern contraception globally, with the largest increases in sub-Saharan Africa (21 million, and increase by 25.6 per cent).

The population of women of reproductive age is projected to grow rapidly through 2030 in countries with the largest gaps between fertility intentions and use of modern methods. Many countries in sub-Saharan Africa with low levels of the proportion of women of reproductive age (15 to 49 years) having their need for family planning satisfied with modern methods are projected to witness rapid growth in the population of women aged 15 to 49 years through 2030 (figure 2), often by more than 10 per cent between 2025 and 2030. The rapid growth of the population of women of reproductive age will create additional challenges in expanding family planning services to keep pace with the growing demand.

Figure 2. Projected change in population of women of reproductive age (aged 15-49 years) between 2025 and 2030 by proportion of demand for family planning satisfied by modern methods and size of population of women of reproductive age in 2025



Additional resources, press releases, etc. with links:

- United Nations, Department of Economic and Social Affairs (2022). World Family Planning 2022. Meeting the changing needs for family planning: Contraceptive use by age and method. UN DESA/POP/2022/TR/NO. 4 https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2023/Feb/undesa_pd_2022_world-family-planning.pdf
- United Nations, Department of Economic and Social Affairs, Population Division (2024). World Contraceptive Use 2024 and Estimates and Projections of Family Planning Indicators 2024. Methodology report. POP/DB/CP/Rev2024 and POP/DB/FP/Rev2024.
- https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesa_pd_2024_methodology-report_world_contraceptive_use.pdf
- United Nations (2025, forthcoming). The new landscape of fertility and family planning 30 years after Cairo and Beijing. *UN DESA Policy brief*
- United Nations (2025). World Fertility 2024. UN DESA/POP/2024/TR/NO.10. New York: United Nations.

Storyline authors(s)/contributor(s): Joseph Molitoris, UN-DESA, Population Division ; Vladimíra Kantorová, UN-DESA, Population Division

Custodian agency(ies): DESA Population Division

Indicator 3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group

Global Decline in Adolescent Birth Rates, But Sub-Saharan Africa Faces Rising Challenges

Adolescent pregnancy remains a critical public health and development challenge, with significant implications for young mothers and their children. Adolescent mothers face higher risks of life-threatening conditions such as eclampsia, puerperal endometritis, and systemic infections. Their newborns are more likely to experience low birth weight, preterm birth, and severe neonatal complications (WHO, 2024).

Over the past two decades, significant progress has been made in reducing adolescent birth rates, marking an important step towards achieving Sustainable Development Goal (SDG) target 3.7., which aims to ensure universal access to sexual and reproductive healthcare services, including family planning, information and education. Among girls and young women aged 15–19 years, the global birth rate fell from 66.3 births per 1,000 in 2000 to 45.9 in 2015 and further to 38.3 in 2024, with projections indicating a further decline to 34.3 by 2030. A similar downward trend has been observed among younger girls aged 10–14, with birth rates falling from 3.5 per 1,000 in 2000 to 1.5 in 2015 and 1.0 in 2024, with a projected decline to 0.9 by 2030 (Figure 1). Despite this progress, adolescent pregnancies remain a global concern. In 2024, adolescent mothers gave birth to 12.4 million babies—representing 9 per cent of all births—down from 13.9 million in 2015 and 19.7 million in 2000. This number is expected to decline further to 11.8 million by 2030 (Figure 2).

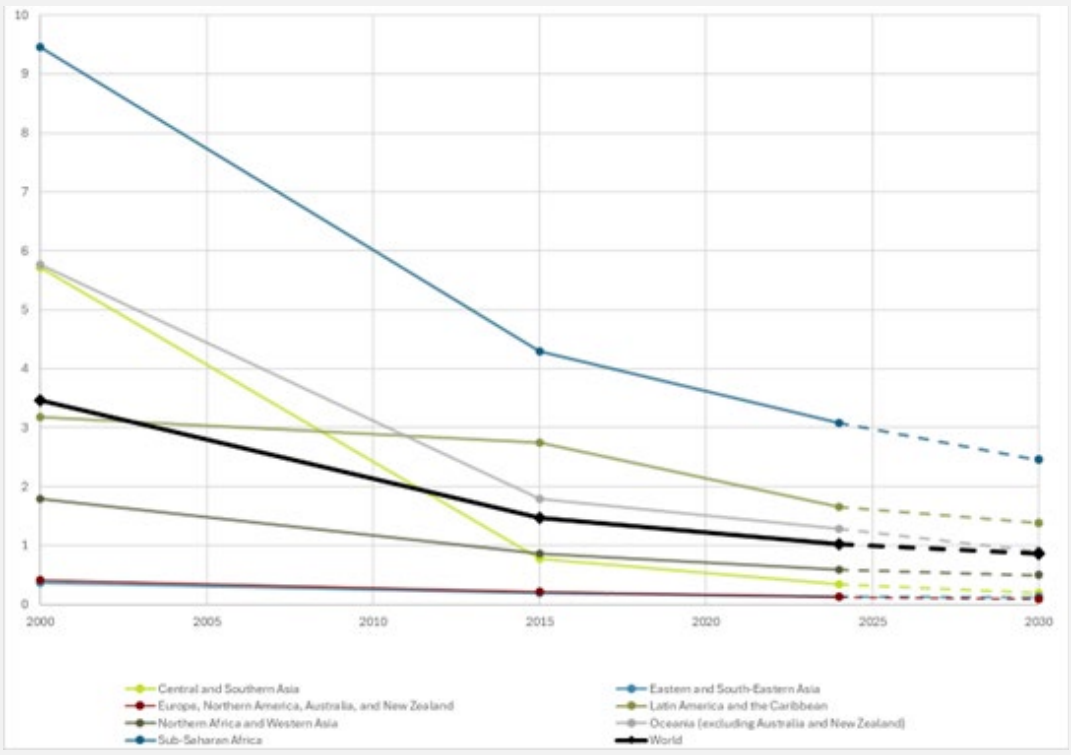
While global trends are encouraging, progress has varied significantly across regions. Some of the most rapid declines in adolescent childbearing since 2000 have been observed in Central and Southern Asia, where the adolescent birth rate decreased from 106 per 1,000 in 2000 to 25.1 in 2024, with a further decline to 20.2 expected by 2030. Among girls aged 10–14, the rate decreased from 5.7 per 1,000 in 2000 to 0.3 in 2024 and is projected to decline to 0.2 by 2030 (Figure 1). In Latin America and the Caribbean, historically a region with high adolescent birth rates, has also made significant progress. The birth rate among girls and young women aged 15–19, decreased from 83.0 in 2000 to 50.3 in 2024, with a projected decline to 45.1 by 2030. For younger adolescents aged 10–14, the rate dropped from 3.2 in 2000 to 1.7 in 2024, with an expected decrease to 1.4 by 2030. Notably, 22 countries and areas in the region have seen adolescent birth rates decline by more than 50 per cent since 2000, including Chile, Curaçao, Guadeloupe, Costa Rica, and Puerto Rico with the declines by more than two-thirds.

Despite the declines, sub-Saharan Africa continues to report the highest adolescent birth rates globally. In 2024, the birth rate stood at 92.9 births per 1,000 among girls aged 15–19 and 3.1 births per 1,000 for girls aged 10–14. Although rates are projected to decline to 83.8 and 2.45 per 1,000, respectively, by 2030, the region will remain the highest globally. Only five countries and areas in this region—Cabo Verde, Ethiopia, Gambia, Kenya, and Réunion—have experienced a decline over 50 per cent from 2000 to 2024.

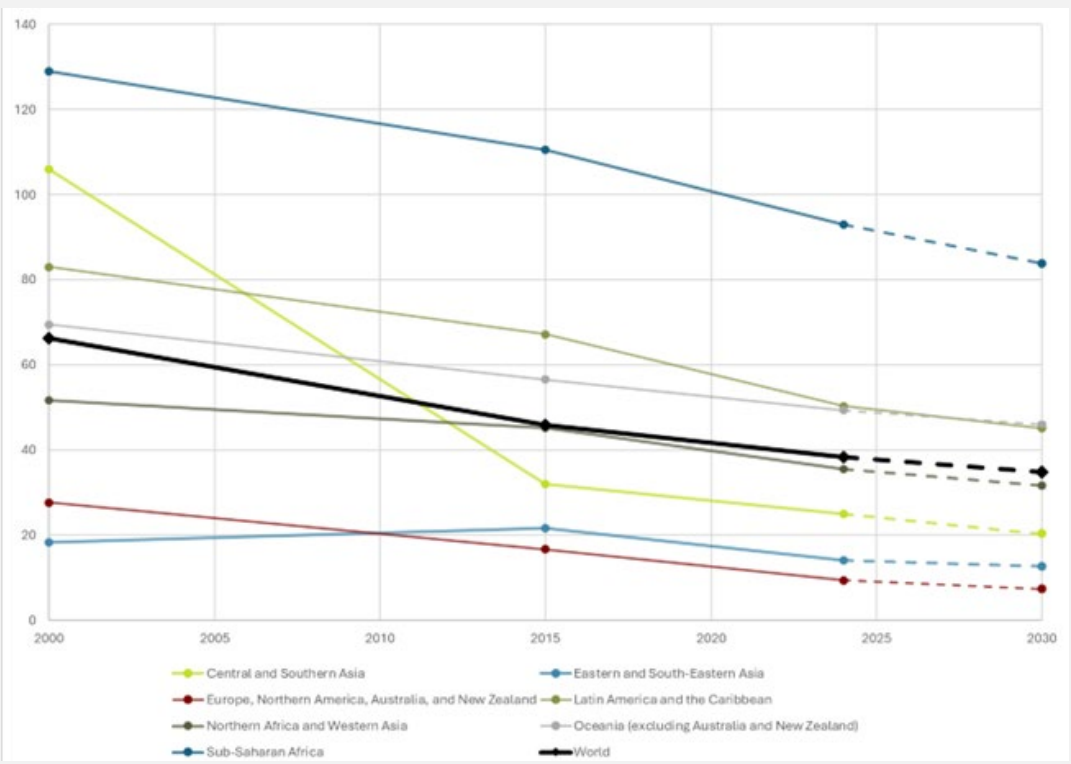
The regional disparities in trends in adolescent birth rates as well as in the growth (or decline) in the numbers of adolescent girls resulted in a shift in the global distribution of adolescent births by regions (Figure 2). In 2000, Central and Southern Asia accounted for nearly half (45 per cent) of global births to adolescent mothers, whereas sub-Saharan Africa accounted for 25 per cent. However, by 2030, more than half (55 per cent) of all births worldwide will occur in sub-Saharan Africa, while Central and Southern Asia's share will decline to 16 per cent. Sub-Saharan Africa is the only region with the increasing numbers of adolescent births due to slow decline in adolescent birth rates combined with rapid population growth leading to increasing numbers of adolescents.

In sub-Saharan Africa, the number of adolescent girls (aged 10-19 years) more than doubled between 2000 and 2024, increasing from 75.5 million to 141 million. It is expected to reach 158 million by 2030, an increase by 12.0 per cent. Such rapid population growth may place additional strains on governments to ensure universal access to sexual and reproductive healthcare services, including the provision of comprehensive contraceptive options, and access to high-quality maternal and neonatal care, immunisations for newborns, as well as adequate nutrition and education for children and adolescents.

Adolescent fertility rates among girls aged 10–14, 2000- 2030, by SDG regions



Adolescent fertility rates among girls and young women aged 15–19, 2000-2030, by SDG regions



Storyline authors(s)/contributor(s): Yumiko Kamiya, UN-DESA, Population Division ; Vladimíra Kantorová, UN-DESA, Population Division

Custodian agency(ies): DESA Population Division

Target 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 Coverage of essential health services

Indicator 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income

Custodian agency(ies): WHO

Target 3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

Indicator 3.9.1 Mortality rate attributed to household and ambient air pollution

Storyline authors(s)/contributor(s): Authors

Custodian agency(ies): WHO

Indicator 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)

Custodian agency(ies): WHO

Indicator 3.9.3 Mortality rate attributed to unintentional poisoning

Custodian agency(ies): WHO

Target 3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

Indicator 3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older

Renewed commitment to implementing the WHO FCTC as we celebrate the 20th anniversary of entry into force of the treaty

The Convention entered into force on 27 February 2005 and is one of the most widely embraced United Nations treaties in history. The WHO FCTC is a landmark in international law: it is the first treaty negotiated under the WHO Constitution, which incorporates multiple measures to control the demand and supply of tobacco. Today the Convention has 183 parties, covering 90% of the world's population. 165 countries have been monitoring tobacco use in their population sufficiently to know the trend over time and, of these, 150 are on a downward trend.

In the past 20 years, the global prevalence of tobacco use has dropped by one-third, and there are an estimated 118 million fewer tobacco users today compared with 2005. Yet still there are an estimated 1.25 billion tobacco users globally, and no country in the world is unaffected by the tobacco epidemic.

Despite the overall impact the Convention had on tobacco control policies worldwide, tobacco use remains one of the main preventable risk factors for non-communicable diseases. SDG 3.4, to reduce by one third premature mortality from non-communicable diseases, is progressing too slowly. To accelerate action, countries adopted the global action plan for the prevention and control of noncommunicable diseases (NCD GAP) under the auspices of the WHO. This plan includes a global target for reducing tobacco use prevalence (SDG 3.a.1): a 30% reduction in prevalence between 2010 and 2025. To date, only 56 countries are on track to achieve this target by 2025.

A multibillion-dollar industry peddles addictive and deadly products and profits from the suffering of those who use them. Faced with dwindling sales of cigarettes, the industry is turning to new products such as e-cigarettes, which are falsely advertised as healthier alternatives even though they generate toxic substances, some of which are known to cause cancer and some that increase the risk of heart and lung disorders.

Tobacco is not only a health problem. It threatens sustainable development as a whole. There is an increasing recognition of the negative impact of tobacco use on various development dimensions such as health, economics, environment, and also on communities. Implementing the WHO FCTC in its entirety helps leverage its impact and the win-wins it offers in projects carried out in all these development dimensions. The economic cost of smoking, from health expenditures and productivity losses, is estimated at 1.8% of the world's annual gross domestic product.

Our planet also counts among tobacco's victims. Roughly 4.5 trillion cigarette butts are discarded every year into our environment – the second highest form of plastic pollution in our world. Valuable agricultural land and water are wasted on growing tobacco instead of food. Production and consumption of tobacco also contribute to global warming, releasing 80 million tons of carbon dioxide into the air every year.

For all these reasons, the WHO FCTC remains as relevant today as it was when it entered into force 20 years ago, although its implementation remains uneven across countries and many areas require strengthening.

Custodian agency(ies): WHO, WHO-FCTC

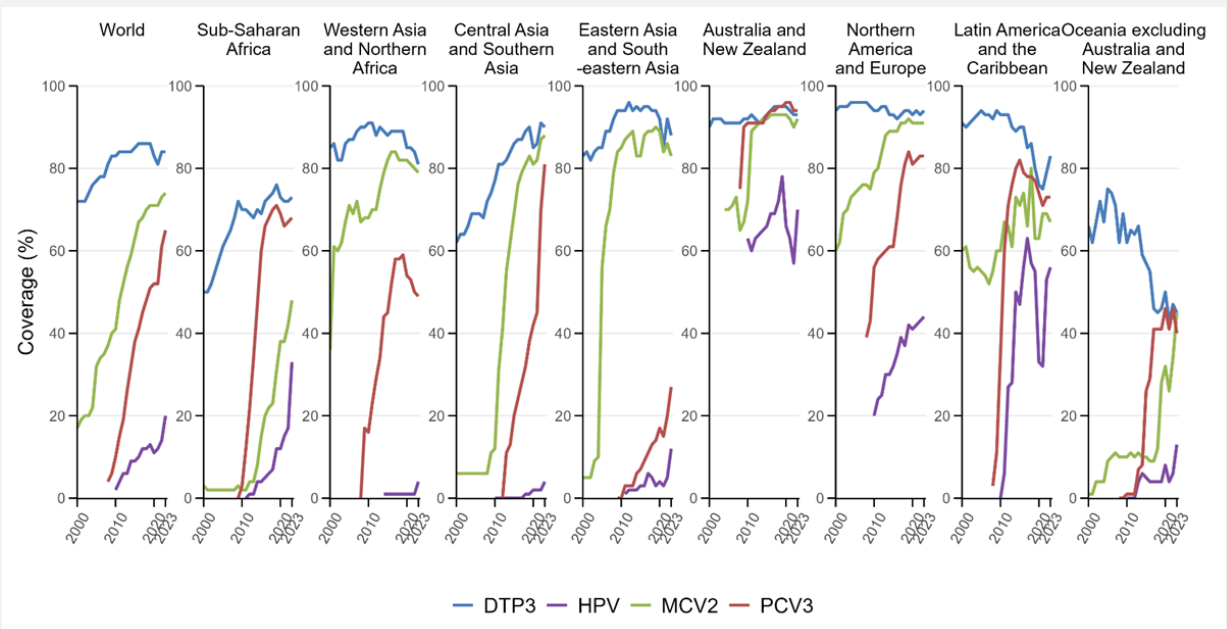
Target 3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

Indicator 3.b.1 Proportion of the target population covered by all vaccines included in their national programme

Global childhood immunization levels stalled in 2023, leaving many without life-saving protection

All four childhood vaccines tracked within Sustainable Development Goal 3.b.1 saw some stagnation or dip between 2020 - 2022. For third dose diphtheria-pertussis-tetanus containing vaccine (DTP3), which is a useful marker of vaccination system functioning, performance by 2023 was still not fully restored to 2019 pre pandemic level for DTP3 coverage, suggesting substantial residual dysfunction in global vaccine delivery systems. The other 3 vaccines increased but this is partially due to new introductions. Globally DTP3 still has the highest coverage of the four vaccines at 84% in 2023. There are huge variation of coverage of the Human Papilloma Virus (HPV) vaccination among girls 9-14 years, but globally HPV coverage remains quite low meaning millions of girls will remain susceptible to cervical cancer over their lifetimes. For third dose Pneumococcal Conjugate Vaccine (PCV3), the the Norther America and Europe, as well as Australia and New Zealand reached the highest uptake with coverage above 80% in 2023. The insufficient coverage of MCV2 in many countries is associated with a dramatic increase in measles disease outbreaks. However, the 90% global target set by the Immunization Agenda is unlikely to be met for any of these vaccinations if current trends continue.

Progress Overtime of Global and Regional childhood immunization



Storyline authors(s)/contributor(s): Dumolard Laure

Custodian agency(ies): WHO, UNICEF

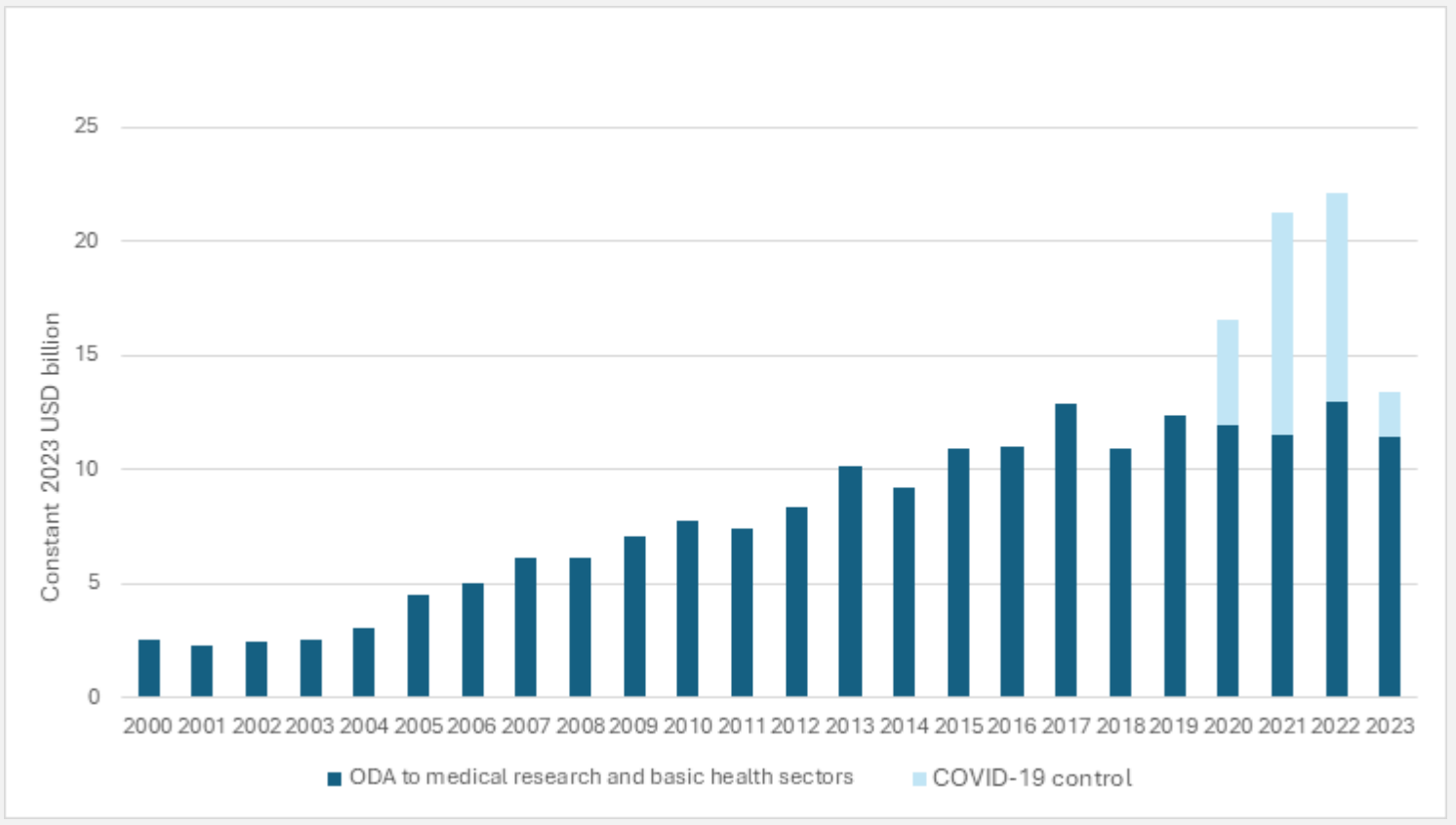
Indicator 3.b.2 Total net official development assistance to medical research and basic health sectors

ODA for medical research and basic health plummets in 2023 but is still above its pre-pandemic level

Gross ODA for medical research and basic health from all donors decreased by 39% in 2023 compared to 2022 and reached USD 13.4 billion, which was slightly above the level in 2019. In 2022 a historic peak had been reached and ODA for for medical research and basic health had more than doubled in real terms compared to 2015, from USD 10.9 billion to USD 22.1 billion (constant 2023 prices), driven by the response to the COVID-19 pandemic. Despite this steep decrease in 2023, ODA to medical research and basic health was still 22.5% higher compared to 2015 and rose from USD 10.9 billion to 13.4 billion in constant 2023 prices.

In 2023, USD 3.7 billion were spent on infectious disease control, i.e. immunisation; prevention and control of infectious and parasite diseases, (except for malaria , tuberculosis, COVID-19, HIV/AIDS and other STD), in addition, USD 2.4 billion were disbursed on malaria control and USD 2.2 billion on basic health care. COVID-19 control (e.g. information, education and communication; testing; prevention; immunization, treatment and care) decreased by 78% compared to 2022 and amounted USD 1.9 billion or 14.5% of ODA for basic health compared to 41.5% in 2022.

Total official development assistance to medical research and basic health sectors. Constant 2023 USD billion



The decrease in 2023 compared with 2022 was mainly due global contributions, which were not allocated by recipient country for COVID-19 and other diseases control (USD 5.2 billion less) and to contributions for COVID-19 control and basic health care in Asia where it decreased by 36% reaching USD 2.8 billion to , Sub Saharan Africa where it decreased by 15% reaching USD 5.9 billion and Latin America and Caribbean where it decreased by 66% reaching USD 429 million.

In 2023, USD 2.2 billion were spent for malaria control, USD 1.5 billion for infectious diseases other than malaria , tuberculosis, COVID-19, HIV/AIDS and other STD and USD 703 million for basic nutrition in Africa and USD 745 million for infectious disease control and USD 596 million for Tuberculosis control in Asia.

Least Developed Countries received USD 5.5 billion representing an decrease in volume of 20% and 40% of the total aid.

The largest recipients in 2022 were Democratic Republic of the Congo (USD 685 million), Nigeria (USD 548 million) and Ethiopia (USD 497 million).

The United States, the Global Fund, GAVI, IDA and the EU Institutions accounted for 65% to the total ODA providing, USD 2.7 billion, USD 2.2 billion, USD 1.8 billion, USD 1.0 billion and USD 704 million respectively.

Storyline authors(s)/contributor(s): Yasmin Ahmad, OECD; Elena Bernaldo de Quiros, OECD

Custodian agency(ies): OECD

Indicator 3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis

Custodian agency(ies): WHO

Target 3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

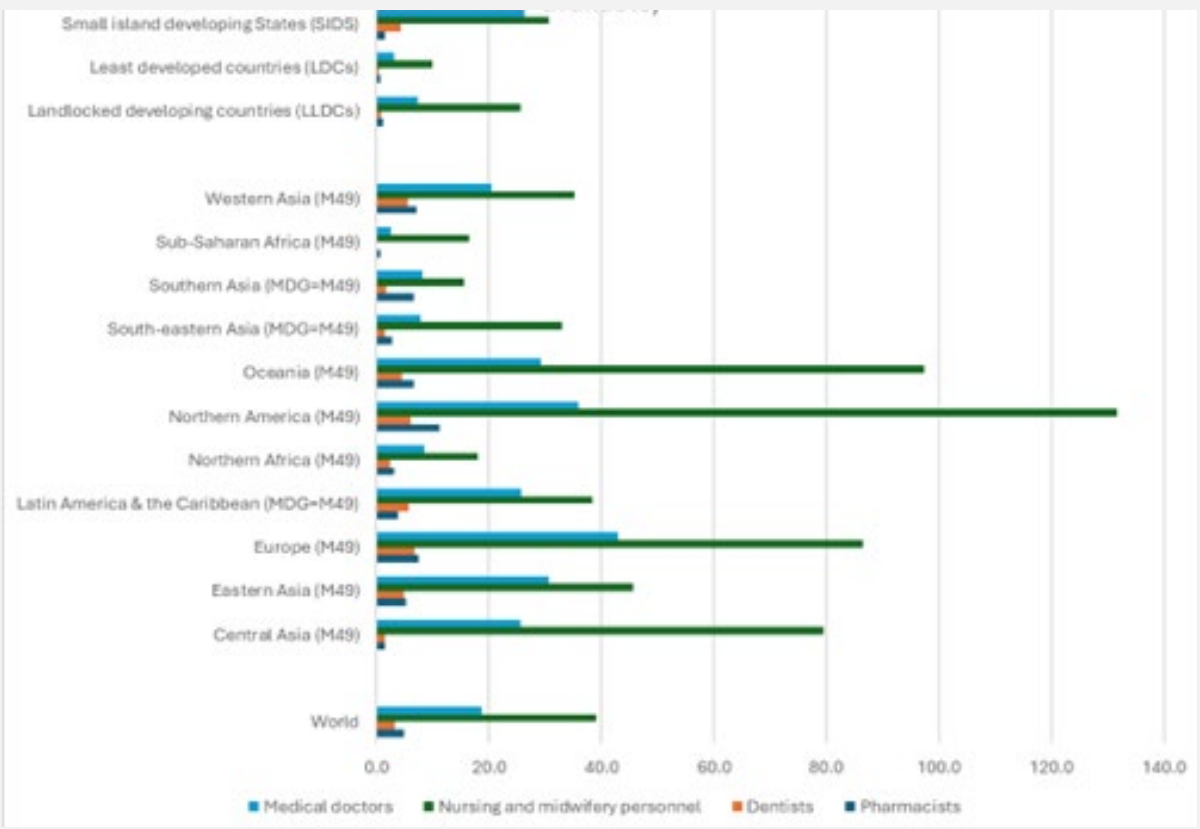
Indicator 3.c.1 Health worker density and distribution

Health worker shortage in 2030 estimated at 11.1 million

Most countries face major challenges to ensure that their health and social systems are ready to address ageing population needs. While a recent study shows that the projected global shortage of health workers by 2030 has been reduced from 18 million to 10 million, catering for the increased needs of the ageing population serviced by an ageing workforce further widens the shortage gap. An estimated additional 1.8 million health workers are needed in fifty-four countries (mostly from high-income countries) just to maintain the age-standardized density of health workers, as they would not be able to compensate for the retirement of health workers by employment of young health workers.

One of regions with the highest disease burden continues to have the lowest proportion of health workers to deliver health services. Between 2014 and 2021, sub-Saharan Africa had the lowest health worker density, with only 2.3 medical doctors, 11.6 nursing and midwifery personnel and less than 1 for both dentists and pharmacists per 10,000 population. In contrast, Europe had the highest density for doctors, at 40.4 per 10,000 population, while Northern America had the most nursing and midwifery personnel, with 117.2 per 10,000 population.

Density of select health professionals per 10,000 population, (latest available)



Additional resources, press releases, etc. with links:

- National health workforce accounts data portal [online database]. Geneva: World Health Organization https://apps.who.int/nhwaportal https://apps.who.int/gb/ebwha/pdf_files/EB156/B156_15-en.pdf

Storyline authors(s)/contributor(s): WHO

Custodian agency(ies): WHO

Target 3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

Indicator 3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness

Custodian agency(ies): WHO

Indicator 3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms

Laboratory testing coverage impact on the assessment of SDG antimicrobial resistance indicator

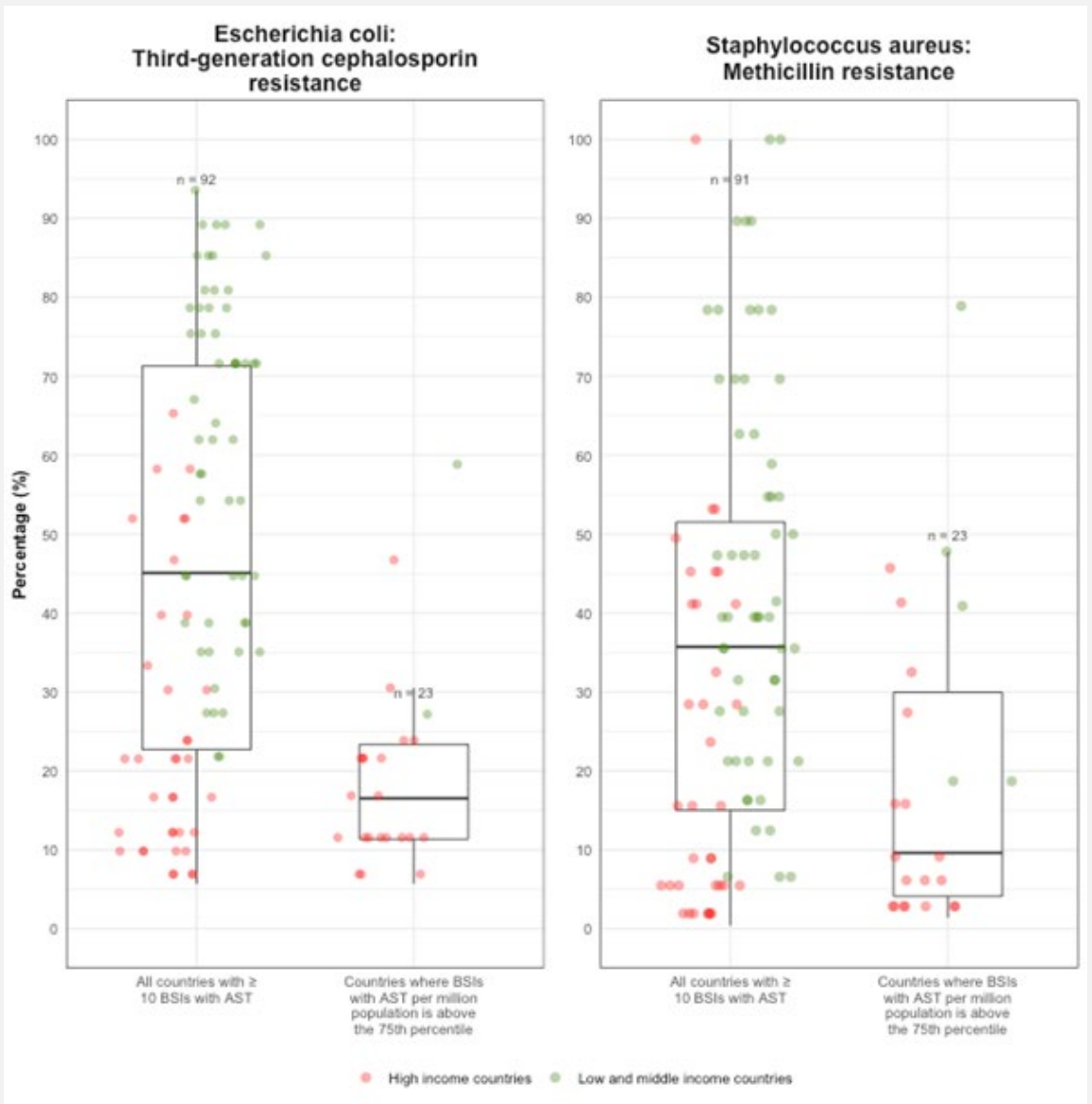
Global surveillance of antimicrobial resistance (AMR) is critical and forms the basis of country-level action and international cooperation on preventing and mitigating a top global health threat. Such information must build upon nationally representative prevalence estimates obtained using standardised methods. The SDG indicator on AMR (3.d.2) monitors the proportion of bloodstream infections (BSIs) due to *Escherichia coli* resistant to third-generation cephalosporins and methicillin-resistant *Staphylococcus aureus* (MRSA). This indicator is considered a building block to help drive the establishment of national AMR programmes for monitoring and tracking the impact of interventions.

Considering settings reporting at least 10 BSIs with antimicrobial susceptibility test results (AST) in 2023, the median proportion of BSIs due to *E. coli* resistant to third-generation cephalosporins in 92 countries and the median proportion of BSIs due to MRSA in 91 countries are 45.1% (IQR 22.7-71.3) and 35.7% (IQR 15.0-51.5), respectively. These rates are much lower (16.5% [IQR 11.3-23.3] and 9.6% [IQR 4.1-29.9] respectively) in 23 countries with better testing coverage (that is, where the number of BSIs with AST per million population is above the 75th percentile). See Figure 1. Currently, global surveillance of AMR relies on voluntary reporting of AMR data from clinical specimens in selected healthcare facilities, and most low- and middle-income countries present lower testing coverage compared to high-income countries. Consequently, the observations are in part consistent with bias resulting from the convenient selection of healthcare facilities in settings where the capacity for routine surveillance is still nascent. For instance, a convenience sample of referral hospitals and/or financial barriers to laboratory testing may result in selecting the most severely ill patients who may have been exposed to antibiotics previously to laboratory testing.

Although lower resistance in settings with high coverage could be due to potentially better diagnostic practices, more robust health systems to combat AMR, and fewer testing biases, conclusions of any genuine differences in resistance prevalence in settings with less established surveillance networks are limited by the vast differences in surveillance coverage and representativeness.

Complementary surveillance approaches are needed to generate representative data and trends to evaluate and inform the AMR response, especially in low-resource countries with weak routine surveillance.

Percentage resistance to third-generation cephalosporins in E. coli and percentage methicillin resistance in S. aureus in countries reporting ≥10 BSIs with AST results compared to countries where the reported numbers per million population were above the 75th percentile in 2023



Custodian agency(ies): WHO